



Roles and responsibilities in the secondary level eye care model



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Introduction

In any secondary level eye care clinic, a number of tasks must be completed. In different countries and different settings, different people will carry out these tasks. The manager is responsible for ensuring that all the tasks are covered, that people are carefully selected to perform them, and that staff are supported and managed. The International Centre for Advancement of Rural Eye Care (ICARE), within the L.V. Prasad Eye Institute (LVPEI) in India, has evolved an eye care team to provide secondary level eye care services to a population of 0.5 to 1 million. The ICARE model emphasises that all cadres of clinical and non-clinical personnel are equally important. Below is a description of the range of jobs at secondary level centres. The tertiary centre at LVPEI manages leadership and training for this model.

The model proposed by ICARE works on the assumption that each link in the chain of eye care personnel is important to achieve comprehensive eye care. It is not always necessary to have all the individual eye care personnel described below. It is possible to have 'cross-functioning' especially for non-clinical personnel. What is important is that everyone knows their roles and responsibilities. In the ICARE model, most of the clinical and non-clinical staff are selected from the local communities. We have found that this supports sustainability of services and generates local community employment.

Readers might like to consider the following questions in reading this article:

- who performs these tasks in your unit?
- are there any gaps that you can identify?
- who could be trained to fill those gaps?

Clinical personnel

Ophthalmologist

The ophthalmologist is the pivot around which secondary level eye care services revolve. The objective is to have a 'comprehensive ophthalmologist' and the training for this role equips them to perform high quality extracapsular cataract surgery with posterior chamber IOL implants (standard procedure with sutures, manual small



Members of the eye care team. INDIA



Using a blindfold during a community-based rehabilitation training session. INDIA

incision cataract surgery and phacoemulsification). Regular educational updates and good equipment are provided to ensure high quality outputs. The ophthalmologist is also responsible for clinical quality assurance. Specialised training in planning, implementation, management and evaluation of eye care programmes and services is available to the ophthalmologist or senior clinical/ executive level staff through a six-month

diploma in Community Eye Health.

Ophthalmic technician

The ideal ratio is at least three to four ophthalmic technicians to one ophthalmologist at the service centre level. This person may be a three-

year trained ophthalmic technician or a one-year trained vision technician. At the service centre, the ophthalmic technician takes the patient's history and conducts assessment of visual acuity, refraction, external eye examination, slit lamp biomicroscopy, applanation tonometry, keratometry, A-scan for IOL calculation, and perimetry for visual fields. Additionally, the ophthalmic technician performs screening

and refraction services at the community level. The vision technician is adept in refraction and recognition of problems needing referral, whereas the ophthalmic technician is trained in all diagnostics in addition to refraction. The ophthalmic technicians also participate actively in community screening and school eye screening programmes when required. Together with the ophthalmologist, they act as trainers for clinical and non-clinical staff in the chain below. Currently, at least one ophthalmic technician from each of the secondary eye care centres managed by LVPEI is being trained for the establishment and delivery of low vision services at the secondary eye care levels.

Ophthalmic nurse

Ophthalmic nurses assist the ophthalmologist in surgery, including IOL surgery. They are also trained as ward nurses and cover all aspects of the care of in-patients. About four nurses are ideal for a secondary care eye centre. Most of the training for this category of nurses includes hands-on practical training as they are selected as ophthalmic nurses from the communities they represent without any previous formal nursing training. In our experience, we have found it difficult to find already trained nurses or midwives who are willing to work as ophthalmic nurses in our centres, hence we have adopted this approach. It is an advantage if there is a pool of trained general nurses available for specialised training and employment in eye care.

Operating room technician

The operating room technician is responsible for getting the patient and operating room ready for surgery and for sterilisation techniques. In some cases they also give supervised local anaesthesia before surgery. Ideally, one operating room technician and a cross-skilled ophthalmic nurse are sufficient for a secondary service centre operating room facility.

Non-clinical personnel

Eye care manager

The value of a dedicated manager at secondary level eye care services cannot be overemphasised. Managers coordinate and supervise all non-clinical services. They should be skilled in human resources, material, and financial management and

marketing. We offer training at our facilities for a period of one year to develop an eye care manager. The manager is responsible for ensuring all aspects of patient administration: recruiting patients, assessing them for free or paid care, organising services, counselling for surgery, and maintaining records. They are also responsible for liaising with agencies, managing the finances and ensuring the quality of non-clinical care.

Community eye care (CEC) coordinator

Coordination of various aspects of community-based programmes serves the community in two important ways. First, those requiring eye care in the community have a link with the eye care centre; second, the preventive aspects are addressed at the community level. In addition, this person oversees the delivery of community-based rehabilitation services to the incurably blind in the local communities. The CEC coordinator is responsible for community screening and community-based rehabilitation programmes. The training of the CEC coordinator enables them to carry out screening and awareness programmes at the community level and supervise a team of four to five field workers who deliver primary eye care services. In addition, the CEC coordinator and the field workers are trained in community-based rehabilitation (CBR). They assist and train the nearest of kin of the incurably visually impaired in daily living skills, orientation and mobility, vocational rehabilitation, access to educational opportunities and public assistance. They report to a dedicated administrator for these programmes at ICARE but are locally supervised by the manager of the secondary eye care centre.

Receptionist

The receptionist is the first contact between the patient and the eye care centre. The value of this important role is usually underestimated in India. A well-trained receptionist can contribute significantly to patient satisfaction by showing the patient that they are respected and will be taken care of, which contributes to higher uptake of services and generation of revenue.

Patient counsellor

The role of the patient counsellor is to explain the surgical procedures to patients, to assess the paying ability of each patient, and to advise the appropriate fee-tier for the surgical package in the multi-tier payment for surgery proposed by ICARE. Good patient counsellors can do much to enhance patient satisfaction.

Medical records 'in-charge'

The quality and maintenance of medical records in India, in general, needs much improvement. The medical records 'in-charge' is responsible for accurate filing and retrieval of records. He or she is also responsible for maintaining accurate patient statistics related to diagnosis and treatment.

Stores/supplies 'in-charge'

Lack of timely availability of medical and other supplies in eye care centres contributes to substandard quality of care. The supplies 'in-charge' maintains an inventory of supplies and anticipates the need for further supplies. Based on our experience, ICARE has developed a custom-made system for this function.

Biomedical and maintenance technician

In many eye care facilities in the developing world, equipment often lies unused because of minor technical problems. This equipment includes retinoscope, slit lamp, ophthalmoscope, operating microscope, steriliser, and generator. A dedicated technical person, whose job is to maintain the equipment and rectify minor problems, increases the quality of services. This ensures that the necessary equipment is available most of the time. The function of this person would primarily be 'preventive maintenance' and to seek help when equipment breaks down. This person also looks after the electricity and plumbing aspects of maintenance for the facility.

Optician

In our model, the ophthalmic technicians perform the refractive services whereas an optician does the dispensing. It is important to achieve financial self-sufficiency at an eye care centre by establishing a balance between good quality of services and free services for those who cannot pay. A well-

trained optician can play an important part in helping to achieve financial self-sufficiency. An optical shop in an eye care centre is an excellent source of income, while at the same time increasing patient satisfaction by ensuring that all services are available under a single roof.

Support staff

In addition to these staff, adequate support staff such as cleaners and housekeepers, patient care assistants, security personnel and drivers are key contributors to the secondary level eye care facility. A team of local volunteers or field-based professionals also participate in community outreach activities.

Partner organisations

ICARE has established partnerships, which may be programmes directly run by ICARE or by other local or international organisations. We follow up their performance after training them to assess the impact of their functioning on the quality of services delivered, their financial self-sustainability, and whether the eye care needs of the target population are being met. ICARE has a dedicated central team which includes public health professionals, microbiologists, consultant ophthalmologists, administrators and the director of the institute who monitor the facilities and programmes at least once a quarter. A reporting and information system, partially manual and partially computerised, assists the process of running the programmes.

Key attributes of a good manager



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Good leaders get the maximum cooperation from their staff. Managers should understand what encourages their staff to give their best and what causes disillusionment.



Victoria Francis

Managers encourage the best of their staff by:

- recognising good performance
- being accessible to workers
- delegating responsibility
- building workers' confidence
- promoting self-improvement
- being supportive at times of personal and family problems
- setting objectives in cooperation with health teams.

Disillusionment and frustration are caused by:

- focusing only on weaknesses in performance
- unjust and corrupt practices
- favouritism and nepotism
- poor interpersonal relationships with staff and subordinates
- lack of integrity and honesty
- poor understanding of problems faced by staff
- concentration of all powers with self.