Cataract Clinic Guidelines for Optometrists

Clinical Guideline Summary
Clinical guidelines for optometrists working in the cataract service

Version: 2.0

Status: FINAL

Approved: 10\textsuperscript{th} October 2014

Ratified: 10\textsuperscript{th} October 2014
## Version History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date Issued</th>
<th>Brief Summary of Change</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>June 2005</td>
<td>New protocol</td>
<td>Vincenzo Maurino</td>
</tr>
<tr>
<td>1.1</td>
<td>February 2008</td>
<td>Minor revisions</td>
<td>Vincenzo Maurino &amp; Aneel Suri</td>
</tr>
<tr>
<td>2.0</td>
<td>June 2014</td>
<td>Rewritten to give comprehensive guidance and incorporate independent prescribing</td>
<td>Aneel Suri &amp; Vincenzo Maurino</td>
</tr>
</tbody>
</table>

For more information on the status of this document, please contact: Aneel Suri and Vincenzo Maurino

<table>
<thead>
<tr>
<th>Guideline Author</th>
<th>Aneel Suri &amp; Vincenzo Maurino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline Owner</td>
<td>Optometry and Cataract Service</td>
</tr>
<tr>
<td>Department</td>
<td>Optometry and Cataract Service</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Vincenzo Maurino</td>
</tr>
<tr>
<td>Service Director</td>
<td>Vincenzo Maurino</td>
</tr>
<tr>
<td>Optometry Lead</td>
<td>Aneel Suri</td>
</tr>
<tr>
<td>Head of Optometry</td>
<td>Dan Ehrlich</td>
</tr>
<tr>
<td>Date of issue</td>
<td>10th October 2014</td>
</tr>
<tr>
<td>Review due</td>
<td>10th October 2017</td>
</tr>
<tr>
<td>Responsible Committee/ Group for approval</td>
<td>Clinical Audit and Effectiveness Committee</td>
</tr>
<tr>
<td>Ratified by</td>
<td>Clinical Audit and Effectiveness Committee</td>
</tr>
<tr>
<td>Audience</td>
<td>All clinical staff in the Cataract Service</td>
</tr>
</tbody>
</table>
**Contents**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>1 Purpose</td>
<td>4</td>
</tr>
<tr>
<td>2 Scope</td>
<td>4</td>
</tr>
<tr>
<td>3 Guidance</td>
<td>4</td>
</tr>
<tr>
<td>4 Duties</td>
<td>12</td>
</tr>
<tr>
<td>5 Training</td>
<td>12</td>
</tr>
<tr>
<td>6 Stakeholder Engagement and Communication</td>
<td>14</td>
</tr>
<tr>
<td>7 Approval and Ratification</td>
<td>14</td>
</tr>
<tr>
<td>8 Dissemination and Implementation</td>
<td>15</td>
</tr>
<tr>
<td>9 Review and Revision Arrangements</td>
<td>15</td>
</tr>
<tr>
<td>10 Document Control and Archiving</td>
<td>15</td>
</tr>
<tr>
<td>11 Monitoring compliance with this Policy</td>
<td>15</td>
</tr>
<tr>
<td>12 Supporting References / Evidence Base</td>
<td>16</td>
</tr>
</tbody>
</table>

**Appendices**

- Appendix 1 Core and advanced clinical skills
- Appendix 2 Observations
- Appendix 3 Postoperative training logbook
- Appendix 4 Postoperative consultant sign off
- Appendix 5 Preoperative training logbook
- Appendix 6 Preoperative consultant sign off
- Appendix 7 Transitional agreement and sign off
- Appendix 8 Non Medical Prescribers Initial Scope of Practice Statement
- Appendix 9 Suture removal consultant sign off
- Appendix 10 Equality Impact Assessment Tool
- Appendix 11 Checklist for the review and approval of Clinical Guidelines
Executive Summary

Cataract extraction is one of the most commonly performed and successful surgical procedures in the NHS. The aim of the surgery is to improve vision and to enhance the patient’s quality of life. Pre and postoperative clinical assessments are frequently carried out by hospital optometrists. This guideline has been developed to ensure there is consistent management of patients seen by optometrists within the cataract service, throughout the Trust. This includes training requirements, scope of practice and defined clinical patient pathways.
1. **Purpose**
   Specify the requirements of optometrists working in the cataract service, defining their scope of practice and clinical patient pathways.

2. **Scope**
   All optometrists involved in pre and postoperative patient assessments within the cataract service (extended role cataract optometrists) at Moorfields Eye Hospital NHS Foundation Trust (MEH).

3. **Guidance**

3.1 **Postoperative Patient Pathway**

i) **Patient base**
   - All patients undergoing cataract surgery at Moorfields Eye Hospital and satellite sites.

ii) **Symptoms & history**
   - Read through patients’ notes and in particular their preoperative assessment, nursing assessment, biometry and surgical notes.
   - Record any relevant additional information that has not been documented elsewhere.
   - Document their subjective status and in particular:
     - Change in vision – improved, unchanged, worse, diplopia, distortion etc
     - Ocular comfort – comfortable, irritable, pain
     - Other symptoms – photophobia, flashes, floaters, negative or positive dysphotopsia
   - Document any prescribed ocular medications and compliance.

iii) **Clinical investigations**
   - Excluding visual acuity, limit investigations to operated eyes only. If appropriate evaluate unoperated eye:
     - Note corrected distance and near visual acuity of the fellow eye should be documented with current refraction or autorefraction and with appropriate near add.
   - Autorefract all post-op patients:
     - Formally refract all high myopes and any other post-op patients at consultant request.
   - Visual acuity:
     - Unaided distance visual acuity and pinhole.
     - Unaided near visual acuity if planned or unplanned myopic outcome or multifocal implant.
     - Distance visual acuity with autorefraction result:
       - If autorefaction acuity is 6/12 or worse, formal refraction if indicated.
     - Near acuity with appropriate add.
   - Full anterior segment slit lamp examination, in particular observe:
     - Postoperative ptosis.
     - Degree of conjunctival/peri-limbal injection.
     - Corneal status.
• descemet's folds/tears, oedema, sutures, incision sites, keratic precipitates
  • pachymetry or pentacam if indicated

  o Anterior chamber
    • Depth
    • Grade of anterior chamber cells (Sun Classification using 1x1mm slit beam)
      o grade 0 – no cells, (0.5+) 1 to 5 cells, (1+) 6 to 15 cells, (2+) 16-25 cells, (3+) 26 to 50 cells, (4+) > 50 cells
    • Flare, Hypopyon, Hyphaema
    • Any vitreous or retained lens matter in AC
      o Iris trauma, prolapse, patency of peripheral iridectomy if ACIOL
      o Pupil shape - peaked pupil & vitreous wick
      o IOL and capsule status
        • IOL position, centration
        • Visually significant posterior capsular opacity/plaque or anterior capsular phimosis
        • Capsule block (distension) syndrome particularly if more myopic than planned
      o Dynamic anterior vitreous examination – cells, pigment

  • IOP – Icare or Tonopen if Goldmann not possible
  • Gonioscopy if required – document presence/absence of any lens matter (seek ophthalmologist opinion if not competent)

  • Dilation of pupil if:
    o Best corrected visual acuity worse than expected
    o Any surgical complications
    o Any patient complaining of flashes and floaters or other symptoms warranting dilation
    o No/poor preoperative fundus view
    o Patients with preoperative diabetic retinopathy
    o Posterior segment co-morbidity requiring assessment postoperatively

  • Slit lamp binocular indirect posterior segment examination if pupil dilation required and in particular
    o Dynamic vitreous assessment – pigment, white blood cells, red blood cells, haemorrhages, retained lens matter
    o Macular assessment – cystoid macular oedema
    o Peripheral fundus assessment if warranted
    o Co-morbidity status
    o If pupil dilation is not required postoperative fundus examination is not necessary

  • Posterior segment OCT if indicated
  • Other clinical investigations if warranted

iv) Treatment and management
• Optometrists can independently manage any postoperative patients who have
  o Uncomplicated surgery and improved vision
  o Best corrected visual acuity of 6/9 or better
Best corrected visual acuity worse than 6/9 which is clearly explicable and compatible with any pre-operative guarded prognosis and not associated with any worsening co-morbidity

- No refractive surprise (i.e. within +/-1 dioptre spherical equivalent from refractive target or less)
- No significant postoperative inflammation (grade 0 or 0.5+ anterior chamber cells)
- No postoperative complications
- No ocular co-morbidity requiring further management or treatment unless unaffected by cataract surgery and managed elsewhere
- No drug related side effects (e.g. toxicity, allergy, steroid response)
- Not specifically requested to see an ophthalmologist

Patients who do NOT meet the above criteria

- Discuss with or show to consultant/senior surgeon as appropriate

Patients who meet the above criteria

- Continue their postoperative drops as prescribed by the operating surgeon
- Individual surgeon prescribing habits differ but will broadly follow the post-op regime below.
  - For light irides
    - G chloramphenicol 0.5% qds for 1-2 weeks
    - G dexamethasone 0.1% qds for 2 weeks, tds for 1 week, bd for 1 week, od for one week then stop
  - For dark irides or patients with diabetes
    - G chloramphenicol 0.5% qds for 1-2 weeks
    - G dexamethasone 0.1% 6x daily for 2 weeks, qds for 1 week, tds for 1 week, bd for 1 week, od for one week then stop
- If the patient’s preoperative management plan states second eye surgery is not required they can be discharged with a letter (GP and patient copy) stating the discharge drop regime
- If second eye surgery has been planned and documented or is inferred in the preoperative assessment
  - Confirmation and valid consent should be sought in accordance with the Trust’s consent policy
    - Any surgical risk factors or guarded prognoses highlighted at the pre-assessment should be re-discussed with the patient. These patients should be seen by a consultant/senior surgeon if appropriate
  - Confirmation of planned refractive outcome required, stress spectacle requirements postoperatively and possibility of not meeting refractive target
  - Confirm surgeon suitability
    - Senior surgeons/Consultants for any surgical risk factors (see preoperative patient pathway) and only eyes
    - Consider experienced surgeon for young, working patient, high visual demands, high expectations, medical personnel/staff members
  - If on warfarin re-advice of INR requirements and print INR letter.
  - Listing for second eye letter (GP and patient copy) and send to booking clerk
• Any patients declining second eye surgery contrary to their preoperative management plan can be discharged (as set out above) providing any postoperative anisometropia can be appropriately managed and there are no adverse implications for the patient or their unoperated eye.

• Where there is no clear inference relating to second eye surgery, optometrists who have successfully completed the preoperative training programme can examine the second eye and list for surgery accordingly. All other cases should be discussed with the consultant/senior surgeon.

v) **Suture removal**

• Optometrists must be appropriately trained by a consultant and signed off as competent before they can remove sutures at the appropriate time (Appendix 9).

vi) **Referral protocol**

• Patients with ocular abnormality discovered incidentally which is unrelated to the condition for which the patient was referred should be referred back to the referring General Practitioner with a recommendation to refer to the appropriate service. Such patients should not be referred direct to another service except in the following situations:
  - Conditions where there is a risk of loss of vision unless the condition is assessed and treated promptly; eg; Neovascular age related macular degeneration or significant corneal disease.
  - Malignancy
  - Ophthalmic conditions in children [under 16]
  - Genetic eye conditions
  - Neurological conditions
  - Ocular co morbidities which need to be managed simultaneously by 2 or 3 services. For example, cataract surgery in patients with diabetic retinopathy.

vii) **Non-Medical Prescribing**

• Independent prescriber optometrists should, in conjunction with the supervising consultant, fill out a Scope of Practice (SOP) defining their area of prescribing in the Cataract Service (Appendix 8).

• Optometrists will prescribe only within their SOP and in accordance with the Moorfields Eye Hospital NMP Prescribing policy document.

• It is a legal requirement for optometrists to keep a log of prescribing practice that is relevant to their scope of practice.

viii) **Medical support**

• An ophthalmologist is required to be present for the duration of any clinic where optometrists work in accordance with this guidance.

• In the rare event an optometrist finds no ophthalmologist present in clinic please do the following:
  - Contact your clinic manager to try and arrange medical cover.
  - Notify your consultant and copy in Aneel Suri, Vincenzo Maurino, Badrul Hussein and Jasmin Singh.
If no cover is available you are still permitted to manage patients independently as set out in this guidance. Any patients requiring a doctor’s opinion will need to be rebooked within an appropriate timeframe. Any patients requiring immediate medical attention should be sent to A/E with a covering letter

o Fill out an incidence form

3.2 Preoperative Patient Pathway

i) Patient base

- All patients referred to Moorfields Eye Hospital and satellite sites for assessment and consideration of cataract surgery

ii) Symptoms & history

- Read through patients' notes and in particular their nursing assessment and biometry and document any relevant information
- Social History: Age, occupation, driver, social status (living alone?), foreign language spoken/ interpreter required
- Ocular complaints
  o Visual - Reduced best corrected vision, difficulty with any visual tasks, worsening glare, monocular diplopia/polyopia, troublesome refractive states, asymptomatic
  o Other - Mobility difficulties, falls etc
- Ocular history
  o Document any ocular treatment, surgery or conditions including any amblyopia, refractive surgery, trauma and contact lens wear
- Medical history
  o Diabetes type, hypertension, prostatic hyperplasia (alpha antagonists)
  o Any conditions compromising a patient’s ability to co-operate or be positioned during surgery
    ▪ COPD, Congestive heart failure, obesity, arthritis, kyphosis, Parkinson’s, head tremors, claustrophobia, dementia, mental illness, learning difficulties, alcohol or drug abuse, communication difficulties, deafness, extreme fear/anxiety etc
  o Severe systemic disease
    ▪ Nursing assessment to detail and advise regarding anaesthetic review
- Family ocular history
- Drug history
  o Steroids
  o Antiplatelet medication: aspirin, warfarin, clopidogrel, dipyridamole
  o Alpha antagonists: tamsulosin, alfuzosin, terazosin, doxazosin
- Allergies/Adverse reactions
  o Latex, iodine, anaesthesia

iii) Clinical investigations

- Distance, near, pinhole visual acuity using optimal correction if available
• Focimetry
• If no refractive data available, autorefraction or formal refraction where possible
  o Pentacam/topography if astigmatism ≥ 3D or biometry Ks <39D, >48D
  o Consider eligibility for toric IOL
• Cover test/Hirschberg – sensory or other strabismus
• Pupils/afferent pupillary defect
• Full external/anterior segment slit lamp examination, in particular observe
  o Prominent brow, deep set eyes
  o Ptosis
  o Blepharitis
  o Any corneal pathology – ectasia, opacities, endotheliopathies etc
    ▪ Pachymetry/pentacam if indicated
  o A/C depth and asymmetry (zoulopathy), Van Herrick’s
  o Signs of active/previous uveitis
  o Pseudoexfoliation
  o Posterior synechiae
  o Sign of previous trauma
  o Coloboma
  o Cataract in visual axis (undilated)
  o If patient already pseudophakic in one eye check if they had a multifocal or toric IOL
• IOP – Icare/Tonopen if Goldmann not possible
• Gonioscopy if indicated (refer if not competent)
• Diagnostic refraction/contact lens assessment if indicated
• If no contraindications (see list below) dilate with G. Tropicamide 1% both eyes
  o Shallow AC
  o Poor pupil/iris view
  o RAPD present
  o Axial Length < 21.00 mm even if deep AC
  o AC inflammation/activity
  o Patient driving home after consultation or unhappy about dilating pupils
  o IOP > 21mmHg even if deep AC
  o In all above cases discuss with doctor
• Dilated slit lamp examination of pupil, lens, vitreous and full binocular indirect posterior segment examination
  o Document poor pupil dilation
  o Check for pseudoexfoliation
  o Grade cataract morphology, severity and aetiology (if known)
    ▪ Document any lenticular instability (phacodonesis), lens subluxation
  o Dynamic vitreous assessment
  o Any macular, retinal, optic nerve disease
  o Staphyloma
  o Document poor fundal view
• Posterior segment OCT if indicated
• Reconsider diagnostic refraction/contact lens assessment if indicated
• Where the fundal view is poor, a B-scan is usually not required in the absence of an RAPD and with good light projection in four quadrants. Consider B-scan in all other cases.
• Other clinical investigations if warranted
Assess patient’s ability to comply with local anaesthesia

iv) Treatment and management

- Optometrists can independently manage any preoperative patients who have
  - Asymptomatic cataracts
  - Symptomatic cataracts
    - Ensure symptoms compatible and consistent with cataract
  - No lens induced ocular disease
  - No comorbidity requiring further management or treatment unless comorbidity currently managed elsewhere and will be unaffected by cataract surgery
    - If fundus not assessable discuss with consultant/senior surgeon
  - No previous complicated cataract surgery
  - Not specifically requested to see an ophthalmologist
    - Always discuss medical personnel/staff members with senior surgeon
  - No risk factors associated with cataract surgery (list below not exhaustive)
    - Any conditions compromising a patient’s ability to co-operate or be positioned during surgery
      - See above ii) symptoms and history
    - Age > 80yrs
      - Fragile capsule/zonulae
    - Deep set eyes/high brow
      - Difficult surgical access
    - High hyperopia
      - Shallow AC, choroidal effusion, IOL calculation errors
    - High myopia/axial length >26mm
      - AC depth fluctuation, RD, IOL calculation errors (staphyloma)
    - Significant blepharitis requiring medical treatment
      - Increased risk of endophthalmitis
    - Fuch’s endothelial dystrophy
      - Prolonged postoperative corneal oedema or decompensation
    - Prior keratorefractive surgery
      - IOL calculation errors, AC depth fluctuation
    - Shallow AC
      - Increased risk endothelial/iris trauma
    - Small pupil
      - Poor visualisation, increased risk capsular tear/vitreous prolapse, iris trauma
    - Posterior synechiae
      - Intra-op miosis, prolonged post-op inflammation, iris bleeding
    - Alpha antagonists: tamsulosin, alfuzosin, terazosin, doxazosin
      - Intraoperative floppy iris syndrome (IFIS), poor pupil dilation, progressive miosis. Greater risk with tamsulosin.
    - Uveitis
      - Posterior synechiae, IOL deposits, CMO, prolonged post-op inflammation
    - Zonular laxity or dehiscence
- Phacodonesis, vitreous prolapsed around lens equator, dropped nucleus, IOL decentration, late IOL dislocation
  - Pseudoexfoliation
    - Poor dilation, zonular laxity
  - Dense (brunescent) nuclear cataract
    - Increased risk of corneal oedema and PC rupture
  - White (mature cortical) cataract
    - Lens intumescence
  - Posterior polar
    - Weak or defective posterior capsule
  - Traumatic cataract
    - Weak zonules
  - Prior pars plana vitrectomy
    - AC depth fluctuation, intra-op miosis, weakened lens capsule and zonules
  - No fundal view
    - PC rupture
  - Glaucoma
    - Reduced functioning of prior filtering surgery, wipe out, poor pupil dilation due to chronic drop use, pc rupture
  - Diabetic retinopathy
    - Risk of worsening diabetic retinopathy/maculopathy, treat diabetic macular oedema first
  - Wet macular degeneration
    - Treat first if newly diagnosed, risk of worsening SRNVM
  - Retinopathy of prematurity
    - Intra-op miosis, weak zonules, RD (6-23%)

**Patients NOT suitable for independent management**
- Discuss with or show to consultant/senior surgeon as appropriate

**Patients suitable for independent management**
- Can be listed for surgery after
  - Confirmation of willingness for surgery and valid consent in accordance with the Trust's consent policy
    - Risks, benefits, implications of doing nothing, alternatives to surgery, postoperative requirements fully explained
    - Any guarded prognoses fully discussed with the patient and with a consultant/senior surgeon if appropriate
  - Confirm anaesthesia
    - Local: Topical
      - Patient tolerates manipulation of lids without blepharospasm and no surgical risk factors
    - Local: Sub-tenon's/sharp needle
    - Local with sedation
      - Allay anxiety
    - If GA indicated as below, discuss with surgeon
      - Pxs refusing LA
Any conditions compromising a patient’s ability to co-operate or be acceptably positioned during surgery
- Previous severe reaction, allergy or complication of LA

- Issue patient cataract information booklet
  - Discussion and confirmation of planned refractive outcome
    - Options of distance, near, monovision correction, impact of astigmatism discussed where appropriate
      - If suitable for toric IOL refer to surgeon for further discussion
    - Stress spectacle requirements postoperatively and possibility of not meeting refractive target
    - Briefly discuss multifocal unavailability on NHS where appropriate
  - Confirm surgeon suitability
    - Senior surgeons/Consultants for any surgical risk factors and only eyes
    - Consider experienced surgeon for young, working patient, high visual demands, high expectations, medical personnel/staff members
  - If on warfarin advise of INR requirements and print INR letter
  - Advise cease contact lens wear prior to biometry
    - 2 weeks soft C/Ls
    - 4 weeks PMMA/RGP C/Ls
  - Listing letter (GP and patient copy) and send to booking clerk

v) Referral protocol
- As postoperative guidance

vi) Non-Medical Prescribing
- As postoperative guidance

viii) Medical support
- As postoperative guidance

4. Duties
4.1 The Service Director, Head of Optometry and Optometry Cataract Lead are responsible for ensuring that this protocol is distributed and implemented within their areas of responsibility and to ensure that optometry staff are aware of the content and procedures to be followed in practice

4.2 The consultant in charge will ensure adequate supervision of optometry staff is in place and sign off competencies when required to do so

4.3 All extended role cataract optometrists have read and understand this protocol and adhere to it. Any incidents will be reported as per the Trusts Incident Reporting Policy

5. Training
5.1 Optometrist prerequisites
- One year of hospital optometry experience or one year of community cataract shared care experience or Darzi Fellowship
Competent in core clinical skills and techniques required to assess the anterior and posterior segment (Appendix 1)

5.2 Postoperative patient management
- Conversant with the Cataract Service Handbook
- Familiar with the Royal College of Ophthalmologists and College of Optometrists guidance on cataract management
- Conversant with the surgical procedure, anaesthesia and surgical day care management (Appendix 2)
- Completion of the Trust’s non-medical consent programme
  - Until complete optometrists can manage patients independently according to the guidance but will be unable to consent for surgery
- Undergo a minimum training period examining and logging 40 post-op patients (Appendix 3) during which all patients seen by the optometrist will be also be seen by a consultant, senior surgeon or senior optometrist (approved by Optometry Cataract Lead and Consultant)
- The optometrist records whether the patient is suitable for independent management in accordance with this guidance and the decision of the supervising clinician
- The consultant reviews the optometrist and their logbook and signs them off as competent if they have achieved ≥95% agreement over the latter consecutive 20 patients (Appendix 4). Copies of these forms should be retained on the optometrist’s file in the optometry department
- If less than 95% concordance is achieved and/or the consultant considers serious clinical management errors to have been made, a further training period with 20 patients will be arranged as above after which the optometrist and their new logbook will be reassessed by the consultant. This process will continue until the required level of competence is achieved or the optometrist is withdrawn from the extended role
- After successful completion of the training and consultant sign off, the optometrist can:
  - Independently assess and discharge postoperative patients in accordance with these guidelines.
  - Consent and list patients for second eye surgery in accordance with these guidelines and the Trust’s consent policy
- The optometrist will be required to maintain relevant CPD/CET

5.3 Preoperative patient management
- Successful completion of the postoperative cataract training programme
- Undergo a minimum training period examining and logging 40 pre-op patients (Appendix 5) during which all patients seen by the optometrist will be also be seen by the consultant, senior surgeon or senior optometrist (approved by Optometry Cataract Lead and Consultant)
- The optometrist records whether the patient is suitable for independent management in accordance with this guidance and the decision of the supervising clinician
- The consultant reviews the optometrist and their logbook and signs them off as competent if they have achieved ≥95% agreement over the latter
consecutive 20 patients (Appendix 6). Copies of these forms should be retained on the optometrist’s file in the optometry department

- If less than 95% concordance is achieved and/or the consultant considers serious clinical management errors to have been made, a further training period with 20 patients will be arranged as above after which the optometrist and their new logbook will be reassessed by the consultant. This process will continue until the required level of competence is achieved or the optometrist is withdrawn from the extended role.
- After successful completion of the training and consultant sign off, the optometrist will be able to assess and either o Consent and list patients for surgery in accordance with the Trust’s consent policy and these guidelines o Discharge patients in accordance with these guidelines
- The optometrist will be required to maintain relevant CPD/CET

5.4 Staff are accountable to their employer to follow their contract of duty and to their regulatory and professional bodies

5.5 Transitional agreements
- Optometrists currently working in the Cataract Service who have received consultant sign of under any older cataract protocol can be signed off as competent against the new guidelines if they (Appendix 7)
  o Meet the prerequisite requirements above
  o Have over the course of their clinical work within the Cataract Service, met the training requirement detailed above as broadly reflected in their extended role patient logs
  o Meet the duty requirements detailed in section 4.3.
- Any sign off will be at the consultant’s discretion
- All other optometrists will be required to complete the training above.

6. Stakeholder Engagement and Communication
6.1 This document has been developed by the Optometry Cataract Lead and the Cataract Service Director for all extended role cataract optometrists

6.2 Consultant ophthalmologists within the cataract service, the Head of Optometry, the Optometry Prescribing Lead and all senior optometrists working within the cataract service have had the opportunity to review and comment on this document

7. Approval and Ratification
7.1 The guideline has been approved by the Cataract Service Director, Head of Optometry and Optometry Cataract Lead and will be approved by the Clinical Audit and Effectiveness Committee

7.2 The guidelines will be ratified by the Clinical Audit and Effectiveness Committee
8. Dissemination and Implementation
8.1 The protocol will be placed on the Trust Intranet and forwarded to the Cataract Service Director, Head of optometry, Optometry Cataract Lead and all extended role cataract optometrists and associated consultants

8.2 Induction for newly appointment optometrists by Optometry Cataract Lead

8.3 Updates via email from Optometry Cataract Lead

9. Review and Revision Arrangements
The guideline will be reviewed by the Policy Owner/Author every three years or earlier if changes to clinical practice facilitating service improvement become apparent or changes in The Royal College of Ophthalmologists or College of Optometry guidance warrant revisions

10. Document Control and Archiving
10.1 The current and approved version of this document can be found on the Trust's intranet site. Should this not be the case, please contact the Head of Clinical Governance

10.2 Previously approved versions of this document will be removed from the intranet by the Head of Clinical Governance and archived on the governance shared drives. Any requests for retrieval of archived documents must be directed to the Head of Clinical Governance

11. Monitoring compliance with this Clinical Guideline

<table>
<thead>
<tr>
<th>Monitoring method</th>
<th>Monitoring frequency</th>
<th>Monitoring lead</th>
<th>Monitoring reported to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rolling audit</td>
<td>Two yearly</td>
<td>Optometry Audit Lead</td>
<td>Clinical audit assessment committee</td>
</tr>
</tbody>
</table>

11.1 All optometrists to keep a log of all patients seen including name and hospital number

11.2 Consultant agreed deviations from the protocol should be logged on the optometrists consultant sign off form or recorded in a patient’s hospital records

11.3 Instances of significant failure to adhere to the protocol not agreed by the consultant should be reported using the trust incident reporting system where there has been actual, potential or near-miss patient harm.

11.4 In addition to the monitoring arrangements described above the Trust may undertake additional monitoring of this clinical guideline as a response to the identification of any gaps, or as a result of the identification of risks arising from the guideline prompted by incident review, external reviews or other sources of information and advice.
This monitoring may include commissioned audits and reviews, detailed data analysis or another focussed study, for example. Results of this monitoring will be reported to the committee and/or individual responsible for the review of the process and/or the risks identified.

Monitoring at any point may trigger a clinical guideline review if there is evidence that the guideline is unable to meet its stated objectives.

12. **Supporting References / Evidence Base**
   - MEH Cataract Service Handbook v1.6
   - MEH Toric IOL Protocol v1.0
   - MEH Consent Policy v2.0
   - MEH Non Medical Prescriber policy document
   - The Royal College of Ophthalmologists Cataract Surgery Guidelines September 2010
   - College of Optometrists Framework for the Optometric Co-Management of Patients with Cataract 2003
   - MEH St Ann’s DTC cataract protocol February 2008
   - MEH Cataract protocol common_v6 (Aug05)
   - MEH St Ann’s DTC cataract protocol June 2005
   - MEH Glaucoma protocol for optometrists 2.0 June 2012
   - MEH Anterior Uveitis protocol for optometrists 1.2 November 2012
   - MEH A&E protocol for optometrists V2.2
Appendix 1

Core clinical skills:
1. Slit lamp biomicroscopy – all slit lamp techniques
2. Tonometry - Goldmann, tonopen, icare
3. Slit-lamp binocular indirect ophthalmoscopy

Advanced clinical skills
1. Gonioscopy
2. Headset binocular indirect ophthalmoscopy
3. Suture removal
4. Imaging
### Appendix 2

<table>
<thead>
<tr>
<th>Observation</th>
<th>Date</th>
<th>Sign off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cataract surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharp needle LA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day care management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 3

Postoperative training logbook

<table>
<thead>
<tr>
<th>Date</th>
<th>Hospital No.</th>
<th>Suitable for independent management</th>
<th>Supervisor decision</th>
<th>Supervisor signature</th>
<th>Complications identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4

Postoperative consultant sign off

Consent of consultant to the optometrist treating and managing patients independently in the cataract clinic as set out in the clinical guidelines:

Signed: _____________________ (Optometrist)

Print name: _____________________  Date: ___/___/___

Signed _____________________ (Consultant Ophthalmologist)

Print name _____________________  Date: ___/___/___

Consultant agreed deviations

Signed: _____________________ (Optometrist)

Print name: _____________________  Date: ___/___/___

Signed _____________________ (Consultant Ophthalmologist)

Print name _____________________  Date: ___/___/___
# Appendix 5

## Preoperative training logbook

<table>
<thead>
<tr>
<th>Date</th>
<th>Hospital No.</th>
<th>Suitable for independent management</th>
<th>Supervisor decision</th>
<th>Supervisor signature</th>
<th>Risk factors identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6

Preoperative consultant sign off

Consent of consultant to the optometrist treating and managing patients independently in the cataract clinic as set out in the clinical guidelines:

Signed: _____________________ (Optometrist)

Print name: _____________________  Date: ___/___/___

Signed _____________________ (Consultant Ophthalmologist)

Print name _____________________  Date: ___/___/___

Consultant agreed deviations

Signed: _____________________ (Optometrist)

Print name: _____________________  Date: ___/___/___

Signed _____________________ (Consultant Ophthalmologist)

Print name _____________________  Date: ___/___/___
Appendix 7

Transitional Agreement

Preoperative/postoperative consultant sign off

Consent of consultant to the optometrist treating and managing patients independently in the cataract clinic as set out in the clinical guidelines:

Signed: _____________________ (Optometrist)

Print name: _____________________  Date: __/__/__

Signed _____________________ (Consultant Ophthalmologist)

Print name _____________________  Date: __/__/__

Consultant agreed deviations

Signed: _____________________ (Optometrist)

Print name: _____________________  Date: __/__/__

Signed _____________________ (Consultant Ophthalmologist)

Print name _____________________  Date: __/__/__
Non Medical Prescribers Scope of Practice Statement & Registration Form

Information collected on this form will remain confidential and will be processed in compliance with the Data Protection Act 1988

Title: __________________________

First Name: ________________________
Surname: __________________________
Work Email: ________________________
Telephone: _________________________
Mobile: ____________________________

Designation: Nurse ☐
Optometrist ☐
Pharmacist ☐

Professional Registration Number: (e.g. NMC, General Optical Council or GPhC)

Non Medical Prescriber’s official stamp __________________________

Form of Prescriber:
Independent ☐
Supplementary ☐

Scope of Practice/Area(s) of Prescribing Competency e.g. Adnexal, A&E

What are your CPD/CET needs relating to prescribing?

Please state date prescribing qualification obtained and institution

Authorised Date to start prescribing (agreed with Line manager): Click here to enter a date.

Non Medical Prescriber Name: __________________________ Signature: __________________________ Date: Click here to enter a date.

Line Manager Name: __________________________ Signature: __________________________ Date: Click here to enter a date.
Appendix 9

Suture removal consultant sign off

The optometrist has been appropriately trained is competent at corneal suture removal

Signed: _____________________ (Optometrist)

Print name: _____________________   Date: ___/___/___

Signed _____________________ (Consultant Ophthalmologist)

Print name _____________________   Date: ___/___/___
### Appendix 10

**Equality Impact Assessment**
The equality impact assessment is used to ensure we do not inadvertently discriminate as a service provider or as an employer. To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th>1. Does the policy/guidance affect one group less or more favourably than another on the basis of:</th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Nationality</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Gender reassignment</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Pregnancy and maternity</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Marriage and civil partnership</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Disability (e.g. physical, sensory or learning)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>• Mental health</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Is there any evidence that some groups are affected differently?</th>
<th>Yes/No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If you have identified a potential discriminatory impact of this procedural document, please refer it to the director of corporate governance, or the human resources department, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the director of corporate governance (ext. 2306)

Please ensure that the completed EIA is appended to the final version of the document, so that it is available for consultation when the document is being approved and ratified, and subsequently published.

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
</tr>
<tr>
<td>4</td>
<td>Is the impact of the policy/guidance likely to be negative?</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>If so can the impact be avoided?</td>
<td>N/A</td>
</tr>
<tr>
<td>6</td>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
</tr>
<tr>
<td>7</td>
<td>Can the impact be reduced by taking different action?</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Appendix 11

Checklist for the Review and Approval of Clinical Guidelines
To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: Cataract Clinical Guidelines for Optometrists
Guideline (document) Author: Aneel Suri & Vincenzo Maurino
Guideline (document) Owner: Optometry and Cataract Service

<table>
<thead>
<tr>
<th></th>
<th>Yes/No/Unsure/NA</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Title</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the title clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Is it clear that this document is a Clinical Guideline?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>2. Scope/Purpose</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the target population clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Is the purpose of the document clear?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are the intended outcomes described?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are the statements clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>3. Development Process</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there evidence of engagement with stakeholders and users?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Who was engaged in a review of the document (list committees/individuals)?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Has the policy template been followed (i.e. is the format correct)?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>4. Evidence Base</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the type of evidence to support the document identified explicitly?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are local/organisational supporting documents referenced?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Approval</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does the document identify which committee/group will approve/ratify it?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?</td>
<td>Yes</td>
</tr>
<tr>
<td>6.</td>
<td><strong>Dissemination and Implementation</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is there an outline/plan to identify how this will be done?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Does the plan include the necessary training/support to ensure compliance?</td>
<td>Yes</td>
</tr>
<tr>
<td>7.</td>
<td><strong>Process for Monitoring Compliance</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are there measurable standards or KPIs to support monitoring compliance of the document?</td>
<td>Yes</td>
</tr>
<tr>
<td>8.</td>
<td><strong>Review Date</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the review date identified and is this acceptable?</td>
<td>Yes</td>
</tr>
<tr>
<td>9.</td>
<td><strong>Overall Responsibility for the Document</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?</td>
<td>Yes</td>
</tr>
<tr>
<td>10.</td>
<td><strong>Equality Impact Assessment (EIA)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Has a suitable EIA been completed?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Committee Approval:** Clinical Audit and Effectiveness Committee

If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner.
<table>
<thead>
<tr>
<th>Name of Chair</th>
<th>Melanie Hingorani</th>
<th>Date</th>
<th>10\textsuperscript{th} October 2014</th>
</tr>
</thead>
</table>

**Ratification by Management Executive (if appropriate)**

If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner.

Date: N/A