Appendix C: Assessment Framework Documents

A. **Personal Development Plan**
B. **BST Consultant Trainer Report**
C. **CAPA A and B Form for BST**
D. **Workplace Based Assessment sample**

Irish College of Ophthalmologists
Eye Doctors of Ireland, protecting your vision

Basic Specialist Training (BST) Individual Development Plan Yr 1a

To be completed for each six months

Trainee Name:_____Hospital_____

Date entered NTP programme ……/……/……

Consultant Trainer_____

Date:……/……/…….

Specific goals:
Academic: (Examinations, Presentations, Publications, Research, Planned Study Leave)

_____
Clinical:

_____
Surgical – incl laser:

_____

Workplace Based Assessments:
Clinical WBA
1. Mini-CEX: Cataract *or* PVD. Please choose (circle or highlight) one.
To be assessed by Consultant Trainer* Ms / Mr _____ by November 30th 2022.

2. DOPs: Gonioscopy Skills or Fundal Skills. Please choose (circle or highlight) one.
To be assessed by Consultant Trainer* Ms / Mr _____ by November 30th 2022.

Surgical WBA
Modular Phacoemulsification:
To be assessed by Consultant Trainer* Ms / Mr _____ by November 30th 2022.

Discussed and Agreed

Trainer: Trainee: Date:

_____ _____ ___/___/_____

* Where trainees have more than one consultant trainer it must be clear which trainer will carry out which assessment.

Irish College of Ophthalmologists
Eye Doctors of Ireland
Protecting your Vision

Consultant Trainers Report (BST 1-3)

For Completion by Basic Training in Surgical Ophthalmology **Consultant Trainer(s)**
Following completion, forward to Irish College of Ophthalmologists, 121 St Stephen's Green, Dublin 2 (Ph: 01-402 2777)

Trainee Name:		**Hospital, Specialty & Consultant Trainer(s):**			
Programme Year:		**Rotation Start Date:** **Rotation End Date:**		**No. of Leave Days taken during rotation:**	**Annual:**
					Study:
					Sick:
					Other:

- More than one trainer during assessment period: Consensus opinion on the form, signed by all the trainers.
- Place an 'X' in one box against each assessment. "Meets Expectations," means trainee met reasonable expectations but no better or worse than average. Most trainees expected to score "Meets Expectations."
- Trainer should consider the trainees' performance in all domains, i.e. elective work on wards, emergency work (on-call) in the ED, and work in out-patients clinic, operating theatre, specialist areas (e.g. endoscopy).

A. Clinical Skills	**Very poor. Unacceptable for level of training**	**Below expectations for level of training**	**Meets expectations for level of training**	**Above expectations for level of training**	**Exceptional. Capable of performing independently**
1.History Taking	Misses important information, inefficient, disorganised; fails to check findings.		Misses some minor facts but relatively precise, logical, purposeful & efficient.		Precise, logical, purposeful & efficient; skilful at checking findings.
	☐	☐	☐	☐	☐
2.Ophthalmic Examination	Poor technique, inefficient, omits many key elements & signs.		Good technique, reasonably efficient; omits some key elements & signs.		Excellent technique, thorough, efficient; picks up key signs.
	☐	☐	☐	☐	☐
3.Diagnostic Skills & Investigations	Haphazard or inappropriate ordering of diagnostic tests. Frequently fails to diagnose common surgical conditions & complications.		Requires some direction to order appropriate lab & imaging investigations & to diagnose common surgical conditions & complications.		Consistently orders most appropriate lab & imaging investigations. Demonstrates a logical approach to diagnosing common surgical conditions & complications.
	☐	☐	☐	☐	☐
4.Clinical Judgement	Fails to recognise obvious clinical conditions or		Recognises obvious symptom patterns & generally uses an		Recognises symptom patterns, effectively gathers information &

	misjudges severity. Does not use an evidence based approach to make or confirm a diagnosis.		evidence based approach to make or confirm a diagnosis.		takes an evidence based approach to make or confirm a diagnosis.
	☐	☐	☐	☐	☐
5. Surgical Skills	Lacks decision making, technical & forward planning skills.		Demonstrates decision making, technical, & forward planning skills.		Demonstrates exceptional decision making, technical & forward planning skills.
	☐	☐	☐	☐	☐
6. Post-operative Management	Requires constant oversight to ensure completion of operation notes & post-operative orders as well as appropriate post-operative patient management.		Requires some direction to complete operation notes & post-operative orders & to manage post-operative patients. Generally anticipates complications.		Efficiently completes operation notes & post-operative orders. Manages post-operative patients in a conscientious manner & anticipates complications, without prompting.
	☐	☐	☐	☐	☐
7. Follow-Up Planning	Seldom anticipates or communicates patient discharge needs without prompting.		Usually anticipates patient discharge needs & communicates these needs in a timely manner.		Consistently anticipates patient discharge needs & communicates these in a timely manner.
	☐	☐	☐	☐	☐

B. Professional Development	**Very poor. Unacceptable for level of training**	**Below expectations for level of training**	**Meets expectations for level of training**	**Above expectations for level of training**	**Exceptional. Capable of performing independently**
8. Teaching Activities	Avoids teaching, & contributes little to the education of students & interns.		Seldom volunteers to teach but will complete teaching assignments in an effective manner.		Excellent, enthusiastic teacher. Seldom misses an opportunity to teach students or interns.
	☐	☐	☐	☐	☐
9. Clinical Audit	Very little participation in clinical audit.		Participates occasionally in clinical audit.		Participates actively in collection & evaluation of clinical audit data.
	☐	☐	☐	☐	☐
10. Presentations	Presentations are inadequately researched & presented in a haphazard manner.		Presentations are adequately researched & well presented.		Presentations are thoroughly researched & presented in an organized & clear manner.
	☐	☐	☐	☐	☐

11. Research	Does not perform research.		Performs research under direction.		Independently performs research using the literature. Appropriate statistical & research methods.
	☐	☐	☐	☐	☐

C. Personal Skills	**Very poor. Unacceptable for level of training**	**Below expectations for level of training**	**Meets expectations for level of training**	**Above expectations for level of training**	**Exceptional. Capable of performing independently**
12. Communication *Especially relating to elderly patients or paediatric patients*	Explanations to patients are often incorrect, confusing. Often treats nurses & colleagues with disdain & has generated a number of complaints.		Good rapport with most patients & usually answers questions clearly. Communicates & works well with nursing staff & colleagues.		Excellent patient rapport, answers patient's questions clearly & accurately. Treats nursing staff & colleagues with respect & is respected in turn.
	☐	☐	☐	☐	☐

13. Teamwork & Leadership *Managing rotas & clinic numbers. Assisting team when manpower is reduced. Contributes to team morale, is collegial*	Poor team player; works alone, does not support or assist colleagues even when numbers reduced. Very limited leadership ability. Poor management of rotas, surgical lists.		Good team player, but average leader. Demonstrates excellence in some leadership skills but not others. Manages rotas, surgical lists well but doesn't always identify or flag problems / issues in advance. Assists team when numbers reduced.		Works well with team members; offers support, coaching and/or feedback & resolves conflict. Exceptional ability to direct / team activities. Assesses needs, allocates tasks, motivates, organises, & maintains a positive team environment. Identifies and flags issues well in advance.
	☐	☐	☐	☐	☐
14. Self-Awareness & Reliability	Little or no understanding of own limitations or deficiencies & does not respond to feedback. No inclination to organize work, needs to be pushed constantly, Sloppy in appearance & work manner.		Demonstrates some insight into strengths & weaknesses & generally responds well to feedback. Does not seek opportunities to learn but accepts these when offered. Generally presents himself/ herself-in a professional manner.		Recognises own deficiencies & makes appropriate changes. Responds well to feedback. Actively seeks opportunities to advance. Presents himself/ herself in a professional manner at all times.
	☐	☐	☐	☐	☐

15. Management & Organization	Constantly disorganised, does not identify priorities, always behind in tasks. Tends to panic in a crisis & is unable to deal with emergencies. Unreliable, frequently forgets significant patient duties / tasks. Does not seek senior opinion appropriately.		Generally prioritises appropriately & is efficient. Usually calm at time of crises. Occasionally needs to be reminded of duties but generally dependable. Generally seeks second/ senior opinion when appropriate.		Exceptionally well-organized. Identifies priorities & remains calm in a crisis. Is able to deal with emergencies. Reliable & seldom forgets significant patient duties / tasks. Always seeks second/ senior opinion appropriately.
	☐	☐	☐	☐	☐
16. Motivation & Drive	Not actively involved in teaching, misses allocated teaching sessions, does not avail of clinical teaching opportunites, shows poor commitment despite prompting to self-directed learning and keeping abreast of literature. Fails to get involved in opportunites to write up case reports or audit.		Involved in teaching, volunteers to present, rarely misses allocated teaching sessions. Avails of clinical teaching opportunites. Self-directed learning, with occasional priompting, keeping abreast of main RCTs in relevant field. Gets involved in opportunites to write up case reports or audit.		Actively organises teaching and volunteers to present at allocated teaching sessions. Actively avails of clinical teaching opportunites. Strong evidence of unprompted self-directed learning beyond the main RCTs in relevant field. Questions with constant reference to evidence base. Does not miss opportunites to write up case reports or audit.
	☐	☐	☐	☐	☐

B. Relationships	**Very poor. Unacceptable for level of training**	**Below expectations for level of training**	**Meets expectations for level of training**	**Above expectations for level of training**	**Exceptional for level of training**
17. Medical Colleagues					
	☐	☐	☐	☐	☐
18. Nursing and Paramedical Staff					
	☐	☐	☐	☐	☐
19. Patients and Relatives					
	☐	☐	☐	☐	☐

Please identify the specific areas of training that this trainee needs to pay particular attention to in future training posts. *These areas will be specifically addressed by the next consultant trainer(s)*:

Final Assessment:

A. Suited for further training	
B. Successful further training depends on appropriate attention to areas of need highlighted above	

Consultant Trainer(s) Signature(s):

Hospital Stamp

_____

_____

Date: _____

CAPA FORM A: Name of BST 1 – BST3 Surgical Trainee:

_____

1. TIMETABLE: Please fill in the details of your timetable and in-house teaching: Please clearly state the name of the CT and clinical content (gen vs subsp) of the OPD

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
In-house teaching Time: Consultant:	*In-house teaching Time: Consultant:*	*In-house teaching Time: Consultant:*	*In-house teaching Time: Consultant:*	*In-house teaching Time: Consultant:*
AM				
PM				
			NPGT	

***CAPA ASSESSOR**: : COMPLIANT : **YES**_____**NO**_____*

2. NUMBER OF PROCEDURES

Please insert no. of procedures performed in each category. M=modular C= complete.

Category	**Procedure**	**Yr 1a**	**Yr 1b**	**Yr 2a**	**Yr 2b**	**Yr 3a**	**Yr 3b**	**Total**
Minor Sx	I & C of Meibomian cyst							
	Removal of papillomas, cysts,etc.							
	*Entropion/Ectropion	M= C=	M= C=					
	Temporal artery biopsy							
Strabismus	Horizontal muscle procedure							
Cataract	*Phaco-emulsification	M= C=	M= C=					
	Anterior Vitrectomy							
Lacrimal	Lacrimal syringing/probing							
	Punctal surgery							
Trauma	Lid and facial lacerations							
	Corneoscleral / scleral repair							
Laser	YAG Capsulotomy							
	YAG Iridotomy							
	Pan-retinal photocoagulation	M= C=	M= C=					
	Focal treatment							
	Laser to retinal tear							
Injections	Intravitreal							
Refractions**	Adult = A, Paediatric = P							

***CAPA ASSESSOR:** : MEETS MINIMUM CRITERIA: **YES**_____**NO**_____*

CAPA FORM B: Basic Specialist Training CAPA PROCESS
To be completed for each six months

Date: _____

Trainee Name _____Hospital_____ SFS_____HFs_____

Date: _____to_____6 months with_____(Trainer/s)

Aims of Development Plan / Learning Agreement with Trainer

1.
2.

Training Unit

- In-house Teaching_____
- Timetable compliance_____
- RSTA compliant_____
- EWTD compliant_____

Clinical Training

- Supervision and training during: 1.OPD_____2. A/E_____3.On-call_____
  _____
  _____
- WBAs: Aligned with teaching and training? Yes / No
  _____
  _____
- WBA Competence
  - Mcex 1_____
  - Mcex 2_____
  - DOPs 1_____
  - DOPs 2_____

Surgical Training

- Access to Surgical Theatre _____
  _____
- Meets minimum criteria: Phaco_____Lasers_____Lids_____
  _____

Academic

- Exams _____
- Audit_____
- Courses _____
- Presentations, Publications, Research_____

Trainer's assessment:

- Clinical_____
- Surgical_____
- Professional_____

CAPA: SATISFACTORY_____**UNSATISFACTORY**_____Trainee issue / Unit issue
REMEDIATION **Yes** **No**

Date:_____Signed:_____(Appraisor1)_____(Appraisor 2)

Figure 1: Trainer:_____ Trainee_____ Date _____Please note: 'non-applicable' can be used no more than once for each assessment.

ICO-Ophthalmology Surgical Competency Assessment Rubric-Modular Phacoemulsification 1 (ICO-OSCAR:phaco)

	Date _____ Prior training: Surgical Steps 1-5 x 6 cases: Yes No Resident _____ Evaluator _____	Novice (score = 2)	Beginner (score = 3)	Advanced Beginner (score = 4)	Competent (score = 5)	Not applicable. Done by preceptor (score= 0)
1	Draping:	Unable to start draping without help.	Drapes with minimal verbal instruction. Incomplete lash coverage.	Lashes mostly covered, drape at most minimally obstructing view.	Lashes completely covered and clear of incision site, drape not obstructing view.	
2	Incision & Paracentesis: Formation & Technique	Inappropriate incision architecture, location, and size.	Leakage and/or iris prolapse with local pressure, provides poor surgical access to and visibility of capsule and bag.	Incision either well-placed or non-leaking but not both.	Incision parallel to iris, self sealing, adequate size, provides good access for surgical maneuvering.	
3	Viscoelastic: Appropriate Use and Safe Insertion	Unsure of when, what type and how much viscoelastic to use. Has difficulty accessing anterior chamber through paracentesis.	Requires minimal instruction. Knows when to use but administers incorrect amount or type.	Requires no instruction. Uses at appropriate time. Administers adequate amount and type. Cannula tip in good position. Unsure of correct viscoelastic if multiple types available.	Viscoelastics are administered in appropriate amount and at the appropriate time with cannula tip clear of lens capsule and endothelium. Appropriate viscoelastic is used if multiple types of viscoelastics are available.	
4	Lens Insertion, Rotation, and Final Position of Intraocular Lens	Unable to insert IOL, unable to produce adequate incision for implant type **FOLDABLE:** unable to load IOL into injector or forcep, no control of lens injection, doesn't control tip placement, lens is not in the capsular bag or is injected upside down.	Insertion and manipulation of IOL is difficult, eye handled roughly, anterior chamber not stable, repeated attempts result in borderline incision for implant type **FOLDABLE:** difficulty loading IOL into injector or forcep,, hesitant, poor control of lens injection, difficulty controlling tip placement, excessive manipulation required to get both haptics into capsular bag.	Insertion and manipulation of IOL is accomplished with minimal anterior chamber instability, incision just adequate for implant type **FOLDABLE:** , minimal difficulty loading IOL into injector of forcep, hesitant but good control of lens injection, minimal difficulty controlling tip placement, both haptics are in the capsular bag.	Insertion and manipulation of IOL is performed in a deep and stable anterior chamber and capsular bag, with incision appropriate for implant type. **FOLDABLE**: Able to load IOL into injector or forcep, lens is injected in a controlled fashion, fixation of IOL is symmetric; the optic and both haptics are inside the capsular bag.	
5	Wound Closure (Including Suturing, Hydration, and Checking Security as Required)	If suturing is needed, instruction is required and stitches are placed in an awkward, slow fashion with much difficulty, astigmatism, bent needles, incomplete suture rotation and wound leakage may result, unable to remove	If suturing is needed, stitches are placed with some difficulty, resuturing may be needed, questionable wound closure with probable astigmatism, instruction may be needed, questionable whether all viscoelastics are thoroughly removed,	If suturing is needed, stitches are placed with minimal difficulty tight enough to maintain the wound closed, may have slight astigmatism, viscoelastics are adequately removed after this step with some difficulty, The incision is checked	If suturing is needed, stitches are placed tight enough to maintain the wound closed, but not too tight as to induce astigmatism, viscoelastics are thoroughly removed after this step, the incision is checked and is water tight at	

		viscoelastics thoroughly. unable to make incision water tight or does not check wound for seal. Improper final IOP.	Extra maneuvers are required to make the incision water tight at the end of the surgery. May have improper IOP.	and is water tight or needs minimal adjustment at the end of the surgery. May have improper IOP.	the end of the surgery. Proper final IOP.	
1	**Global Indices** Wound Neutrality and minimizing Eye Rolling and Corneal Distortion	Nearly constant eye movement and corneal distortion.	Eye often not in primary position, frequent distortion folds.	Eye usually in primary position, mild corneal distortion folds occur.	The eye is kept in primary position during the surgery. No distortion folds are produced. The length and location of incisions prevents distortion of the cornea.	
2	Eye Positioned Centrally Within Microscope View	Constantly requires repositioning.	Occasional repositioning required.	Mild fluctuation in pupil position.	The pupil is kept centered during the surgery.	
3	Conjunctival and Corneal Tissue Handling	Tissue handling is rough and damage occurs.	Tissue handling borderline, minimal damage occurs.	Tissue handling decent but potential for damage exists.	Tissue is not damaged nor at risk by handling.	
4	Intraocular Spatial Awareness	instruments often in contact with capsule, iris and corneal endothelium' , blunt second hand instrument not kept in appropriate position.	Occasional accidental contact with capsule, iris and corneal endothelium , sometimes has blunt second hand instrument between the posterior capsule and the activated phaco tip.	Rare accidental contact with capsule, iris and corneal endothelium. Often has blunt second hand instrument between the posterior capsule and the activated phaco tip.	No accidental contact with capsule, iris and corneal endothelium , when appropriate, a blunt, second hand instrument, is always kept between the posterior capsule and the tip of the phaco when the phaco is activated.	
5	Iris Protection	Iris constantly at risk, handled roughly.	Iris occasionally at risk. Needs help in deciding when and how to use hooks, ring or other methods of iris protection.	Iris generally well protected. Slight difficulty with iris hooks, ring, or other methods of iris protection.	Iris is uninjured. Iris hooks, ring, or other methods are used as needed to protect the iris.	
6	Overall Speed and Fluidity of Procedure	Hesitant, frequent starts and stops, not at all fluid.	Occasional starts and stops, inefficient and unnecessary manipulations common, case duration about 60 minutes.	Occasional inefficient and/or unnecessary manipulations occur, case duration about 45 minutes.	Inefficient and/or unnecessary manipulations are avoided, case duration is appropriate for case difficulty. In general, 30 minutes should be adequate.	

Please give feedback to the trainee after the assessment has taken place.

Comments: _____

_____

_____

Difficulty of case: Easy Moderate Difficult

Trainee: _____ Date: _____

Trainer: _____ Date: _____

Date _____Trainee: _____ Yr of training :_____ Trainer _____Please note: 'non-applicable' can be used no more than once for each assessment.

ICO-Ophthalmology Surgical Competency Assessment Rubric-Modular Phacoemulsification 2 (ICO-OSCAR:phaco)

Steps 1-9 x 6 cases Yes No Trainer: _____ Trainee:_____		Novice (score = 2)	Beginner (score = 3)	Advanced Beginner (score = 4)	Competent (score = 5)	Not applicable. Done by preceptor (score= 0)
1	Capsulorrhexis: Commencement of Flap & follow-through.	Instruction required, tentative, chases rather than controls rhexis, cortex disruption may occur.	Minimal instruction, predominantly in control with occasional loss of control of rhexis, cortex disruption may occur.	In control, few awkward or repositioning movements, no cortex disruption.	Delicate approach and confident control of the rhexis, no cortex disruption.	
2	Capsulorrhexis: Formation and Circular Completion	Size and position are inadequate for nucleus density & type of implant, tear may occur.	Size and position are barely adequate for nucleus density and implant type, difficulty achieving circular rhexis, tear may occur.	Size and position are almost exact for nucleus density and implant type, shows control, requires only minimal instruction.	Adequate size and position for nucleus density & type of implant, no tears, rapid, unaided control of radialization, maintains control of the flap and AC depth throughout the capsulorrhexis.	
3	Hydrodissection: Visible Fluid Wave and Free Nuclear Rotation	Hydrodissection fluid not injected in quantity nor place to achieve nucleus rotation.	Multiple attempts required, able to rotate nucleus somewhat but not completely. Tries to manually force rotation before adequate hydrodissection.	Fluid injected in appropriate location, able to rotate nucleus but encounters more than minimal resistance.	Ideally see free fluid wave but adequate if free nuclear rotation with minimal resistance is achieved. Aware of contraindications to hydrodissection.	
4	Phacoemulsification Probe and Second Instrument: Insertion Into Eye	Has great difficulty inserting the probe or second instrument, AC collapses, may damage wound, capsule or Descemet's membrane	Inserts the probe or second instrument after some failed attempts, may damage wound, capsule or Descemet's membrane.	Inserts probe and second instrument on first attempt with mild difficulty, no damage to wound, capsule or Descemet's membrane.	Smoothly inserts instruments into the eye without damaging the wound or Descemet's membrane.	
5	Phacoemulsification Probe& 2nd Instrument:Effective Use and Stability	Tip frequently not visible, has much difficulty keeping the eye in primary position and uses excessive force to do so.	Tip often not visible, often requires manipulation to keep eye in primary position.	Maintains visibility of tip at most times, eye is generally kept in primary position with mild depression or pulling on the globe.	Maintains visibility of instrument tips at all times, keeps the eye in primary position without depressing or pulling up the globe.	
6	Nucleus: Sculpting	Frequently incorrect power used during sculpting, applies power at inappropriate times, excessive phaco probe movement causes constant eye/nucleus movement, the groove is of inadequate depth or width (divide and conquer), cannot control Phacodynamics. Unable to correctly work foot pedals.	Moderate error in power used while sculpting, tentative, frequent eye/nucleus movement produced by phaco tip,) or groove adequate only after many attempts (divide and conquer), poor control of phacodynamics with frequent anterior chamber depth fluctuations. Has difficulty working foot pedals.	Uses correct power with minimal error when sculpting, occasional eye/nucleus movement caused by phaco tip,) groove adequate with minimal repeat attempts, fairly good control of phacodynamics with occasional anterior chamber depth change. Minimal mistakes using foot pedals.	Sculpting is performed using adequate ultrasound power regulated by the pedal, with forward movements that do not change the eye position or push the nucleus) the groove is appropriate in depth and width (d and c technique), phacodynamics are controlled as evidenced by the internal anterior chamber environment. Adept at foot pedal control.	
7	Nucleus: Rotation and Manipulation	Unable to rotate nucleus.	Able to rotate nucleus partially and with zonular stress.	Able to rotate nucleus fully but with zonular stress.	Nucleus is safely and efficiently manipulated producing minimal stress on zonules and globe.	
8	Nucleus: Cracking	**CRACKING**: Grooves are not centered or deep enough and go into epinucleus, nucleus is constantly displaced from central position, unable to crack nucleus at all, eye	**CRACKING**: Some grooves are centered & deep enough & some go into epinucleus, displaces nucleus in most grooves, attempts to split nucleus with instruments too shallow, able to crack	**CRACKING**: Most grooves are centered and deep enough, rarely goes into epinucleus, rarely displaces nucleus, sometimes attempts to split in mid-nucleus but succeeds, eye usually in	**CRACKING**: Grooves are centered, deep enough to ensure cracking, length does not reach epinucleus, nucleus is not displaced from central position, places instruments deep enough to	

			portion of nucleus, eye often moving.	primary position.	easily and successfully crack nucleus, eye stays in primary position.	
9	Phacoemulsification of Segments	**SEGMENT PHACOEMULSIFICATION**: produces significant wound burn, great difficulty pursuing fragments around the anterior chamber and into the bag, poor awareness of second instrument tip and difficulty keeping the second hand instrument under the phaco tip,	**SEGMENT PHACOEMULSIFICATION**: produces light wound burn, pursues most fragments around the AC and into the bag, the second hand instrument is sometimes under the phaco tip	**SEGMENT PHACOEMULSIFICATION**: produces minimal wound burn, pursues some fragments around the AC and into the bag, the second hand instrument is usually under the phaco tip	**PHACOEMULSIFICATION**: No wound burns, Pieces are "floated" to the tip without "pursuing" the fragments around the anterior chamber and the bag, The second hand instrument is kept under the phaco tip to prevent posterior capsule contact if surge arises.	
10	Irrigation and Aspiration Technique With Adequate Removal of Cortex	Great difficulty introducing the aspiration tip under the capsulorrhexis border, aspiration hole position not controlled, cannot regulate aspiration flow as needed, cannot peel cortical material adequately, engages capsule or iris with aspiration port.	Moderate difficulty introducing aspiration tip under capsulorrhexis and maintaining hole up position, attempts to aspirate without occluding tip, shows poor comprehension of aspiration dynamics, cortical peeling is not well controlled, jerky and slow, capsule potentially compromised. prolonged attempts result in minimal residual cortical material.	Minimal difficulty introducing the aspiration tip under the capsulorrhexis, aspiration hole usually up, cortex will engaged for 360 degrees, cortical peeling slow, few technical errors, minimal residual cortical material.	Aspiration tip is introduced under the free border of the capsulorrhexis in irrigation mode with the aspiration hole up, Aspiration is activated in just enough flow as to occlude the tip, efficiently removes all cortex, The cortical material is peeled gently towards the center of the pupil, tangentially in cases of zonular weakness.	
1	**Global Indices** Wound Neutrality andMinimizing Eye Rolling and Corneal Distortion	Nearly constant eye movement and corneal distortion.	Eye often not in primary position, frequent distortion folds.	Eye usually in primary position, mild corneal distortion folds occur.	The eye is kept in primary position during the surgery. No distortion folds are produced. The length and location of incisions prevents distortion of the cornea.	
2	Conjunctival and Corneal Tissue Handling	Tissue handling is rough and damage occurs.	Tissue handling borderline, minimal damage occurs.	Tissue handling decent but potential for damage exists.	Tissue is not damaged nor at risk by handling.	
3	Intraocular Spatial Awareness	instruments often in contact with capsule, iris and corneal endothelium' , blunt second hand instrument not kept in appropriate position.	Occasional accidental contact with capsule, iris and corneal endothelium , sometimes has blunt second hand instrument between the posterior capsule and the activated phaco tip.	Rare accidental contact with capsule, iris and corneal endothelium. Often has blunt second hand instrument between the posterior capsule and the activated phaco tip.	No accidental contact with capsule, iris and corneal endothelium , when appropriate, a blunt, second hand instrument, is always kept between the posterior capsule and the tip of the phaco when the phaco is activated.	
4	Iris Protection	Iris constantly at risk, handled roughly.	Iris occasionally at risk. Needs help in deciding when and how to use hooks, ring or other methods of iris protection.	Iris generally well protected. Slight difficulty with iris hooks, ring, or other methods of iris protection.	Iris is uninjured. Iris hooks, ring, or other methods are used as needed to protect the iris.	
5	Overall Speed and Fluidity of Procedure	Hesitant, frequent starts and stops, not at all fluid.	Occasional starts and stops, inefficient and unnecessary manipulations common, case duration about 60 minutes.	Occasional inefficient and/or unnecessary manipulations occur, case duration about 45 minutes.	Inefficient and/or unnecessary manipulations are avoided, case duration is appropriate for case difficulty. In general, 30 minutes should be adequate.	

Please give feedback to trainee after the assessment has been completed.

Comments: _____

Trainee _____ Date _____Trainer_____ Date _____