Instructions: Use one form per trainee. For each competency, allocate a score to the *trainee's* level of execution of said skill, with a 2 for Novice, 3 for Beginner, 4 for Advance Beginner, and 5 for Competent. Each skill/competency has notes on what each level should be able to demonstrate. Please complete this form once at the beginning and once again at the end of their training and email to Alyssa Kropp at Alyssa.kropp@orbis.org.

Competency assessment rubric for Orbis MSICS practical training sessions 2 and 3.
Based on the ICO-Ophthalmology Surgical Competency Assessment Rubric-SICS (ICO-OSCAR: SICS)

Date _____ 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	Microscope set up	Unable to set up microscope	Requires assistance from others to set up microscope	Sets up microscope without assistance but fails to reset center or zoom functions or fails to focus properly	Sets up microscope without assistance and appropriately resets center and zoom functions. Sets focus appropriately	
3	Scleral access & Cauterization	Unable to successfully access sclera. Cauterization insufficient or excessive both in intensity and localization.	Accesses sclera but with difficulty and hesitation. Cauterization insufficient or excessive in location or intensity.	Achieves good scleral access with mild difficulty. Adequate cauterization.	Precisely and deftly accesses sclera. Appropriate and precise cauterization.	
4	Sclerocorneal Tunnel	Inappropriate incision depth, location, and size, hesitant dissection. Iris prolapse may occur	One of the following correct: incision depth, location or size. Able to dissect forward but not able to perceive depth	Two of the following are correct: incision depth, location or size. Understands that tunnel depth is incorrect but unable to correct.	Good incision depth, location and size. Tunnel constructed at right plane, if inappropriate plane, able to rectify.	
5	Corneal entry	Hesitant keratome entry into AC. Unable to extend the internal valve. Significant shallowing of anterior chamber. Require wound extension or suturing.	Enters into AC but difficulty in extension. Follows a different plane. Entry either anterior or posterior to dissection site. Mild AC shallowing. Require wound extension or suturing.	Entry at right plane. Able to extend but with repeated use of viscoelastic. Internal valve irregular. Require wound extension or suturing.	Fluently enters in right plane. Wound length adequate with no further need for extension. Retains viscoelastic during extension. Self-sealing, provides good access for surgical maneuvering.	

6	Paracentesis & Viscoelastic insertion	Chamber collapses on performing paracentesis. Inappropriate width, length and location. Pierces anterior capsule on entry. Unsure of when, what type and how much viscoelastic to use. Has difficulty accessing anterior chamber through paracentesis.	Appropriate incision width, location or length. Anterior chamber shallows mildly. Requires minimal instruction. Knows when to use but administers incorrect amount or type of viscoelastic.	Inappropriate location, width or length. Anterior chamber almost stable Requires no instruction. Administers viscoelastic at appropriate time, amount, type, and cannula position.	Wound of adequate length, width, and correct location. Viscoelastics administered in appropriate amount, at appropriate time, with cannula tip clear of lens capsule and endothelium.	
7	Capsulorrhexis: Commencement of Flap & follow-through.	Instruction required, tentative, chases rather than controls rhexis, cortex disruption may occur.	Minimal instruction, 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.	
8	Capsulorrhexis: Formation and Circular Completion	Size and position are inadequate for nucleus density, tear may occur.	Size and position are barely adequate for nucleus density, difficulty achieving circular rhexis, tear may occur.	Size and position are almost exact for nucleus density, shows control, and requires only minimal instruction.	Adequate size and position for nucleus density, no tears, rapid, unaided control of radialization, maintains control of the flap and AC depth throughout the capsulorrhexis.	
9	Hydrodissection: Visible Fluid Wave and Free prolapse of one pole of nucleus	Hydrodissection fluid not injected in quantity or place to achieve nucleus rotation or prolapse.	Multiple attempts required, able to prolapse nuclear pole after multiple efforts. Manually forces nucleus prolapse before adequate hydrodissection; cheese wiring.	Fluid injected in appropriate location, able to prolapse one pole of nucleus but encounters more than minimal resistance.	Ideally see free fluid wave, adequate for free nuclear hydroprolapse or mechanical prolapse with minimal resistance. Aware of contraindications to hydrodissection.	
10	Prolapse of nucleus completely into AC	Unable to dial nucleus into AC. Hooks anterior or posterior nuclear surface, nucleus rotates in the bag, iris and corneal touch, pupillary constriction, may damage capsule or zonules.	Prolapses nucleus after repeated awkward attempts, needs instruction, churns cortex causing reduced visibility; iris or corneal touch; no damage to capsule or zonules.	Prolapses nucleus into AC with more than minimal resistance. No corneal touch.	Prolapse with minimal resistance. No damage to pupil and iris.	
11	Nucleus extraction	Damages endothelium, iris or capsule, unable to hold and extract nucleus, movements not coordinated.	Movements coordinated but unable to extract nucleus, iris or corneal damage, unable to assess wound size in relation to nuclear density.	Removes nucleus after repeated attempts, more than one piece, might need wound extension prior to extraction.	Extracts nucleus with one or two attempts; proper wound size in relation to nuclear density.	
12	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. Some difficulty in removing sub incisional cortex	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. No difficulty in removing subincisional cortex	

13	Lens Insertion, Rotation, and Final Position of Intraocular Lens	Unable to insert IOL.	Difficult insertion, manipulation of IOL, rough handling, unstable anterior chamber. Repeated hesitant attempts placing lower haptic in capsular bag, repeated attempts needed to rotate upper haptic into place with excessive force.	Insertion and manipulation of IOL accomplished with minimal anterior chamber instability, the lower haptic is placed with some difficulty, upper haptic is rotated with some stress.	Insertion and manipulation of IOL is performed in a deep and stable anterior chamber and capsular bag, with incision appropriate for implant type. The lower haptic is smoothly placed inside the capsular bag; the upper haptic is rotated or gently bent and inserted into place without exerting excessive stress to the capsulorrhexis or the zonule fibers.	
14	Wound Closure (Including Suturing, Hydration, and Checking Security as Required)	If suturing is needed, instruction is required and sutures are placed in an awkward, slow fashion with much difficulty, astigmatism, bent needles, incomplete suture knot rotation and wound leakage may result, unable to remove viscoelastics thoroughly. Unable to make incision watertight or does not check wound for seal. Improper final IOP.	If suturing is needed, sutures are placed with some difficulty, resuturing may be needed, questionable wound closure with probable astigmatism, instruction may be needed, questionable whether all viscoelastic is thoroughly removed, Extra maneuvers are required to make the incision water tight at the end of the surgery. May have improper IOP.	If suturing is needed, sutures 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 and is water tight or needs minimal adjustment at the end of the surgery. May have improper IOP.	If suturing is needed, sutures are placed tight enough to maintain the wound closed, but not so tight as to induce astigmatism, viscoelastics are thoroughly removed after this step, the incision is checked and is water tight at the end of the surgery. Proper final IOP.	
15	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.	

Comments: _____