Shining a little light

In this second column on pre-reg matters, **Neil Constantine-Smith** looks at two competencies that should be achieved early on but their apparent simplicity can trip up some students.

5.3 The ability to assess the tear film

This competency is an 'ability to…' so requires DO or PR evidence (see Table 1 for key to abbreviations used by the College for evidence type). Although it doesn't actually specify the assessment of a poor tear film, details for a patient with dry eye would allow much more scope to show off knowledge. I would find it hard to believe that in even just a week of testing that a pre-reg wouldn't encounter at least one patient with dry eye symptoms.

If gritty, sore or mild foreign-body sensations are elicited during symptom-taking then this should be the cue for a student to take full measures to ensure a fully documented record is created that can be used for PR evidence. Remember also to annotate the record in the log book.

So the best evidence for competency 5.3 would be a full PR including specific symptom-taking, investigation and final conclusion and management with advice to the patient. Although management and history-taking is not explicit in the competency it means that the record can also be used to evidence competencies 6.1 'The ability to interpret and investigate the presenting symptoms of the patient' and 6.2 'The ability to develop a management plan for the investigation of a patient'. It also should impress the assessor by showing the pre-reg was fully switched on to what needed to be done for the patient.

I would expect symptom-taking to include questions about duration, onset, severity, which eye and accompanying symptoms eg red eye, blurry vision. There are numerous tear film investigations I would not expect to be available in most practices eg tearscope, lissamine green or Schirmer strips. Observations that could be carried out in all practices would include slit-lamp examination of the tear quality, tear prism evaluation and use of fluorescein to assess staining and tear break-up time. It should go without saying (although after a while as an assessor nothing surprises you) that it is important to know what 'normal' versus abnormal results for each test would look like. This can all be told to the assessor while explaining the PR. If a PR was used for a patient with a 'normal' tear film then the assessor would almost certainly need to ask further questions (Q) or offer case scenarios (CS) to ensure the student knew what they were looking for. A good PR with explanation should avoid the need for this.

Finally, few people would argue that it would be impossible to complete an adequate tear film assessment without good slit-lamp skills, so achieving this competency would be dependent also on passing 5.5 'The ability to use a slit lamp'.

It is worth noting that this competency is also specifically assessed at Stage 2, the assessor instructing the student to conduct a tear film assessment as part of their contact lens aftercare routine.

TABLE 1
Key to abbreviations

- **DO** Direct observation by assessor of patient episode
- **PR** Examples of patient records
- **Log** Log book signed by supervisor, ophthalmologist or hospital optometrist
- **WT** Witness testimony
- **CS** Case scenarios provided by assessor
- **Q** Questioning by assessor
- **FP** Field plots
- **I** Images provided by assessor
- **K** Keratometry readings taken
- **PI** Prescription Interpretation
- **RL** Referral letter
- **V** Verification of supplied spectacles

Pupil defects can show up life-threatening conditions

5.4 The ability to assess pupil reactions

This is another 'Ability to…' competency that requires DO and PR evidence and again a PR of a pupil anomaly is much more use than a 'normal'.

The two essential elements for this competency are a good technique and a knowledge of the reasons for pupil anomalies with required management. In my experience, pre-reg optometrists most often let themselves down by poor knowledge of pupil pathways. This is one of a relatively few competencies that if not evidenced could result in an optometrist being unsafe. Pupil defects can show up life-threatening conditions so the student needs to know, for example, the possible reasons for a RAPD, the difference in an efferent and afferent defect, what the Edinger-Westphal nucleus is and, most importantly, what needs to be referred and what doesn't.

Good technique should include dimming the room lights, holding the pen-torch from the side or below to avoid stimulating accommodation and proper timing of the duration of illumination. However, the best technique observed in an eye exam and a host of PRs recording 'PERLLA, no RAPD, DCN normal' are not really enough for an examiner to alone accept a student as competent here. It may show you can shine a light at an eye and write good records but doesn't show real 'assessment' of the pupils. CS or Q may be required unless this can be covered in an interesting PR, or even WT if pathology related pupil problems are seen while on hospital visits.

The recurring message of this column is going to be: show evidence of interesting stuff that shows off your knowledge and ability, not the dull norm that opens up a whole can of question worms in which an assessor can go off in any direction.

After two relatively straightforward competencies, next month we will tackle binocular vision, a subject that unfortunately seems to strike fear into even qualified optometrists.

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