{Insert} Name of Trust

Clinical policy for non medical healthcare professionals working in the paediatric ophthalmology clinics.

Summary
This policy describes the processes required for non-medical healthcare professionals to see patients safely in paediatric outpatient clinics.

Version: X.0
Status: x
Approved: X.X.20XX
Ratified: X.X.20XX

Clinical Unit or Department:	
Name of author(s)	
Name of responsible individual	
Approved by:	
Ratified by :	
Date issued:	
Review date	
CQC relevant domains	
Target audience:	Nursing, orthoptists, optometrists, ophthalmologists, ophthalmology managers

Version History

Version	Date Issued	Brief Summary of Change	Author

1. Introduction

In recent years, the involvement of non medical healthcare professionals (HCP) in delivering an extended scope of practice assessing and managing patients and/or performing procedures has become widely accepted practice to cope with significantly rising demand for eye care and to support the expansion of non medical roles, and is supported by the Royal College of Ophthalmologists and other HCP professional organisations.

2. Purpose

This policy sets out the process required for designated HCPs to train and to deliver advanced practice care in paediatric eye clinics, where practice extends beyond the core roles and responsibilities of their profession. This will contribute to the efficient delivery of the ophthalmology service and will enhance and develop patient-centred care which fulfils national safety and service delivery targets. Service provision will be more flexible and resilient, with the potential for increased and consistent capacity for treatment. Staff will be able to develop their roles further, increasing the overall level of expertise in the department and promoting greater job satisfaction, and better recruitment and retention. It will allow consultants to direct senior input to those cases which are most in need of it such as complex patients.

This policy will also support those non-medical personnel who wish to work in an advanced or extended role capacity within the paediatric ophthalmology service by ensuring that:

- There is a robust framework to work within.
- Standardisation of training of non-medical staff in extended roles.

3. Scope

This policy applies to all trust sites where paediatric eye clinics are carried out and is relevant to ophthalmic nurses, orthoptists and optometrists who are working, or wish to work, as advanced practitioners in paediatric ophthalmology clinics, ophthalmologists including consultants and those managing ophthalmology services.

It should be read in conjunction with other relevant trust documents:

- Consent Policy
- Health Records Policy
- Clinical Governance/Risk Policy
- Safeguarding Policy
- Trust Policies on paediatric care.

To be eligible for delivering this care the procedure staff must have a minimum time of 1 years post registration hospital ophthalmic experience and be:

- Registered nurse (RN) at band 6 or above who must either hold an ophthalmic nursing qualification or have sufficient ophthalmic and paediatric experience to be judged by their manager as competent to commence training;
- Registered orthoptist at band 6 or above who has sufficient ophthalmic experience to be judged by their manager as competent to commence training;
- Registered optometrist at band 6 or above who have sufficient ophthalmic experience to be judged by their manager as competent to commence training.

Pathways will be delivered based on clinical risk stratification, with patients' risk defined by the consultant ophthalmologist. Low risk patients have a low likelihood of their disease being sight or life threatening and may be seen independently by the HCP once deemed competent by the paediatric ophthalmologist. High risk patients are those whose eye condition is presently sight or life threatening or there is a high probability that their eye condition will severely affect their vision in future. These patients require careful discussion with the paediatric ophthalmologist and/or assessment of the patient by the consultant on the same day. This is to be decided on at the discretion of the consultant ophthalmologist and based on individual patient cases, but guidance is as follows:

Low risk patients

- Blepharitis
- Dry eye
- Congenital nasolacrimal duct obstruction
- Allergic conjunctivitis (excluding those with shield ulcers or severe keratitis requiring urgent treatment)
- Viral conjunctivitis (without keratitis)
- Bacterial conjunctivitis
- Chalazion and lid lumps and bumps
- Corneal / conjunctival abrasion (superficial)
- Keratoconus (non progressing)
- Concomitant strabismus
- Incomitant strabismus as recognised as part of a recognised non-progressive disorder such as Duane's syndrome, Brown's syndrome etc.
- Pseudosquint
- General eye screening including:
    - parental concerns for squints
    - FHx of refractive error or amblyopia
    - Incidental low risk fundal findings such as naevi.
    - Neurodevelopmental delay
- Congenital nystagmus of known cause
- JIA screening
- Convergence insufficiency
- Ptosis – congenital, previously diagnosed
- Consenting patients for squint surgery provided the consultant has previously agreed that surgery is a viable option and practitioner is consent trained.

High risk patients

- Babies under 6 months with unexplained reduced vision
- Nystagmus with undiagnosed cause
- Ptosis with unequal pupils with undiagnosed cause
- Sight threatening or serious adnexal pathology
- VKC / AKC / BKC – severe or with active keratitis
- Ocular trauma / penetrating injury
- Progressing keratoconus
- Non-accidental injury
- Orbital or preseptal cellulitis

- Severe visual impairment at first attendance or if cause undiagnosed
- Cranial nerve palsies
- Second opinion
- Possible tumour
- Paediatric cataracts
- Paediatric glaucoma
- JIA-active uveitis
- Ocular signs indicating life threatening illness
    - Papilloedema or suspicious discs for papilloedema
    - Leucocoria
    - Paediatric proptosis

These lists are not exhaustive and those patients seen in the low risk category may still require assessment by/discussion with the paediatric ophthalmologist if there are any queries or if the clinician requires pharmacological management of the patient and is not an independent prescriber.

4.0 Duties and responsibilities

4.1 Practitioners responsibilities

Practitioners undertaking the training are responsible for compliance with trust policies; engaging actively with the training, keeping up to date, accurate training records; ensuring they act within their sphere of competence; completing accurately the relevant parts of the medical records; following SOPs; reporting adverse events and safety concerns to their supervisor, consultant or their line manager.

Once signed off as competent to practice, the HCP is required to:

- keep a record of their competency sign off
- attend regular clinical update sessions on paediatric ophthalmology
- regularly audit their patient records and care
- maintain and update their portfolio
- review these as part of their annual appraisal / individual performance review.

From the point of registration, each practitioner must adhere to their professional body/regulatory code of conduct and is accountable for his/her practice.

4.2 Consultant ophthalmologist's and trainer's responsibilities

The paediatric consultant must ensure the HCP has achieved a satisfactory knowledge base and competencies with which to perform this enhanced role. The consultant can undertake this directly or can delegate some or all parts to a senior colleague with appropriate experience, knowledge and training that is an HCP with more than 2 years' experience of this role, or a fellow or ST 6 and above ophthalmic trainee. However, the consultant retains responsibility for the training and sign off before the HCP begins independent practice.

The trainer will:

- Examine the HCP to ensure she/he has the knowledge base required

- Provide adequate time for the HCP to observe care and to subsequently supervise and assess the HCP's skills and knowledge
- Only sign the competency when all aspects of the competency standards have been demonstrated by the practitioner.

The consultant will arrange that they or another suitably qualified other ophthalmologist are available to support the HCP during clinics. The doctor should either be present on site or by phone with a pathway in place to see a doctor urgently with the appropriate safe timescale if required, once the HCP has undertaken any initial urgent or unplanned treatment.

The patient remains under the care of a named consultant ophthalmologist at all times.

4.3 Manager's responsibility

The manager(s) [lead nurse, lead orthoptist, lead optometrist or ophthalmology department manager] will keep a record of all competencies and a register or list of trainers and HCPs eligible to perform advanced paediatric ophthalmology practice.
Managers must only endorse practice if such development is in line with the practitioner`s job description and existing trust policies and service requirements.

Managers must ensure that the HCP is supported in skills development in the form of:

- opportunities for supervised practice
- assessment of competency and sign off.

4.4 Employer's responsibilities

The employer will ensure that the HCP's training and supervision is provided in a timely manner, ensuring trainers and supervisors are supported to deliver the time required. Employers will ensure HCPs are appropriately banded for the work they undertake and are given the time to undertake the training and audit during their current role.
The employers will ensure that, subject to following trust policy, HCPs have suitable indemnity for this scope of practice.

5.0 Training

HCPs can only commence training after approval by their line manager and the paediatric ophthalmologist.

5.1 Baseline competencies for training

Orthoptists, optometrists and nurses will have had differing training and experience in a number of **baseline skills** in terms of:

- Paediatric medical care and family communication skills
- Slit lamp
- Tonometry
- Retinoscopy and refraction
- Direct / indirect ophthalmosocopy
- Strabismus, binocularity and motility
- Slit lamp fundoscopy with fundus lens
- Binocular indirect ophthalmosocopy

For these baseline skills and knowledge/experience, the paediatric ophthalmologist and line manager will need to agree if there is any basic training required to bring the HCP to a level where the extended role paediatric training can commence and make a plan to train and evidence competencies for any areas which are not covered as part of core training before embarking on the paediatric advanced practice training.

5.2 Paediatric advanced practice training and sign off

The HCP will gain the appropriate **theoretical knowledge** of anatomy, assessment and examination, disease, investigations and management from a combination of the following:

- Attending local, regional or national courses
- Informal in house training or sessions with the consultant or other trainer
- Additional reading around the subject area in books and journals
- Reading of any local paediatric ophthalmology care guidelines
- E-learning modules.

The HCP will gain **practical knowledge** as follows:

- This period will usually last at least 3 months
- The HCP will initially observe practice and discuss cases with their trainer
- Once the trainer agrees they are ready, the HCP will start to see patients for an initial assessment and the trainer will then assess each patient and agree management
- As the HCP progresses, they will undertake more of the assessment and management, but continue to discuss all cases with the consultant and will sit in on interesting cases/continue to observe the consultant's practice
- For each clinical competency area assessed there should be in the portfolio a disease specific logbook of at least 10 cases (Appendix) and at least 2 successfully completed work based assessments (Appendix).
- For surgery specific outpatient areas e.g. chalazion, strabismus, the HCP should attend at least 1 surgical session.

The HCP will **maintain a portfolio** of their learning, experience and performance, and will add to this as they progress. The portfolio will contain:

- Evidence of theoretical training, courses, teaching and CPD
- Records of their cases and experience
- A log of discussions and unfamiliar conditions seen
- Reflective learning on a small number of cases (see Appendix: Reflective Practice template)
- Further reading e.g. books, review articles, research papers
- Written summaries of key conditions (symptoms, assessment and signs, investigations, management, red flags, complications (see Appendix: Disease Summary Portfolio)
- Workplace based assessments
- Competency sign off documents.

At **sign off**, the HCP will discuss the knowledge and experience gained and the work place based assessments in their portfolio with their consultant / trainer. The consultant / trainer

will, if satisfied, record the HCP as competent using the final competency checklist form (Appendix).

Once signed off:

- The HCP must practice in accordance with the clinic protocol (see Appendix: Protocol for Advanced Practice Paediatric Ophthalmology clinics).
- The practitioner must be satisfied with his/her own level of competence in accordance with the guidelines and codes of conduct from their relevant regulator and professional body.
- The HCP will undergo an informal review of practice with their trainer and/or the consultant paediatric ophthalmologist after three to six months of independent practice.

5.3 Sign off for current or experienced practitioners

For **Current Practitioners** who have:

- Completed the HCP training programme or equivalent previously and are currently practicing in this area (eg. specialist paediatric extended-role optometrists)
- Completed training from another provider/trust previously and have proof of continuing competency in the form of a completed and signed recent (within the last two years) competency document.

You must be assessed as competent at the discretion of the supervising consultant or HCP trainer. This should include:

- Open discussion of relevant diseases to ensure theoretical competence
- Successful completion of at least 1 workplace based assessment;
- Creation / update and review of a portfolio
- Sign off of the competency assessment form (Appendix)

For staff who have had a **Gap in Service** (≥6months):
Competence can be reassessed at the discretion of the supervising consultant or trainer; this may involve some of the following:

- Case discussion
- Observed practice
- The HCP observing in clinic
- Work placed based assessment

The portfolio must be updated and reviewed and a competency assessment form (Appendix) must be signed off.

6 Frequency of practice

HCP paediatric clinics will be carried out according to service need. Once a practitioner has been signed off as competent, they should be performing clinics regularly to maintain skills.

7. Performance measures

Data to be collected is:

- Record of all cases to be kept by HCPs for activity levels.

- Regular audit of adherence to protocol, case management and record keeping in conjunction with trainer
- Regular documented reflective practice on cases of interest or with learning opportunities
- Regular updates of portfolio with reading/learning documents and condition summaries
- Any incidents or serious incidents or patient complaints, including the result for the patient or of any investigation, with appropriate reflective practice and learning recorded
- Patient experience / satisfaction survey at discretion of HCP and line manager.

The HCP will undertake an audit and/or review of their practice on an annual basis as part of their annual appraisal and individual performance review.

8.0 Stakeholder engagement and communication

This guideline was developed by the medical retina medical team with other ophthalmic medical staff, orthoptic, optometrist, nursing staff and the management team.
Stakeholder engagement with consultants and other relevant staff has been through insert name of appropriate meetings and other methods e.g. emails or team meetings.

9.0 Approval and ratification

This policy was approved by the insert name of committee and ratified by the insert name of committee.

10.0 Dissemination and implementation

This policy will be implemented and disseminated to all staff involved in the administration of intravitreal injections or medical retinal care, and will be communicated to key stakeholders and policy users via email, and highlighted at team meetings and insert name of other meetings or insert other methods of dissemination.

This policy will be published on the trust intranet site.

11.0 Review and revision arrangements

This document will be reviewed on a 3 year basis by the Policy Owner/Authors.
Changes to the legislation or national guidelines of the administration of intravitreal injections by non-medical personal, or any trust serious incidents will trigger a review of this document.

12.0 Document Control and Archiving

Insert standard trust information of document storage and removal old versions/archiving

13.0 Monitoring compliance with this policy

Monitoring compliance will include:

Element to be Monitored	Staff conducting	Tool for Monitoring	Frequency	Responsible Individual/Group for results/actionst
Service delivery and unit outcomes	Paediatric Ophthalmology Clinical Team	Audit and patient/carer satisfaction	Every 1-2 years	Paediatric ophthalmologist Ophthalmic clinical governance/audit meetings
HCPs	Senior paediatric ophthalmology clinicians and line manager	Appraisal and individual performance review - portfolio of audit, practice and knowledge	Annually	Line manager and paediatric ophthalmology trainer
Complications or adverse events to be recorded	All staff	Incident reporting	ongoing	Paediatric ophthalmologist Risk team Ophthalmology CG
Complaints	Complaints team	Complaints process	ongoing	Lead consultant Ophthalmology manager PALS Ophthalmology CG

14.0 Supporting References / Evidence Base

National documents

Nursing and Midwifery Council (2015) code of professional conduct, NMC London http://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/revised-new-nmc-code.pdf.

The British & Irish Orthoptic Society Code of Ethics. https://orthoptics.org.uk/Resources/Documents/Standards/BIOS_Code_of_Ethics.pdf

The Health & Care Professions Council (HCPC) Standards of Conduct, performance & ethics http://www.hpcuk.org/aboutregistration/standards/standardsofconductperformanceandethics/

BIOS – Competency document 2016..

General Optical Council. Standards of Practice. https://www.optical.org/en/Standards/

College of Optometrists Guidance for Professional practice. https://guidance.college-optometrists.org/home/

Royal College of Ophthalmologists (2017) OCCCF

Royal National Institute of Blind People. Future Sight Loss UK 1: Economic Impact of Partial Sight and Blindness in the UK Adult Population. London: RNIB; 2009. Available

from: http://www.rnib.org.uk/aboutus/research/reports/otherresearch/pages/fsluk1.aspx. Accessed February 12, 2014.
RCOphth Quality Standards for paediatric eye services. RCOphth 2015.

Local documents
Safeguarding policy
Ophthalmology department guidelines
Consent policy
Clinical record keeping policy
Clinical governance /. Risk policy
Paediatric trust policies and guidelines
Add other relevant trust document

Appendix 1.
Paediatric eye conditions: Competency checklist – Generic*

Successful completion of this competency will enable the HCP to assess specified condition/subspecialty patients autonomously with the paediatric ophthalmology service.

Aims and Objectives	The HCP is able to demonstrate supporting knowledge, understanding and has been observed as competent to effectively examine patients with **x specific diseases/low risk diseases/high risk diseases** in the **X** subspecialty of the paediatric ophthalmology service
Training Prerequisite	Prior to this assessment the practitioner has successfully completed the following: **Teaching/training, course or e-learning** **Observational work based training** **Background reading, learning and theory portfolio produced for x specific diseases/low risk diseases/high risk diseases ‘**
Your Responsibility	All staff should ensure they keep their knowledge and skills up to date through local policies, standard operating procedures and guidance. It is the responsibility of the individual to work within their own scope of competence relevant to their job role and follow their professional bodies Code of Conduct.
Employee signature/print name: …….. Assessor signature print name: …… Date: ……..	
Policies, Guidelines and Protocols:	**Date policy read by clinician and initials**
Local policies x	
Local policies x	
Local policies etc	
Local policies etc	
Paediatric Ophthalmology Policy Document	

- **Disease and subspecialty assessments forms are available**

	Underpinning knowledge and understanding	Date and assessor initials
Local clinical policies or guidelines	• Demonstrates knolwedge x local policy • Demonstrates knolwedge x local policy etc • (key policies such as child safeguarding and consent)	
Knowledge specific to X sub-speciality	• Demonstrates knowledge of **X** anatomy. • Demonstrates knowledge of **X** disease. • Demonstrates knowledge of when additional testing is required including imaging (photography, ultrasound, CT and MRI), blood tests etc. • Is aware of any possible red flags and how to escalate concerns.	
Professionalism	• Demonstrates a working knowledge of own responsibilities and accountability in relation to current policies and procedures as well as national standards of professionalism such as HCPC, BIOS, GOC and NMC standards. • Demonstrates an in depth understanding of their duty to maintain professional and ethical standards of confidentiality	
Performance Criteria	**Date of assessment and assessor initials**	
WpBA for **X** disease undertaken and passed		
WpBA for **X** disease undertaken and passed		
Disease specific caselog (10 patients)		

{Insert} Name of Trust

Workplace based assessment recording form: Generic*

Brief description of case:		
Expectations:	**Achieved**(or not applicable)	**Not Achieved**
History: Symptoms, duration, past ophthalmic history, medical and birth history, medications, family history, allergies, any key questions		
Correct **set-up/start** phase.		
Correct selection of **equipment** and able to use with confidence:		
Appropriate examination undertaken including as appropriate: • Observation of face and lid appearance • Assessment of lids including: ○ X ○ X • Assessment of globe position/size ○ • Assessment of lacrimal system ○ X • Assessment of external eye: ○ . • Assessment of ocular motility • Assessment of pupils and iris • Assessment of AC and lens • Fundoscopy • IOP • etc		
Correct documentation of findings.		
Correct investigations e.g. imaging, other tests		
Correct management plan/follow up.		

Areas of particularly good practice:	Areas for improvement:
Discussion:	

Actions:
Outcome: Pass/ Fail

- **Disease and subspecialty assessments forms are available**

Set-up phase: Clinician ensures room set up and equipment required present and records and test results all present. Checks back through referral and notes. Introduces themselves to the patient/parents and identifies all parties in the room. Engages effectively with the parents AND child. Builds good rapport with the child and puts them at ease before beginning examining phase of consultation. Ensures local infection control policy is adhered to by cleaning hands before interacting with patient and also ensuring equipment is cleaned prior to patient use in line with local policies.
History: Takes a history which is directed at the presenting complaint, ensures medical, birth, medications, allergy and family history completed. Asks any important key questions.
Examination: The clinician selects the age appropriate assessments which will help them to gain the best clinical picture whilst minimising distress caused to the patients and parents.
The clinician carries out a targeted examination ensuring a detailed enough examination is undertaken to formulate an appropriate management plan, and also detect any abnormality whilst not over examining the patient. The examination is done in a logical order i.e. anterior to posterior Appropriate selection and use of equipment, accurate findings..
Documentation: Correctly documents findings and plans in sufficient detail so as to inform future clinicians of patient's disease status at the time of the examination and strategy for going forward. Record should adhere to local information governance policy and local healthcare records policy; in addition all documentation used must be in accordance with professional codes of documentation. Records a diagnosis/Impression (working diagnosis). Records a management plan
Investigations: Plans, documents and organises suitable tests. Does not over investigate.
Clinician is able to discuss with family what additional testing is required and the reasoning for this.
Management: Clinician suggests a suitable management plan for their given level of experience and is able to give sound reasoning for the decision taken, and is able to answer any follow-up questions posed by parents/ consultant on condition/findings.
Clinician suggests an appropriate follow-up time taking into account severity of disease and predicted impact on vision/impacts on psychological wellbeing.
Clinician is able to answer queries.

Appendix 2. Record of 10 supervised cases

Name, designation and signature …….

Date	Pt record Number	Comments	Signature of practitioner	Signature of Supervisor

Appendix 3. Reflective practice template

Name, designation and signature ……

Date	Brief description of case and comments or reflections by practitioner	Trainer/assessor comments and constructive feedback

Appendix 4 Example of disease summary for portfolio

Allergic conjunctivitis –AKC

Definition

- Hypersensitivity reaction type 4 to allergens including: pollen +dust- This leads to inflammation of bulbar and tarsal conjunctiva and can lead to permanent damage if left untreated.

Clinical signs/presentation

- Itchy, red sore eyes, conjunctivitis lasting more than 2 weeks.
- History of eczema/asthma or family history of atopy or AKC.
- Bulbar conjunctiva
    - Hyperaemia of conjunctiva
    - Trantas dots (yellow-white) accumulation of inflammatory cells at limbus
    - Diffuse limbitis
    - Chemosis of bulbar conjunctiva
- Tarsal conjunctiva
    - Giant papillae or can be small papillae
    - Mucous discharge-usually yellow-white.
    - Cicatrization if chronic
- Eyelids
    - Blepharitis
    - Loss of eyelashes, notching of lid margin-if chronic
    - Change in pigmentation of eyelids from chronic inflammation
- Cornea
    - SPEEs
    - If Severe may develop a shield ulcer (oval form ulcer usually in lower 3rd of cornea) May have a plaque of bacteria on anterior surface of ulcer.
    - Pannus
    - Corneal perforation if severe

Management

- Antihistamine drops such as: Lodoxamide
- Mast cell inhibitors such as; sodium cromoglycate (olopatadine is both)
- Steroid if corneal involvement to reduce immune response-Maxidex, FML, predforte
- May consider oral erythromycin to reduce immune response as an adjunct to mast cell inhibitor if marked blepharitis.
- Topical ciclosoprin becoming more used as steroid sparing drug.

Red Flags

- Failure to improve with steroid
- Signs of corneal breakdown-thinning, ulceration
- Deterioration in visual acuity
- Shield ulcer

Appendix 5 Clinic protocol

Protocol for Advanced Practice Paediatric Ophthalmology Clinics

Department: Ophthalmology

1. Introduction
This protocol is for all non medical health care professionals (HCPs) whether nursing, orthoptist or optometrist, who have completed the training and competency assessments for delivering advanced practice care in paediatric ophthalmology clinics.

2. Purpose
The purpose of this protocol is to describe the process for advanced practitioners to deliver care and ensure consistency, safety and best practice.

3. Low and high risk cases
Pathways will be delivered based on clinical risk stratification, with patients' risk defined by the consultant ophthalmologist. Low risk patients have a low likelihood of their disease being sight or life threatening and may be seen independently by the HCP once deemed competent by the paediatric ophthalmologist. High risk patients are those whose eye condition is presently sight or life threatening or there is a high probability that their eye condition will severely affect their vision in future. These patients require careful discussion with the paediatric ophthalmologist and/or assessment of the patient by the consultant on the same day; this is to be decided on at the discretion of the consultant ophthalmologist and guidelines for this are:

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- Keratoconus (non progressing)
- Concomitant strabismus
- Incomitant strabismus as recognised as part of a recognised non-progressive disorder such as Duane's syndrome, Brown's syndrome etc.
- Pseudosquint
- General eye screening including:

    - parental concerns for squints
    - FHx of refractive error or amblyopia
    - Incidental low risk fundal findings such as naevi.
    - Neurodevelopmental delay
- Congenital nystagmus of known cause
- JIA screening
- Convergence insufficiency
- Ptosis – congenital, previously diagnosed
- Consenting patients for squint surgery provided the consultant has previously agreed that surgery is a viable option and practitioner is consent trained.

High risk patients

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- Nystagmus with undiagnosed cause
- Ptosis with unequal pupils with undiagnosed cause
- Sight threatening or serious adnexal pathology
- VKC / AKC / BKC – severe or with active keratitis
- Ocular trauma / penetrating injury
- Progressing keratoconus
- Non-accidental injury
- Orbital or preseptal cellulitis
- Severe visual impairment at first attendance or if cause undiagnosed
- Cranial nerve palsies
- Second opinion
- Possible tumour
- Paediatric cataracts
- Paediatric glaucoma
- JIA-active uveitis
- Ocular signs indicating life threatening illness
    - Papilloedema or suspicious discs for papilloedema
    - Leucocoria
    - Paediatric proptosis.

These lists are not exhaustive and those patients seen in the low risk category may still require assessment by/discussion with the paediatric ophthalmologist if there are any queries or if the clinician requires pharmacological management of the patient and is not an independent prescriber.

4. Exemptions and exclusions

The assessment and management should not be performed by the HCPor further medical advice sought if:

- The patient will not provide valid consent or refuses care by the HCP
- The HCP does not feel it is safe to proceed or has concerns
- The HCP does not have access to the appropriate medical support (

- The consultant or senior fellow decides that the patient requires a member of the medical team to conduct the care
- High risk patient in low risk independent clinic

5. Protocol

An initial assessment is completed by the HCP to assess the vision/visual acuity, pinhole acuity (where possible), ocular movements and binocularity (where appropriate), if these have not already been conducted by other members of the team e.g. HCA or orthoptist.

Following this, unless the orthoptist has already covered them, the HCP will

Assess the history for new patients

- Symptoms including duration and details of referral
- Previous ophthalmic history (including previous spectacles, occlusion, surgery, injury, infection)
- General health history
- Birth history
- Medications: current ophthalmic therapy and systemic medications
- Known allergies
- Family ocular history.

Assess the history for follow up patients:

- Summarise diagnosis and management to date.
- List current medication regimen including compliance
- Symptoms, with emphasis on new symptoms and side effects
- Enquire as to state of general health and any change in systemic medication since last visit.

Conduct the examination

The examination will be dictated by which disorder is suspected and which subspecialty and may include:

- Colour vision
- Observation of face and lids
- Assessment of globe position
- Assessment periocular lumps and lesions including palpation, size etc
- Assessment of ocular motility
- Assessment of lid position, function and health including assessment skin and lumps and lesions
- Ptosis examination to include measurements of palpebral aperture, marginal reflect distance, levator function, skin crease, lid closure, Bells phenomenon and extraocular movements
- Slit lamp (hand held or full size) assessment of eyelids, eyelid margins, conjunctiva, limbus, cornea, anterior chamber, pupils, iris external eye and anterior segment:
- Pupil size and reactions
- Pupil dilatation
- Examination of the lens
- Examination of the vitreous gel

- Cycloplegic or subjective refraction (where appropriate)
- Dilated or undilated fundus examination including optic disc, macula and retina.
- IOP

In clinics where dilation is not possible by a supporting nurse, the dilating drops will be instilled by the HCP. Existing protocols for using dilating drops in children should be followed.
NB – All of these should be examined in as much detail as possible given patient's age and co-operation and suspicion of serious disease.

Document:

- Accurately record history, findings, impression/working diagnosis/status of known condition or any new condition, and necessary further action.
- Formulate and organise any investigations and record this.
- Formulate management plan including further attendance and timing or referral where indicated.
- Document any consenting advice given to parent.

If working in high risk clinic or need doctor's input, present plan to doctor for opinion, altering plan if necessary and note initials or name of doctor consulted.
Arrange letter to GP/community optometrist and cc to patient for every visit, and any referral if required.
Legible name, designation and signature on medical notes.

Prescription and medications:

- Supplied in the department by the HCP using a Patient Group Direction (PGD).
- Prescribed by those HCPs who hold the non- medical prescriber qualification
- Obtained from a prescriber.

When prescribing, check (BNF or www.medicines.org.uk) for guidance to see if the drug is licensed to be used in children first.
If off-license or off-label, ensure the trust policy for unlicensed or off label drugs is followed and it needs to be in the best interest of the child and within the competency of the practitioner. Note that independent optometrist prescribers are not allowed to prescribe unlicensed preparations so if a child needs an unlicensed drug to be used for an ocular condition, a medical practitioner will need to prescribe it.

Communication

Explain to the patient and family/carers:

- The name of the condition, what this means
- Any investigations required
- Treatment and care advice
- Prognosis
- Initial management plan and longer term plan of care including timing of next visit and likelihood future visits or treatment e.g. surgery
- Ask if there are any questions and answer them.
- Give relevant patient information leaflets about the eye condition.

Outcome: complete a clinic outcome form for each patient detailing recall time and future investigations required at the next visit, e.g. imaging, visual fields, refraction, etc and any RTT18 requirements.

Appendix 6 Risk Assessment

Department / Directorate	Ophthalmology
Description of risk	**This risk assessment is to assess any risks associated with non medical practitioners expanding their role and undertaking advanced practice care for patients in the paediatric ophthalmology service.** All eye care in children carries associated risks such as :- • Safeguarding issues • Potential for missed diagnosis • Potential for associated systemic disease • Potential for affecting vision • Complications of treatment • Miscommunication with family. The above could occur for all competent practitioners whether medical or non medical professional. These complications are rare. However some are sight or health threatening, or may affect the confidence fo the patient and family in the care and the trust especially if any problem is not spotted or acted upon in a timely manner. Risks associated with a non medical HCP carrying out this care include:- • Perception by patient/family that problem was due to care not performed by doctor] • Failure of HCP to detect problem • Having the experience and ability to identify or manage problems which may occur; • Non enough staff or time to undergo training • Not enough senior staff or consultant time to supervise and sign off training • Capacity issues creating pressure to have excessive numbers on clinics • Insert any others here or amend the above •
Existing controls in place when risk was identified	• The guidelines from the Royal College of Ophthalmologists, BIOS and College of Optometrists are followed.. • Compliance with Consent, safeguarding and othre key trust Policies • Ready availability of an ophthalmologist by phone or on site. • Adherence to the paediatric advanced practice policy. • Paediatric ophthalmic consultant leadership and supervision of service. • An Incident Reporting process in place for adverse events. • An audit of the service is regularly carried out. • Regular patient feedback is sought. • Governance structures in place where issues / concerns can be raised. • A complaints system is in place where these are reviewed and lessons are learned and shared. • Regular mandatory training in paediatric issues such as BLS and safeguarding for all staff

Initial Risk Score i.e. with existing controls in place	Consequence (1-5)	

{Insert} Name of Trust

	Likelihood (1–5)	
	Risk Score (1 – 25)	

Actions to reduce the risk to an acceptable level			
Description of actions	Cost	Responsibility (Job title)	Completion Date
Register risk on DATIX (for all risks > 3) if appropriate	nil		
Existence of Policy complaint with College and similar guidance			
HCP to follow professional codes of conduct and guidance			
Trainers and trainees given enough time in job plan to train and learn			
Clear detailed training programme and competency recording led by paediatric ophthalmic consultant.			
Regular audit of practice and log books			
Doctor on site at all times OR immediate access to named doctor for advice and pathway to send patient			
HCPs trained and competent to diagnose and/or provide immediate treatment for complications or unexpected issues			
Insert details of any staffing number or availability adaptations or other mitigations			
Maximum number of patients on HCP clinics at X			

Target Risk Score i.e. after **full** implementation of action plan	Consequence (1-5)	
	Likelihood (1–5)	
	Risk Score (1 – 25)	
	Date for completion	

Assessment undertaken by: Name	Job title		
Lead:			
Date of assessment		Date of next review	