Patient standards for ophthalmology services

There are many national standards covering patient focus and patient experience in healthcare, such as those from NICE, which should be respected for patients receiving ophthalmology services. This document outlines the standards for care which are very specific, or most important, to those receiving eye care and those with ophthalmic or visual conditions. They have been developed by patients, patient charities and eye care professionals working together, and include key elements of existing national guidance. They should be used as a supplement to existing non-ophthalmic-specific-patient standards and cover the whole care pathway for those with ophthalmic disease.

Access to treatment

- **Services should be able to accommodate:**
  - New patients seen in line with clinical urgency and guidelines from NICE, national screening and The Royal College of Ophthalmologists (RCOphth)
  - Review (returning) patients seen by an appropriately trained professional in line with clinician-requested timing of appointments and NICE and RCOphth intervals
  - Access to conveniently located co-ordinated care across primary care, hospital, community, rehabilitation, support and voluntary services
  - Timely access to rehabilitation, vision aids, and specialist counselling
  - Patients with rare conditions and comorbidities
  - Identification of, and rapid care for, urgent and emergency cases at all times
  - Avoidance of repeated cancellations or delays to care
  - Ability to book next appointment before leaving the care setting if possible.
- Direct referrals, referral refinement and advice and guidance services involving community health care professionals (HCPs) such as optometrists should be used to minimise unnecessary hospital attendances.
- In-clinic, waiting times should be kept to a minimum, be audited and patients kept informed on the day of current waiting times.

- Services should be able to identify, and make reasonable adjustments for, patients with dementia, communication needs and learning difficulties, which may include specialist clinics, flexible appointment times, shorter wait times, or longer appointments, taking into account patient passports or similar e.g. 'This is Me'
- Non-attendance policies should be sufficiently flexible to account for specific patient needs, and include communication with patient and GPs on decisions.
- Access to support services should not be driven by clinical parameters and certification status alone, but also by social, emotional, psychological, educational and occupational effects.

Understanding and supporting patients

- Patients should be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.
- Healthcare professionals should develop an understanding of the patient, by regularly asking about and addressing:
  - Their domestic, social, work and driving situation
  - The impact of patients' physical and visual disabilities, general health and any cognitive impairment on care
  - Their psychological adjustment to vision loss; identify and manage possible depression according to NICE guideline CG91.
- Staff should know how to meet, greet and guide patients with sight loss.
- Visual function should be assessed in drivers (adults/teenagers reaching driving age), with advice given on Driver and Vehicle Licensing Agency (DVLA) regulations and findings reported to driving assessment agencies as patient requires.
- Low vision leaflet (LVL), Referral of Visual Impairment (RVI) or Certificate of Vision Impairment (CVI or CVI Scotland) should be offered to all people as soon as eligible, even during active treatment, to bring patients to the attention of social care services.
- Recognise the impact of even partial uncorrectable vision loss, and provide appropriate support.
- Eye Clinic Liaison Officers [ECLOs] should:
  - Always be provided within the hospital eye service

  - Adhere to, and be trained in accordance with, the RNIB ECLO Quality Framework, and have completed the Eye Clinic Support Studies course accredited by City University.
  - Always provide a person-centred service to people of all ages affected by sight loss including relatives and carers
  - Offer information, practical advice on aids and adaptations, and emotional support
  - Empower people to access appropriate statutory and community support services
  - Offer an initial screening of needs and signpost and refer clients to local and national services and organisations to meet their needs
  - Utilise agreed referral processes to local services such as Rehabilitation, Low Vision and Social Care
  - Assist with local certification and registration processes.
- Low vision, habilitation and rehabilitation services should:
  - Provide support early to prevent loss of skills, confidence and motivation, and be ongoing to respond to changes in circumstances
  - Assess patient concerns about independence, engaging in activities, family interactions, fears, emotional support, visual impairment registration and Charles Bonnet Syndrome
  - Be seamlessly incorporated into the eye care and sight loss pathway with other clinical services (hospital eye units, education, social care, voluntary organisations and stroke, learning disability, and falls teams)
  - Be open to people beyond those who meet specific visual thresholds or have a CVI
  - Help people to regain or maintain as much independence as possible
  - Help carers to understand the impact of the patient's condition on vision and lifestyle.

Communication [with patients]

- Patients should be welcomed acknowledged on arrival, with check in procedures accessible to those with sight loss
- All staff involved in care who meet the patient should introduce themselves clearly, with name and role

- Staff should communicate effectively and sensitively, and listen carefully to patients' needs, concerns and preferences. Staff need to be alert to unspoken signals which could indicate a patient's lack of understanding, discomfort, or lack of consent. Adequate time should be allowed so that the discussions do not feel rushed.
- Reasonable adjustments should be made to ensure that physical or learning disabilities, sight, speech, hearing and reading difficulties, or problems. understanding or speaking English do not limit patients' participation in consultations and care
- Staff should avoid jargon, explain unfamiliar terms, and confirm understanding by asking questions.
- Patients should be informed how to seek advice and care in and out of hours, including for urgent problems at any time, and should be able to make contact successfully.
- Systems should be in place for patients who have communication/information needs:
  - Identify needs with a standard question(s) over the phone, at the reception desk or with an admission form, ideally upon first contact with the service
  - Record a patient's communication needs in a standard and highly visible way and ensure that is respected for future interactions
  - Provide communication support and allow additional time for appointments where required.

Information provision and shared decision-making

- Healthcare professionals should routinely provide oral information, an opportunity for asking questions, and accessible (e.g. email, large print [minimum font size 14 for **all** patients], braille, electronic / on line or audio) easy to understand information to take away to patients and family members/carers about:
  - Diagnosis and condition
  - Prognosis including sight retention
  - Treatment options including risks and benefits
  - Medication use and potential side effects

  - Patient's role in treatment (e.g. adherence, lifestyle, self-monitoring)
  - The importance of regular monitoring, what appointments and investigations will entail, where they will take place, and anticipated wait times
  - What to expect or what will happen next
  - Discharge and re-referral.
- The patient should be advised where to find reliable high-quality information and support after consultations (e.g. national or local support groups and charities, networks and information services).
- Formal tools for ophthalmic shared decision making should be used where helpful.
- Patient should be offered a written record of what was agreed during the consultation and copies of letters between healthcare professionals.
- Consider writing clinical letters directly to the patient, using suitable language, with copies to professionals rather than the other way around.
- Letters and other written information should be minimum font size 14 and high contrast.
- In Wales patients have the right to request written information in the Welsh language under the Welsh Language Act.

Communication/information sharing between professionals

- Relevant documentation should be available at each clinical encounter, including clinical notes and results of specialist investigations across all care settings.
- There should be a communication plan that shares information securely with relevant practitioners (optometrists, ophthalmologists, orthoptists, GPs, support services, education services), to keep all informed, and to co-ordinate, and prevent duplication of, care. Ask patient consent before sharing information beyond the healthcare team (e.g. education, voluntary).
- Hospitals should provide feedback on referrals and training on referral quality and pathways to colleagues especially community optometrists.

Active participation of patients in care

- Patients should be advised to continue regular visits to their primary eye care professional (usually optometrist) at clinically appropriate intervals e.g. for glaucoma screening, if not being done as part of eye clinic care.
- Professionals should consider the ease of use of medications and provide advice and practical guidance on medication and available aids (e.g. drop administration devices) for each patient, taking into account all aspects of the patient.
- Professionals should ask about treatment adherence and check eye drop technique where relevant e.g. for glaucoma.
- Information provided to patients (or family members/carers) should promote active participation in their care by:
  - Outlining the importance of self-monitoring and attending regular clinic visits
  - Encouraging patients to make a note of questions to raise at future appointments
  - Informing patients who to contact if their vision changes or there are serious symptoms, and to do so promptly
  - Increasing awareness about community services to help them self-manage, including from the IGA, the RNIB and local voluntary groups.

Environment

- Hospital eye services and community clinics should ensure a good environment for people with low vision in line with RNIB Visibly Better standards:
  - Good use of natural light and ability to block sun using blinds etc.
  - Glare is managed
  - Good use of general light, ensuring sufficient lux levels (at last 100 lux) and avoiding dark shadows on the floor
  - Consider use of task lighting where people are signing forms etc.
  - Good use of contrast - ensuring that key features and furniture have sufficient contrast with their environment, e.g. adding high contrast strips to the edges of steps can make them much easier to detect and thus

reduce falls, chairs in waiting areas have sufficient contrast with flooring / walls
    - Contrasting door furniture and surrounds (handles, frames)
    - Clear high contrast large font signage
    - Floors are not shiny / reflective
    - Patient areas are not cluttered nor have obstacles.
- For people with dementia, or other conditions associated with sensory processing difficulties (eg autistic spectrum disorder), consider:
    - A pre-appointment visit for them to become familiar with the surroundings
    - Quiet rooms, and pathway for managing their clinic visit can be helpful
    - Changes to lighting, colour schemes, floor coverings, assistive technology, signage, wide doorways, colour contrasts, minimising reflections and glare and notice boards.
- Provide additional chairs for parents/carers/interpreters.
- For important or sensitive discussions, there should be a suitable private place to talk, away from noise, distractions and interruptions.

Evidence sources

Organisation/authors	Title
NICE	Glaucoma diagnosis and management NG81
NICE	Cataracts in adults: management NG77
NICE	Age related macular degeneration NG82
Royal College of Ophthalmologists	Quality standards for cataract services
Royal College of Ophthalmologists	Quality standards for glaucoma services
Royal College of Ophthalmologists	Quality standards for medical retina services
Royal College of Ophthalmologists	Quality standards diabetic retinopathy services
Royal College of Ophthalmologists	Quality standards for patients with sight loss and dementia in an ophthalmology department

Royal College of Ophthalmologists	Commissioning guidance glaucoma
Royal College of Ophthalmologists	Commissioning guidance cataract
CCEHC	Low vision, habilitation and rehabilitation framework for adults and children
CCEHC	Primary eye care framework
CCEHC	Community ophthalmology framework
Vision 2020	Vision 2020 portfolio of public health indicators
Vision 2020	Eye health network for London achieving better outcomes
British and Irish Orthoptic Society	Competency standards and professional practice guidelines 2014
College of Optometrists	Professional practice guidance : communication, partnership and teamwork: partnership with patients
College of Optometrists	Commissioning better eye care – adults with low vision 2013
American Academy of Ophthalmology	Vision rehabilitation preferred practice patterns
Academy of Medical Royal Colleges	Please write to me. 2018
RNIB	Make Sight loss a public priority
RNIB	Visibly Better
NICE	Patient experience in adult NHS services (CG138)
NICE	Patient experience in adult NHS services Quality standard QS15
NHS Constitution	The NHS Constitution: the NHS belongs to us all
NHS England	Accessible patient information standard specification
NHS England	Accessible patient information standard specification change paper
NHS England	Accessible patient information standard implementation
NHS England	Accessible patient information standard implementation change paper
Northern Ireland Public Health Agency	10,000 Voices Report – Hospital Eye Services (2018)