Acute eyecare and the DO
Q&A responses by
Max Halford and Shabana Younas

1 Should there be separate training for the dispensing optician for Acute eyecare issues for those not necessarily wanting to be a contact lens Optician?

It can be difficult to diagnose pathological conditions without the use of a slit lamp and other examinations which Dispensing Opticians may not be able to perform or have access to. However, as registered professionals we have a duty of care and are qualified to recognise signs/symptoms associated with ocular conditions. It is important to try to keep your knowledge and skills up to date with relevant CPD and other training available but do work within your scope of practice. Work with professional colleagues to consolidate and maintain theoretical knowledge which will be crucial when managing patient conditions.

2 What is the most common acute eye condition that is likely to be encountered?

Subconjunctival haemorrhage (SCH) are very common presentations – they look quite frightening for patients and therefore they do tend to contact their ECP. Details of this condition are included in our "A-Z of common eye conditions on the ABDO website- https://www.abdo.org.uk/dashboard/clinical-hub/a-z-of-common-eye-conditions/sub-conjunctival-haemorrhage/

3 What is a good electronic Triage system?

Key features of a good triage system be it electronic or paper- based is that it is easy to use, accessible when required, can be kept as part of the patients records and most importantly signposts the patient to the correct care in a safe and timely manner

4 Do practices keep chloramphenicol in their practices? I have never worked in a practice which have them on site.

Some practices may do, and this will vary, possibly dependant on whether you have a MECS clinic running within your practice.

5 Although we can recommend chloramphenicol. How would you go about prescribing it?

Dispensing opticians can supply chloramphenicol under certain conditions- details are at https://www.abdo.org.uk/regulation-and-policy/advice-and-guidelines/clinical/use-and-supply-of-drugs/

6 When prescribing topical antibiotics as a DO how should that be done?

DO's can prescribe chloramphenicol- please see details at https://www.abdo.org.uk/regulation-and-policy/advice-and-guidelines/clinical/use-and-supply-of-drugs/

7 What's the easiest way to deal with a sub conjunctival haemorrhage? I always think people are very alarmed by the sight of one.

The appearance of a sub conjunctival haemorrhage can be alarming due to the 'redness'. The most important factor is to rule out an orbital fracture so you must check if the posterior border of the haemorrhage is visible. Ask the patient about any trauma or head injuries. If there are no signs of an orbital fracture, reassure the patient that the condition is self-limiting but can take 1-2 weeks. Ocular lubricants can be advised but usually not needed and do communicate that the patient should return if there is no improvement.

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8 A person enters the practice presenting with what you know to be an urgent eye condition. The person has never been to your practice before, and you know that you don't have an appointment to see an optometrist within the safe time frame. Do you take all the persons details creating a record for them and then triaging them when you know at the end of it you are sending them elsewhere. Would it be appropriate to give this person verbal signpost to another practice?

As registrants, Dispensing Opticians must abide and conform to the standards of practice. This includes maintaining adequate patient records which must show consent obtained for a referral. Recording details of advice given is strongly advised and can be referred to at a later date by other clinicians if needed. However, if you can signpost patients directly into other services or pathways in your area then local protocols should be followed.

9 Is there further courses or anything we could do to get better at our diagnosis of acute eyecare?

We hope to have CPD coming in this new cycle on acute eyecare

10 For acute onset anterior eye conditions, do you as contact lens opticians feel comfortable taking the initial referral?

Referrals should be made to the appropriate clinician who is qualified to help. If the management of acute eye conditions is within your scope of practice i.e. you have the Extended Services qualification, then you should be able to help the patient.

11 Could you record VAs uncorrected and corrected at presentation? Alongside any historic information the practice may/may not have alongside the internal referral?

Yes, absolutely if you feel confident to do this and this would be beneficial for the clinician that you are referring to. Include as much detail as possible so that the patient can be treated as quickly as possible.

12 Also, a question about social care in practice. I've seen a patient that was seen by an optometrist for an initial CL assessment. It transpired after some question and reticence from the patient she was struggling with day-to-day life due to care she was giving to her mother. The Optom referred to the GP for a consultation on the viability for occupational health to discuss further options. Is this something a DO can do? I've never seen it done on behalf of a patient by their registered carer.

This is an unusual scenario and possible we are not best placed to comment on this. However, my thoughts are that as eye care professionals we can refer for "eye related" conditions outside of this we can and should be able to offer support and guidance to patients and perhaps in this type of case "sign post" them to the GP.

13 Where does the responsibility lie when you have clearly told the px the urgency of going to the hospital in such cases, but they choose to say things like "I'll go tomorrow" or "I'll go at the weekend" (despite you stressing the urgency)?

This can be difficult – try and explain 'why' they should be seen and what the implications could be if there is a delay. Most patients present at a practice because they want the condition to be managed and treated However, if the patient is reluctant to take your advice and you have recorded the nature of the advice and time and date it was given then, you have maintained your professional responsibility. Remember to always keep a full and accurate record of the visit.

14 What if the optometrist doesn't want to get involved when they seem to think that a DO must do this and that they are out the picture?

Sorry I would need a bit more detail to answer this

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15 Why would Fusidic Acid be prescribed over chloramphenicol for babies?
Both are equally effective for the treatment of bacterial conjunctivitis, however Fucidic acid can be applied twice per day, rather than the more demanding four-hourly regimen required by Chloramphenicol. Fucidic acid appears in a gel-like formulation and persists in the lacrimal fluid and aqueous humour for at least 12 hours. Also because of its viscosity, it makes it easy to administer.

16 If the patient was a baby, only a few weeks or months old. We know she/he has bacterial conjunctivitis. Who is best to see them the DO, Optom or send to their GP.
Chloramphenicol must not be given to a child under 2 years due to boron which can impair fertility in the future. Parents presenting for guidance should be directed to their GP by any ECP

17 Should there be development for separate training for the dispensing optician for acute eyecare issues for those not necessarily wanting to be a contact lens optician?"
See Q1

18 As a DO, what level of care can we provide compared to an extended services practitioner? (Currently a student CL cert practitioner)
Everyone has a duty to provide the best level of care they can to patients, and this will depend on the experience, qualifications and confidence of the individual DO. All DOs are capable of triage and giving patients appropriate A&G and signposting them onwards to other ECPs if the need arises.