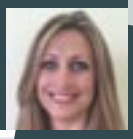


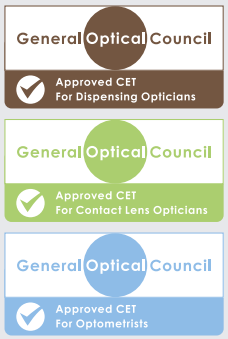
COMPETENCIES COVERED

DISPENSING OPTICIANS
Communication, Standards of Practice, Ocular Examination, Ocular Abnormalities

CONTACT LENS OPTICIANS
Communication, Standards of Practice, Ocular Examination

OPTOMETRISTS
Communication, Standards of Practice, Ocular Disease

This CET has been approved for 1 point by the GOC. It is open to all FBDO members, and associate member optometrists. The multiple-choice questions (MCQs) for this month's CET are available **online only**, to comply with the GOC's Good Practice Guidance for this type of CET. Insert your answers to the six MCQs online at www.abdo.org.uk. After member login, go into the secure membership portal and CET Online will be found on the L menu. **Questions will be presented in random order**. Please ensure that your email address and GOC number are up-to-date. The pass mark is 60 per cent. The answers will appear in the July 2020 issue of Dispensing Optics. The closing date is 10 June 2020.



C-74109 Approved for 1 CET Point

Triaging: reassurance, CLO, optometrist or ophthalmologist?

By Suzanne Dunn FBDO (Hons) CL

You wake up in the morning with a red eye; it's sore and gritty. What would you do? Would you visit the pharmacist for some advice? Or head to your General Practitioner (GP) so they could investigate the cause? Or would you go to eye casualty because it is red? How about your local opticians? Whilst the latter may seem the obvious choice, the first port of call for more than a quarter of patients with an ocular issue is to visit the GP[1].

It is well established that there is increased pressure on the National Health Service (NHS) as demand increases annually[2] and the demand on the Hospital Eye Service (HES) has increased by eight per cent in the last two years[3]. The prevalence of eye conditions increases with advancing age, and the population is still growing. People are also living longer. The demand for eyecare is following an upwards curve and, consequently, it is more important than ever for patients to understand who else and where else is available to provide ocular medical help.

Approximately one million bottles of chloramphenicol are sold over the counter in UK pharmacists yearly[2] and two per cent of GP consultations are eye related[4]. Furthermore, eight to nine per cent of all NHS outpatient attendances are from ophthalmology[5,6] – with approximately 30 per cent of these being non-emergency conditions that could be managed elsewhere[6]. This suggests that patients are unaware of where to turn for ocular help.

There is no charge for the above services, however, attending a High Street optical practice is likely to incur a charge for investigating an ocular issue, depending on the region. What is important is a referral pathway and a triage protocol to reduce the number of HES visits and to encourage more patients into primary eyecare.

WHAT IS TRIAGE?

Triage is defined as a process to assess and determine the severity of a patient's symptoms and then classify them according to urgency. In ocular cases, treating a patient is classified into immediate treatment, urgent treatment, referring them to be seen 'soon' or routinely. The urgency of their treatment will depend on their presenting signs, and the symptoms they are experiencing. However, patients do not often describe their symptoms in the way a practitioner may like to hear them, which can make it more difficult to assess the root of the problem. They will attempt to explain the situation in layman's terms and if worried about the outcome of their sight, an efficient triage may be more difficult.

Eyecare practitioners' roles, and the way in which triage within the eyecare system occurs, is changing. Previously, a patient would attend an optical practice for an eye examination, or the GP surgery, and if any ocular abnormality was observed, they would be referred to an ophthalmologist at the hospital for further investigation. The General Optical Council (GOC) re-issued rules relating to injury and disease of the eye[7] allowing optometrists to manage certain

conditions themselves if it is within their scope to do so, hence reducing the number of unnecessary referrals.

Depending on the postcode, the triage system allows for self-referral, between optometrist colleagues, to contact lens opticians (CLOs) and direct to ophthalmologists. With the introduction of minor eye conditions services (MECS) more patients can be seen in a primary care setting without a charge.

WHY IS THERE A NEED TO TRIAGE?

Triage directs the patient to the most appropriate source of help, quickly and efficiently. In an emergency, this is required as delays in waiting to see the practitioner can have adverse effects on the patient. Not all triage is an emergency but may be required soon – or with urgency. Triaging within a primary eyecare setting is more cost-effective and more efficient in terms of clinic capacity. Furthermore, patients are seen more rapidly and often in locations that are convenient.

GPs (for the most part) are not experts in eyecare and do not always have the necessary equipment and specialist knowledge to investigate ocular conditions, hence further referral. Similarly, whilst pharmacists have an extensive knowledgeable background, eyes are not a speciality.

In an optical practice setting, a patient enters to make an appointment. Before booking the appointment in the most appropriate clinic, a series of questions must be asked of the patient to understand their needs and requirements. Is it a routine eye examination? Are they having any issues with their sight? Are they experiencing any issues that are not affecting their sight? Do they wear contact lenses? Are they entitled to an NHS sight test or is it private?

The General Ophthalmic Services (GOS)[8] will only pay for a sight test when it is due and only if it is clinically necessary. If a patient attends who is not due a sight test for another 12 months but is complaining of floaters, a 'sight test' is not required. A sight test is to determine whether there is any sight defect and, if so, how this may be corrected with an optical appliance. Therefore, if a patient attends with symptoms, and is not due for a sight test, but they have no visual disturbance, then a sight test is not required.

Establishing patients' needs is why triaging is important. In this scenario, an appointment for an eye health examination is required, whereby refraction is omitted from the examination. This was known as an enhanced service, but is now called a primary eye care service (PECS), which is an add-on to the eye examination[5]. A PECS is delivered in optical practices and precedes referral decisions. The urgency of said appointment is based on the patient's symptoms, and how this triage is conducted depends on the postcode.

Triaging also helps with clinic capacity. The result of 'squeezing' all patients complaining of an eye issue into the clinic is poor patient care and management; not just for the patients being added in, but for those patients already in the clinic. Practitioners are left feeling under pressure as they are unable to dedicate the amount of time and care required to each patient, even those who are booked in routinely. Clinics are delayed, which impacts on the service received by routine patients too.

In a non-hospital, private High Street practice, this also impacts on the business and the service the staff are able to provide to those patients seeking routine eye examinations, contact lens aftercare and spectacle dispensing. This further highlights the need to triage appropriately as many cases may be suitable to wait for 48 hours for examination, and may be triaged elsewhere within the PECS.

WHO WILL TRIAGE?

As already established, the demand on HES is increasing, in some regions by seven to 10 per cent within five years[4], so sourcing this elsewhere will help. The NHS works with local clinical commissioning groups (CCGs) which decide what hospital and community services are required in the local regions they are responsible for, and then provide them. However, this is very much a postcode lottery and the type of service provided depends on where you live.

According to the NHS, an ophthalmologist is a doctor that specialises in eyecare medically and surgically[9]. As eye surgeons, they attempt the prevention of eye injury and eye disease. Is an ophthalmologist the best practitioner to triage? Since they are specialists in their field, perhaps it is more vital for them to focus their attention on the referrals they are specialised in, as opposed to cases of red eye that can be triaged and managed in a PECS.

Ophthalmologists have a different skillset to optometrists and these skills may be put to better use to help reduce waiting times for surgery or other treatments that only they can perform. However, some CCGs also commission a community ophthalmology service (COS) where patients are assessed and managed when eye conditions are at low risk of deterioration, and when discharged from secondary care for monitoring. In this respect, this type of scheme is valuable because ophthalmologists are the right people to perform this and can do so outside of the hospital environment.

Optometrists are now better equipped with the investment of optical coherence tomography machines, anterior segment and fundus cameras, and higher quality visual field analysers, which can deliver earlier diagnoses. Optometrists are trained to recognise abnormalities in the eyes and with participating local schemes – such as MECS, primary eyecare assessment and referral services (PEARS) and glaucoma repeat measures – patients are offered more convenient locations with a reduced waiting time if triaged within primary eyecare. Additional qualifications including independent prescribing (IP) are on offer for optometrists and this, alongside other specialisms in glaucoma, low vision and medical retina, further serve to support PECS.

August 2018 saw the first intake of CLO MECS assessments. With slit lamp skills and advanced anterior eye knowledge, referrals and triage can also be directed to them. CLOs are resources that perhaps are not used as frequently as they could be, and GPs and pharmacists, and even optometrist colleagues, should make more use of them. With presenting symptoms that include redness, pain, itching and dry eye, an anterior eye specialist is not one to be forgotten.

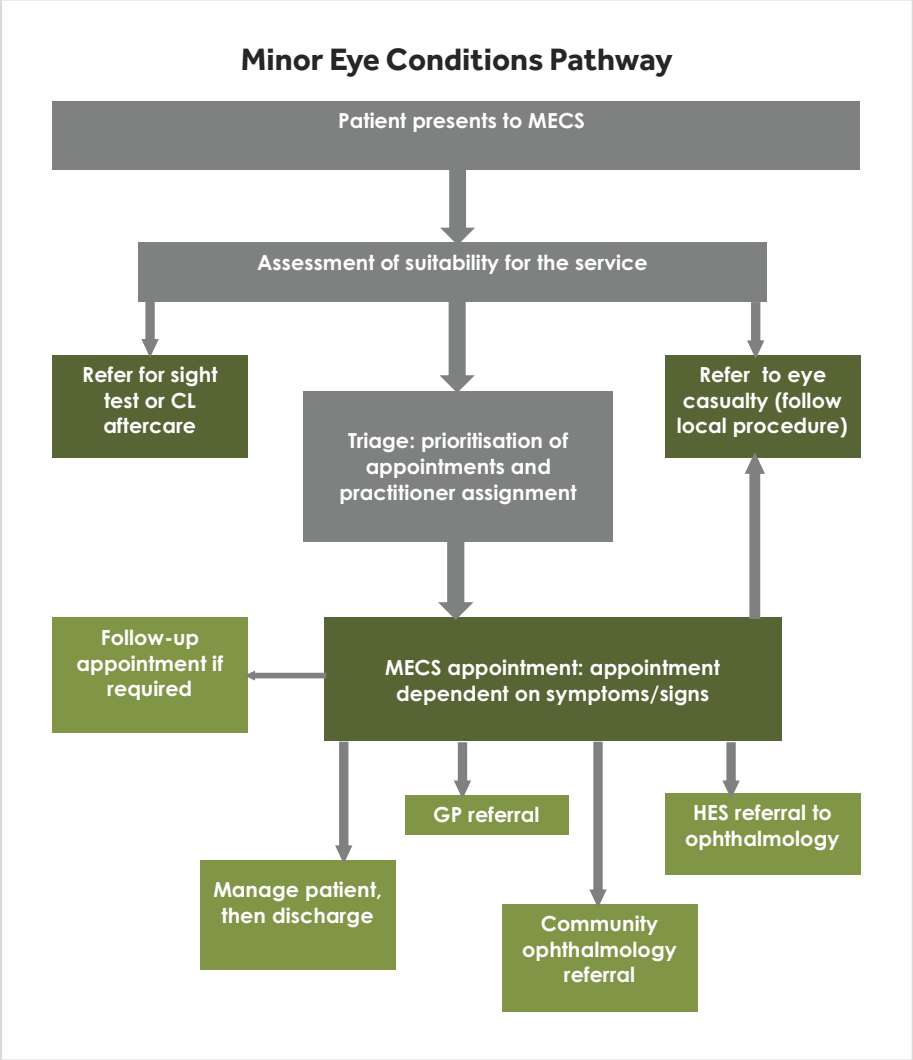


Figure 1. LOCSU's suggested MECS pathway (Pathway ©LOCSU with permission)

According to the Royal College of Ophthalmologists[4], the use of a slit lamp is fundamental in diagnosing most urgent ocular conditions. Many GPs (those with an interest in ophthalmology excepted) will not ordinarily use a slit lamp, and those who do may not necessarily possess the expertise a CLO or optometrist does.

The resultant diagnosis for the majority of patients who self-refer to their GP with an ocular issue is anterior segment related[4], hence further suggesting that a CLO would be competent in triaging. It can be argued that patients would be assessed more effectively and monitored more efficiently by an expert – as opposed to waiting longer if visiting their GP.

Dispensing opticians (DOs) are also a vital resource that should be utilised for triage. The role of the DO in respect of low vision patients should not be forgotten as they are qualified to fit and dispense low vision aids. We should not be remiss regarding triage in a PECS as this is likely to increase with the ageing population. Skill enhancement in low vision is available as an extra course through ABDO, and an increased uptake in specialising in contact lenses would encourage triaging in this sector more so.

HOW IS TRIAGE COMMENCED?

The three main objectives from conducting the triage are to: determine the chief complaint; assess the severity; and follow protocol. The first step is difficult as the patient will rarely supply just one main issue. When describing their ocular complaint, a variety of signs and symptoms will follow suit and therefore the person triaging must decipher the primary concern.

In doing so, assessing the severity must encompass the chief concern in corporation with the other signs and symptoms as these will often determine the potential diagnosis. This will determine what protocol is followed: should the patient be assessed immediately or booked routinely. Where should they be triaged or referred?

The PEARS model is an enhanced services contract whereby patients either self-refer or are directed via their GP. It offers a triage service where patients can be assessed and monitored, as opposed to referring via a GP and into the HES. In a practice setting, optometrists can detect – and in a lot of cases manage – ocular conditions. This not only serves to be time efficient for patients but also reduces the numbers who have to be triaged elsewhere. This is also advantageous over GPs who may lack the equipment, skills and experience in comparison to optometrists who have the expertise in this field.

MECS was commissioned by the Local Optical Committee Support Unit (LOCSU) as a pathway to triage, manage and prioritise patients in primary eyecare (**Figure 1**)[10]. The aim of this service is to examine patients within the primary

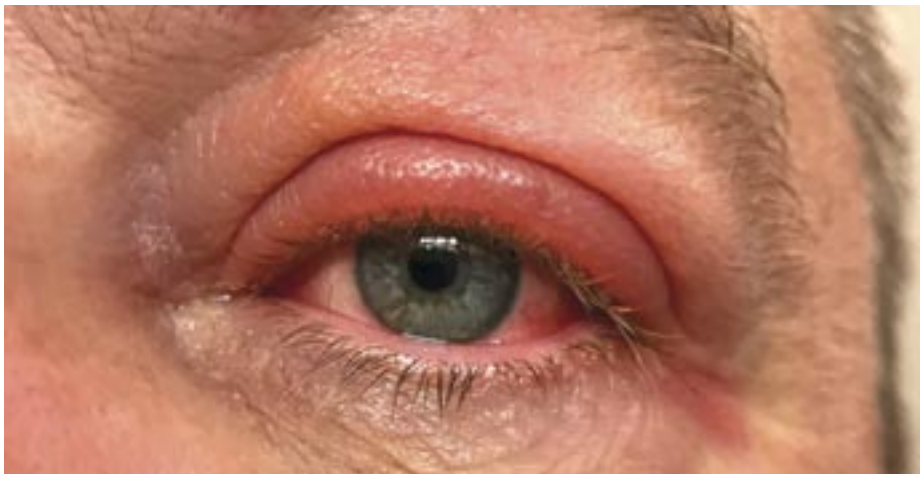


Figure 2. To refer or not to refer?

eyecare setting to reduce the number of referrals to the HES. Such schemes, where available, have been found to be clinically effective, produce high patient satisfaction, trust from GPs and cost savings[6].

The most common attendances of symptoms include flashes and floaters, red eye and painful eye. Many ocular conditions with symptoms of red eyes can be managed in a PECS, depending on the other accompanying symptoms. For example, red eye (**Figure 2**) could indicate conjunctivitis, or another condition which does not need to be seen at eye casualty, or even at the GP. Increasing patient awareness of optician-led services and their specialisms is important for accurate triage.

MECS is unavailable in some regions, which impacts on care and costs as patients are required to wait longer for an appointment if there is no PECS. However, there is a private MECS service available whereby patients can be seen sooner for a fee. Visiting a private optician for a MECS appointment will vary in cost; this is often a barrier to attending, which could have consequences.

If patients are not able to, or do not want to pay for the service, they will either do without the eyecare (which could be sight-threatening) or attend eye casualty and have to wait, which as previously mentioned can impact on other cases. Consequently, the vicious circle continues whereby patients attend their GP surgeries or pharmacists for advice instead. The burden on GP surgeries of potentially unnecessary appointments will continue to increase, and whilst pharmacists are a source of help and guidance and can advise on the level of urgency of an ocular condition, they do not have the use of a slit lamp or other optical equipment for confirmation.

Research indicates that regions with a MECS scheme helps to reduce waiting times and avoid unnecessary referrals to the HES[6]. Since the GOC 'Rules relating to injury or disease of the eye'[7] has removed the referral obligation if it is deemed not needed and can be managed in practice, practitioners can refer to other 'specialists' in the community who have undergone further qualifications to manage some conditions.

If patients were more aware of these services, eye casualty would be able to manage its department more effectively as opposed to managing approximately 30 per cent of non-emergency conditions that could be managed within the community instead[6]. Additionally, appointment waiting times at GP surgeries for more serious issues could be reduced.

The triage process does differ depending on postcode and this can make it difficult for both practitioners and patients. The author practices in a region whereby patients live between two CCGs and there is no MECS scheme available. Therefore, if a patient attends for an eye examination and requires a referral, optometrists must refer everything through the patient's GP, unless it is an emergency. However, in the next postcode along, a rapid access clinic exists whereby patients have easier access to care and will possibly be assessed sooner.

RED FLAGS: REFER IMMEDIATELY TO LOCAL EYE CASUALTY ACCORDING TO YOUR LOCAL PATHWAY
Veil or curtain coming across the eye which does not go away (often preceded by an increase in floaters or flashing lights). Suspect retinal detachment.
Sudden onset painful (not gritty) eye. Suspect corneal abrasion or foreign body, acute glaucoma, scleritis or iritis.
Contact lens wearer with a painful red eye that does not resolve on contact lens removal. See optometrist the same day if available. If not available, refer to eye casualty. Suspect microbial keratitis.
Sudden onset pain and blurry/misty vision. Suspect acute glaucoma or iritis (however, see **Figure 3**)
Sudden unilateral painless loss of vision. Suspect vascular event of the retina or optic nerve.
Chemical burn: ocular first aid by washing eye and surrounding area immediately with saline if available or water. Then refer to eye casualty.
Trauma (blunt or penetrating) – refer immediately to eye casualty.

Table1: Emergency eye triage protocol by the College of Optometrists[11]

SIGNS AND SYMPTOMS

The presence of specific signs and symptoms will indicate the severity of the ocular issue and dictate the next step regarding the urgency of the referral. Generally, an immediate referral is within 24 hours, an urgent referral is within one week and a routine referral is in turn. There are 'red flags' that indicate an immediate referral, although it is best practice to follow local pathways for eye casualty. According to the College of Optometrists[11], the conditions in **Table 1** should be referred to eye casualty immediately.

An ocular emergency is a condition with a sudden onset and would typically be considered as such if the following symptoms occur: loss of vision trauma, red eye, severe eye pain, flashes and floaters and headaches. Conditions that could result from these symptoms include orbital cellulitis, sudden vision loss, chemical or penetrating injury and acute glaucoma and may be considered as true ocular emergencies.

Patients describing these symptoms require an immediate referral to an optometrist or ophthalmologist at eye casualty for further investigation. An immediate referral should be seen within 24 hours if there are signs and symptoms suggestive of the conditions in **Table 1**.

There are ocular conditions that require further investigation urgently, but not necessarily immediately, which is usually within three to seven days. This system varies regionally and the College of Optometrists recommends familiarisation with protocols and referral pathways in local CCGs.

Distinguishing between immediate and urgent care is difficult due to the presenting symptoms of the patient. A recent onset (rather than sudden) of distortion on straight lines, or a gritty red

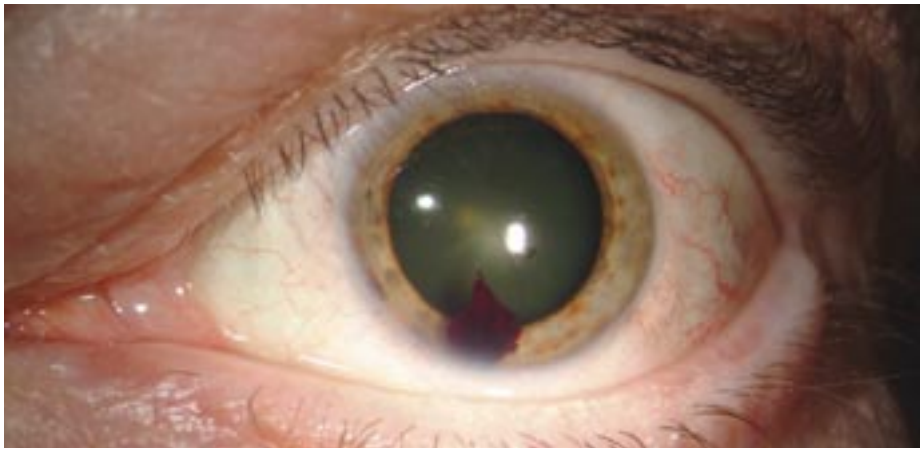


Figure 3. Although hyphema usually occurs due to trauma or infection, it can also occur spontaneously in patients using strong blood thinners or with hemolytic conditions. The patient above had hyphema secondary to warfarin use

eye with discharge, are not immediate emergencies. However, they should be investigated with some urgency. Similarly, a monocular red eye but without pain or any effect on vision, should be examined with urgency but not necessarily immediately.

Anterior segment conditions such as dry eye, watery eyes, lid lumps and foreign body sensations are all irritable for a patient, however, they are classified as non-emergency conditions. These should ideally be seen within a PECS and monitored within that setting as opposed to eye casualty. Patients will often present complaining of gritty, sore, watery eyes, itchy eyes or tired eyes. Any slow change in vision (usually over weeks or months) usually suggests a refractive change or cataract and a routine eye examination is required.

SUMMARY

In summary, triage should divert patients to an appropriate service and determine the level of urgency. Doing so helps to keep the right people available to assess those patients who need them most. Practitioner education and training are vital in deciding what and when to refer, and whilst DOs are not expected to make a definitive diagnosis, awareness of when specialist help is required – and for which conditions – is important.

As practitioners, an over-riding factor for when to triage or not to triage is to always act in the best interests of the patient. Furthermore, proactively advertising and raising awareness of triage services to patients will help direct them to the most appropriate source of help.

Each year, ocular conditions account for five million GP consultations and 270,000 A&E attendances[3]. The capacity pressure on the NHS is ever-increasing, and triaging within the community is an important step in helping to significantly reduce the number of hospital 'emergency' visits, impacting on efficiency in terms of time, costs and patient experience.

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