

{Insert} Name of Trust

# Clinical Policy for extended role for non-medical Practitioners in Cataract clinics

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## Clinical Guideline Summary

*This guideline describes the processes required for non- medical staff to assess patients in cataract clinic.*

**Version:** X.0

**Status:** Final :

**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

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## 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 as well as the NHS England National Elective Care High Impact Intervention and GIRFT

## 2. Purpose

This policy sets out the process required for designated HCP to train for and to deliver cataract assessment in extended roles to the standards required by NICE and the RCOphth. This will contribute to the efficient delivery of the cataract 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 capacity for the ophthalmology service. Staff will be able to develop their roles further, increasing the overall level of expertise in the department and promoting greater job satisfaction.

The policy provides details of:

- the training and competencies
- guidance for the management of patients
- standard operating procedures
- the process to be used for monitoring compliance with the process and outcomes

## 3. Scope

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

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

- Consent Policy
- Clinical Governance/Risk Policy
- Biometry/intraocular lens policy
- Local Safety Standards for Invasive Procedures (SSIPs)
- Preoperative assessment policy.

To be eligible for delivering this care the procedure staff must have a minimum of 1 year's 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 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.

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Suitable staff members from a nursing or orthoptic background at band 5 level may commence training for an extended role in paediatric ophthalmology and progress to band 6 on completion of their training.

## **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, keeping 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
- undertake regular clinical update sessions or CPD on cataract 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 responsibilities**

To 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 who is a named cataract clinic trainer that is a cataract HCP with more than 2 years' experience, or a fellow or ST 6 and above ophthalmic trainee. However the consultant retains responsibility for the training and sign off of the HCP before they begin 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 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**

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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 cataract 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 employers will ensure that the HCPs 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 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.

### 5.1 Baseline competencies for training

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

- Slit lamp
- Tonometry
- Slit lamp funduscopy with fundus lens
- Understanding refractive errors and refractive correction
- Basic knowledge of cataract and ophthalmic disease.
- Consenting.

For these baseline skills and knowledge/experience, the trainer / 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 cataract 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 cataract advanced practice training. Staff wishing to undertake consent for cataract surgery must complete the trust consent training.

### 5.2 Cataract advanced practice training

The HCP will gain the appropriate **theoretical knowledge** of anatomy and physiology, 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 local and national cataract care guidelines

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- E-learning modules e.g. RCOphth cataract modules on *E-Learning for Health*.

The HCP will need to know:

- Anatomy and physiology of the eye
- Causes of cataract
- Classification of cataract
- Assessment of cataract and other ocular and systemic disease
- Knowledge of refraction, refractive errors and refractive targets in cataract surgery
- Imaging (A scan, B scan, OCT) relevant to cataract related conditions and comorbidities
- Biometry, choosing an IOL, avoiding wrong IOLs
- Ocular and systemic and personal risk factors for surgery and how to risk stratify cataract surgery
- Principles of cataract surgery
- Latest clinical information on cataract surgery and treatment delivery
- Process of cataract surgery, including the practicalities, the pathway, the on the day journey
- Anaesthetic types, risk and benefits, anaesthetic choices for cataract surgery
- Any CCG thresholds for surgery
- Infection control for cataract surgery
- Pharmacology to include relevant drugs to assess, during and following cataract surgery, drugs that affect cataract surgery
- Recognition of intraoperative and postoperative complications and what actions to take
- Is aware of any possible red flags and how to escalate concerns
- Risk and legal issues around extended role development
- How to audit NMP practice

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 (pre and post op cataracts, other specific areas) there should be in the portfolio a disease specific logbook of at least 20 cases (Appendix) and at least 2 successfully completed work based assessments (Appendix).
- 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

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- 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 for 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 Cataract 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.
- The HCP will undergo review of practice and the portfolio as part of their annual appraisal / individual performance review.

### 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 cataract 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

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- 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 cataract 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. Outcome 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 Engagements and Communication

The cataract team developed this guideline with contributions from 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 provision of cataract service, and will be communicated to key stakeholders and protocol 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.

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## 11.0 Review and Revision Arrangements

The Policy Owner/Authors will initially review this document on a 3-year basis. Changes to the legislation or national guidelines of the administration of cataract assessment and consultation - 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

Element to be Monitored	Staff conducting	Tool for Monitoring	Frequency	Responsible Individual/Group for results/actionst
Service delivery and unit outcomes	Lead Cataract Consultant	Audit	Every 12 months	Ophthalmic or cataract clinical lead
HCP	Senior cataract ophthalmology clinicians and line manager	Appraisal and individual performance review - portfolio of audit, practice and knowledge	Annually	Line manager and cataract ophthalmology trainer
Complications or adverse events to be recorded	All staff	Incident reporting	On-going	Ophthalmology CG
Complaints	Complaints team	Complaints process	On-going	Ophthalmology CG

## 14.0 Supporting References / Evidence Base

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

The British & Irish Orthoptic Society Code of Ethics.

[https://orthoptics.org.uk/Resources/Documents/Standards/BIOS\\_Code\\_of\\_Ethics.pdf](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/>

org/aboutregistration/standards/standardsofconductperformanceandethics/

BIOS – Competency document 2016..

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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) Ophthalmic Common Clinical Competency Framework (CCCF).

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> , 2014.

RCOphth Quality Standards for cataract services. RCOphth 2015.

NICE guidance for adult cataract NG17. 2017

RCOphth/UKOIA IOL quality standard 2018

Moorfields Optometrists Protocol for Cataract Clinics

## **Local documents**

Ophthalmology department guidelines

Consent policy

Clinical record keeping policy

Clinical governance /. Risk policy

Local safety standards for invasive procedures

Preoperative assessment policy

Mental capacity policy.

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## Appendix 1. Competencies. Cataract eye conditions: Competency checklist -

Successful completion of this competency will enable the HCP to assess specified condition/subspecialty patients independently with the cataract service.

Aims and Objectives	The HCP is able to demonstrate supporting knowledge, understanding and has been observed as competent to effectively examine patients in the cataract subspecialty of the ophthalmology service
Training Prerequisite	Prior to this assessment the practitioner has successfully completed the following: <b>Theoretical knowledge via courses, e-learning or local training</b> <b>Observational work based training</b> <b>Background reading, learning and theory portfolio produced for cataract</b>
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: .....	
<b>Policies, Guidelines and Protocols:</b>	<b>Date policy read by clinician and initials</b>
Local policies x	
Mental capacity policy	
Consent policy	
Trust IOL/biometry policy	
NG7 NICE guidance for adult cataracts	
RCOphth/UKOA IOL quality standard	

	<b>Underpinning knowledge and understanding demonstrated for:</b>	<b>Date and assessor initials</b>
<b>Local clinical policies or guidelines</b>	<ul style="list-style-type: none"> <li>• Consent policy</li> <li>• Mental capacity policy</li> <li>• Local policy etc</li> <li>• (key policies such as mental capacity,</li> </ul>	

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	safeguarding and consent)	
<b>National policies and guidelines</b>	<ul style="list-style-type: none"> <li>• Demonstrates understanding of NICE cataract guidance</li> <li>• Demonstrates understanding of UKOA / RCOphth IOL quality standard</li> </ul>	
<b>Knowledge specific to cataract sub-speciality</b>	<p>Demonstrates knowledge of:</p> <ul style="list-style-type: none"> <li>• Anatomy and physiology of the eye</li> <li>• Causes of cataract</li> <li>• Classification of cataract</li> <li>• Assessment of cataract and other ocular and systemic disease</li> <li>• Knowledge of refraction, refractive errors and refractive targets in cataract surgery</li> <li>• Imaging (A scan, B scan, OCT) relevant to cataract related conditions and comorbidities</li> <li>• Biometry, choosing an IOL, avoiding wrong IOLs</li> <li>• Ocular and systemic and personal risk factors for surgery and how to risk stratify cataract surgery</li> <li>• Principles of cataract surgery</li> <li>• Latest clinical information on cataract surgery and treatment delivery</li> <li>• Process of cataract surgery, including the practicalities, the pathway, the on the day journey</li> <li>• Anaesthetic types, risk and benefits, anaesthetic choices for cataract surgery</li> <li>• Any CCG thresholds for surgery</li> <li>• Infection control for cataract surgery</li> <li>• Pharmacology to include relevant drugs to assess, for and following cataract surgery, drugs that affect cataract surgery</li> <li>• Recognition of post-op complications and what actions to take</li> <li>• Is aware of any possible red flags and how to escalate concerns</li> <li>• .</li> </ul>	
<b>Professionalism</b>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Demonstrates an in depth understanding of their duty to maintain professional and ethical standards of confidentiality</li> <li>• Risk and legal issues around extended role development</li> <li>• How to audit NMP practice</li> </ul>	
<b>Performance Criteria</b>	<b>Date of assessment and assessor initials</b>	

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WpBA for preop cataract undertaken and passed x 2	
WpBA for postop undertaken and passed x 2	
Attended 1 surgical sessions	
Disease specific caselog (20 patients)	

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## Workplace based assessment recording form - Preoperative

Brief description of case:		
Expectations:	Achieved(or not applicable)	Not Achieved
<b>Notes review</b> <b>History:</b> Symptoms, duration, effects on lifestyle and daily activities, past ophthalmic history, medical history, medications, family history, social history, allergies, any key questions Correct <b>set-up/start</b> phase.		
Correct selection of <b>equipment</b> and able to use with confidence:		
<b>Appropriate examination</b> undertaken including as appropriate: <ul style="list-style-type: none"> <li>• Observation of face, lid and bodily appearance</li> <li>• <b>Best corrected visual acuity, pinhole and current refractive status</b></li> <li>• Assessment of lids including:               <ul style="list-style-type: none"> <li>○ Blepharitis</li> <li>○ Entropion, ectropion</li> <li>○ Lid squeezer</li> </ul> </li> <li>• Assessment of conjunctiva</li> <li>• Assessment of cornea including endothelium:</li> <li>• Assessment of pupils and iris including:               <ul style="list-style-type: none"> <li>○ pupil reactions/RAPD</li> <li>○ pupil size after dilatation/synechia</li> </ul> </li> <li>• Assessment of AC</li> <li>• Assessment of lens, cataract morphology and severity</li> <li>• Fundoscopy: disc, macular, retina</li> <li>• IOP</li> <li>• etc</li> </ul>		
Correct documentation of findings.		
Correct investigations and interpretation e.g. imaging, biometry, other tests		
Correct counselling, advice, risk, benefits, refractive aims, information provision		
Correct management plan/follow up including identification and highlighting risks or surgical or anaesthetic requirements		
Areas of particularly good practice:	Areas for improvement:	
Discussion:		

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Actions:

**Outcome: Pass/ Fail**

## **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 patient AND carers.

Builds good rapport with the patient 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, social,, medications, allergy and family history completed. Asks any important key questions.

## **Examination**

The clinician selects the appropriate assessments which will help them to gain the best clinical picture.

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. Able to provisionally plan IOL and identify unusual biometry or IOI results.

Clinician is able to discuss with patient 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, is able to identify risk of patient and suitability for different lists and anaesthesia. Clinician can provide information on disease, options, risks, benefits, pathway and practicalities. Clinician is able to answer queries.

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## Workplace based assessment recording form - Postoperative

<b>Brief description of case:</b>		
<b>Expectations:</b>	<b>Achieved(or not applicable)</b>	<b>Not Achieved</b>
<b>Notes/op note review</b> <b>History: Vision</b> , symptoms, d, any key questions		
Correct <b>set-up/start</b> phase.		
Correct selection of <b>equipment</b> and able to use with confidence:		
<b>Appropriate examination</b> undertaken including as appropriate: <ul style="list-style-type: none"> <li>• Unaided and corrected visual acuity, pinhole and current refractive status</li> <li>• Mainly assessing operated eye</li> <li>• Assess other eye in terms of second eye surgery and previous assessment</li> <li>• Assessment of lids</li> <li>• Assessment of conjunctiva</li> <li>• Assessment of cornea including wound:</li> <li>• Assessment of pupils and iris including</li> <li>• Assessment of AC</li> <li>• Assessment of IOL</li> <li>• Fundoscopy: disc, macular, retina as required</li> <li>• IOP</li> <li>• Identification of any issues or complications</li> </ul>		
Correct documentation of findings.		
Correct investigations and interpretation e.g. OCT, other tests		
Correct counselling, advice, risk, benefits, information provision including advice on drops, postop community optometrist, other eye surgery		
Correct management plan/follow up.		
Areas of particularly good practice:	Areas for improvement:	
Discussion:		

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Actions:

**Outcome: Pass/ Fail**

## **Set-up phase**

Clinician ensures room set up and equipment required present and records and test results all present. Checks back through notes including op note. Introduces themselves to the patient/parents and identifies all parties in the room. Engages effectively with the patient AND carers.

Builds good rapport with the patient 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 postop results, recovery or any complications, ensures checks medication use. Asks any important key questions.

## **Examination**

The clinician selects the appropriate assessments which will help them to gain the best clinical picture.

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. Identifies any complications.

## **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 suitable management plan

## **Investigations**

Plans, documents and organises suitable tests. Does not over investigate, able to interpret tests eg OCT. Clinician is able to discuss with patient 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, is able to identify issues or complications. .

Clinician can provide information and advice on routine care and discharge, issues or seek medical help for complications.

Clinician is able to answer queries.

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**Appendix 2. Record of 20 supervised cases**

Name, designation and signature .....

Date	Pt record Number	Comments	Signature of practitioner	Signature of Supervisor

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### 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

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## 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 3<sup>rd</sup> 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 ciclosporin 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

# Protocol for advanced practice for cataract clinics

## 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 cataract 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 criteria and the consultant ophthalmologist. Low risk patients have a low likelihood of intraoperative or postoperative complications and will usually be able to be operated on in high volume local anaesthetic lists and may be managed independently by the HCP once deemed competent. High risk patients are those whose eye, general health or general condition have a higher than usual risk of intraoperative complications, postop complications difficult surgery, or may not be suitable for high volume local anaesthetic lists or are complex for decision making e.g. toric lenses. These patients require careful discussion with the ophthalmologist and/or assessment of the patient by the consultant

Low risk cases. Usually managed independently by HCP:

- Asymptomatic cataracts
- Symptomatic cataracts note - ensure symptoms compatible and consistent with cataract
- No lens induced ocular disease
- No comorbidity requiring further management or treatment
- Binocular visual potential (ie not “only eye”)
- No previous complicated cataract surgery
- Not specifically requested to see an ophthalmologist
- No risk factors associated with cataract surgery (list below not exhaustive)
- No reduced mental capacity

High risk cases: should be discussed with or seen by the ophthalmologist

Ocular/associated ocular findings	Associated risk
Any conditions compromising a patient’s ability to co-operate or be positioned during	General increase in surgical risk

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surgery e.g. communication and language difficulties, hearing loss, spinal or back problems, cough or poor breathing, tremor, nystagmus, obesity, claustrophobia, extreme fear/anxiety, reduced mental capacity, dementia, psychiatric disease, lid squeezer	
Age >85 years	General increase in surgical risk or less good visual outcome
Only seeing eye	If serious complications, could get total loss of vision, no "spare" eye
Complications in first eye operation	Higher surgical risk
High myopia/axial length $\geq$ 26mm	Retinal detachment (RD), AC depth fluctuation, IOL calculation errors (staphyloma) and refractive surprise
High hyperopia <22mm	Shallow AC, choroidal effusion, IOL calculation errors (refractive surprise)
Prior keratorefractive surgery	IOL calculation errors (refractive surprise), AC depth fluctuation
Deep set eyes/high brow	Difficult surgical access
Blepharitis	Increased risk of endophthalmitis
Corneal opacification	Reduced surgical view
Corneal guttata/Fuch's endothelial dystrophy	Prolonged postoperative corneal oedema or decompensation
Irregular corneal astigmatism (scarring, ectasia, other causes)	IOL calculation errors (refractive surprise), possible limited postop vision
Shallow anterior chamber	Increased risk endothelial/iris damage, technically more difficult therefore increased surgery risk
Small dilated pupil	Poor visualisation, increased risk capsular tear/vitreous prolapse, iris damage, requirement for extra steps to enlarge pupil
Posterior synechiae	Intra-op miosis, prolonged post-op inflammation, iris bleeding, inflammatory deposits on IOL
Current or previous use of alpha adrenergic antagonist <i>Tamsulosin, alfuzosin, terazosin, doxazosin</i>	Intraoperative floppy iris syndrome (IFIS), poor pupil dilation, progressive miosis. Overall higher risk surgery. Greater risk with Tamsulosin.
Active or previous uveitis	Posterior synechiae, IOL deposits, cystoid macular oedema (CMO), prolonged post-op inflammation
Zonulopathy (laxity, dehiscence, loss) <i>Trauma, pseudoexfoliation, coloboma, age &gt;80, asymmetric anterior chamber depth</i>	Phacodonesis (lenticular instability), iridodonesis, lens subluxation, vitreous prolapse, cataract loss into vitreous, late IOL

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<i>possible sign</i>	decentration/dislocation
Pseudoexfoliation	Poor dilation, zonulopathy
Dense (brunescant) nuclear cataract	Increased risk of corneal oedema and posterior capsule (PC) rupture, guarded visual prognosis
White (mature cortical) cataract	Lens intumescence, capsular tear, guarded visual prognosis
Posterior polar cataract	Weak or defective posterior capsule, increased risk PC tear, vitreous loss, dropped nucleus
Traumatic cataract	Zonulopathy, higher risk PCR, risk or early/late IOL subluxation
Prior pars plana vitrectomy	AC depth fluctuation, intra-op miosis, weakened lens capsule and zonules, increased nuclear sclerosis/lens hardness
No fundal view	PC rupture, vitreous loss, dropped nucleus, guarded prognosis as do not know if back of eye healthy
Glaucoma <i>Patients with glaucoma and cataract should be referred to their glaucoma consultant for consideration cataract surgery</i>	Shallow AC (angle closure), poor pupil dilation due to chronic drop use, increased/decreased functioning of prior filtering surgery, wipe out, guarded visual prognosis
Retinal detachment	Patients with high myopia and previous RD are at increased risk of detachment after cataract surgery. Less likely if have full PVD.
Diabetes <i>Patients with confirmed or suspected macular oedema and/or moderate, severe or proliferative retinopathy should be appropriately referred to medical retina (MRCRNLC at City Rd only) or local MR and not listed</i>	Risk of worsening diabetic retinopathy/maculopathy, CMO, increased risk post-op uveitis, guarded visual prognosis
Age related macular degeneration (ARMD) <i>Patients with confirmed or suspected wet ARMD and cataract should be appropriately referred to medical retina</i>	No proven risk of worsening wet or dry AMD with cataract surgery Guarded prognosis
Retinitis Pigmentosa	Cystoid macular oedema Guarded prognosis
Retinopathy of prematurity	Intra-op miosis, weak zonules, RD
Poor quality biometry or IOL calculation difficulties or unusual results	Higher risk refractive surprise

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Suitable for toric IOL	Needs more careful surgical and biometry planning and extra patient discussions
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These lists are not exhaustive and those patients seen in the low risk category may still require assessment by/discussion with the ophthalmologist if there are any queries or if the clinician believes the case may not be straightforward.

## 4. Exemptions and exclusions

The assessment and management should not be performed by the HCP or 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. Process

### 5.1 Pre-operative assessment

#### **Review the notes**

- Ensure the patient has been referred for cataract assessment (if new patient)
- Assess information provided in referral.
- Check a visual acuity test has been performed.

#### **Assess the history**

- Take a directed history relevant to the cataract
- Enquire about symptoms of different cataract types (blurred vision, glare, difficulty reading, monocular diplopia/polyopia, frequent glasses changes, asymptomatic, affecting mobility, causing falls)
- Enquire about past ophthalmic history including amblyopia, refractive surgery, trauma, contact lens wear and prior complicated cataract surgery
- Past medical history especially factors that affect positioning or co-operation e.g. Parkinson's, COPD, heart failure, obesity, arthritis, kyphosis, head tremors, claustrophobia, dementia, mental illness, learning difficulties, alcohol or drug abuse, communication difficulties, deafness, extreme fear/anxiety; also things that affect anaesthesia e.g. *Unstable angina, Uncontrolled hypertension, uncontrolled DM, Recent MI or CVA; also endophthalmitis risks ie any evidence active infection*
- D and drug history relating to cataract surgery especially alphasblockers such as tamsulosin, anticoagulants,
- Allergies especially Latex, iodine, anaesthesia, drugs used in cataract surgery- highlight allergies on booking form. e.g. latex allergy will need to go 1<sup>st</sup> on list
- Take relevant refractive/optical history
- Enquire about impact on lifestyle
- Take a directed social history including living alone or carers

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- Identify any specific communication needs e.g. poor hearing, English not first language
- Establish patient's need and willingness with regard to surgical intervention
- HCP must identify factors in ophthalmic and general medical history that may place patient at higher risk of surgical or anaesthetic (LA or GA) complications or difficulties.

## ***Conduct the examination***

- Distance, corrected, pinhole vision
- Observation of face and lids, posture, mobility in case of difficulties of access or positioning
- Cover test
- Slit lamp assessment of eyelids, eyelid margins, conjunctiva, limbus, cornea, anterior chamber (including angle), pupils, iris:
- Pupil size and reactions including RAPD
- IOP
- Pupil dilatation
- Examination of the lens
- Examination of the vitreous gel
- Dilated fundus examination including optic disc, macula and retina
- Patients likely ability to comply with local anaesthesia from reaction to examination or lid squeezing.

## ***Investigations***

- Note refractive error from referral or perform or obtain focimetry or auto-refraction for current spectacle prescription
- Perform or order and interpret keratometry, biometry
- Note and discuss with an ophthalmologist any unusual biometry or IOL powers
- OCT for any macular pathology
- B scan if no fundal view.

## ***Treatment and management***

Patients suitable for independent management the HCP should counsel and undertake valid consent if trained to do so:

- Advise patients on ability to meet driving requirements
- Discuss and counsel the patient on the options including the option for doing nothing, alternatives to surgery (eg adaptive and refractive management) , the process and pathway for surgery, the risks and benefits, postoperative expectations and care
- Establish willingness for surgery
- Any guarded prognoses fully discussed with the patient and with a consultant/senior surgeon if appropriate
- Discuss the options for refractive outcomes and the limitations of refractive predictability – most corrected for distance need readers and may need some

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distance correction as well, any options for anisometropia whilst awaiting 2<sup>nd</sup> eye surgery

- Discuss as per local requirements toric lenses, multifocals not on NHS
- Discuss the options for anesthetic, including risks and benefits, allay anxiety where possible:
  - Local: Topical usually suitable if patient co-operative and tolerates manipulation of lids without lid squeezing and no surgical risk factors
  - Local: Sub-tenon's if more anxious, mild difficulties with co-operation or eye
  - Local with sedation if very anxious, can cause confusion or moving during operation especially if dementia
  - GA if patient refusing LA or in some case due to ocular or systemic health, communication or positioning issues.
  - Advise patient surgeon or anaesthetist may rediscuss or suggest change anaesthetic plan on the day.

GA and sedation require discussion with the ophthalmologist

- Confirm willingness for surgery
- Confirm desired anaesthesia.
- If on warfarin advise of INR requirements and print INR letter
- Undertake obtaining valid consent in accordance with the Trust's consent policy – note if the HCP has not undergone the trust consent training, the consent will need to be completed by the ophthalmologist or a HCP competent to consent.

Patient can then be listed for surgery.

Highlight issues for surgery, place on list of anaesthesia e.g. general health, anxiety, allergies, ocular issues, positioning, language, ocular risk factors – specifically highlight if not suitable for topical or if requires senior surgeon or consultant e.g. only eye etc

Provide cataract surgery and anaesthetic leaflet and copy of consent form.

Patient should undergo prep anaesthetic and health assessment as per unit policy.

## 5.2 For postoperative visits:

### **Review notes**

- Operation and discharge notes, also the preoperative assessment, nursing assessment, biometry.

### **History**

- Document
  - 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.

### **Examination**

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- Visual acuity distance both eyes unaided, with current glasses and pinhole if 6/9 or worse
- Examine operated eyes only.
- Examine the fellow eye only if there is a clinical indication to do so e.g needs reassessment for consideration of second eye cataract surgery. If full assessment completed at preop visit, short repeat examination of anterior segment satisfactory. If full preop assessment second eye not completed pre-operatively, undertake full assessment as above.
- Refraction: Autorefractometry of all patients at minimum, subjective refraction is ideal if available and required if any refractive surprises (>1D sph equivalent from target)
- Full external/anterior segment slit lamp examination.
- IOP
- Dilation of pupil if and slit lamp posterior segment examination if:
  - Best corrected visual acuity worse than expected
  - Any surgical complications
  - Any patient complaining of flashes and floaters or other symptoms warranting dilation
  - No/poor preoperative fundus view
  - All patients with diabetes
  - Posterior segment co-morbidity requiring assessment postoperatively
- If pupil dilation is not required postoperative fundus examination is not necessary
- Any other clinical investigations if warranted
- Macular OCT for all patients with diabetes, ERM, confirmed or suspected macular pathology including patients with visual outcomes worse than expected

The second eye should be reassessed, with the level of assessment and examination at discretion depending on the detail of the original assessment and the desire/requirement for surgery.

If second eye surgery is desired, then the appropriate investigations should be undertaken or checked and the treatment and management completed as above.

## ***Treatment and management***

### **Routine patients**

HCP can independently manage all uncomplicated patients not requiring any medical opinion as follows

- Continue their postoperative drops as prescribed by the operating surgeon. Individual surgeon prescribing habits differ but will broadly follow the post-op regime
  - G chloramphenicol 0.5% qds for 1-2 weeks
  - G dexamethasone 0.1% qds for 2 weeks, bd for 2 weeks
  - Patients with dark irides, diabetes or other issues may have a different regime
  - For patients considered at risk of pseudophakic cystoid macular oedema (PCMO) g ketorolac 0.5% (acular) may be prescribed qds for 4 weeks
- If second eye surgery is not required discharge the patient with a letter (GP and patient copy) stating the discharge drop regime and need for refraction with local optometrist
- Advise patient about obtaining community optometrist refraction at 4-6 weeks postop
- If second eye surgery required, follow procedure as above for preop requirements.

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## Postoperative issues

- Patients with routine postop issues can be managed by the HCP. All patients with intraoperative complications should be seen by a doctor.
- Any postoperative pathology identified and not covered below should be managed appropriately.
- Patients with ocular abnormality discovered incidentally which is unrelated to the condition for which the patient was originally referred should be referred internally to the appropriate service or back to the GP if the patient wishes to go elsewhere

Post-op findings	Considerations	Action
<b>Lids</b>		
Postoperative ptosis	Cosmesis	Reassure, mild ptosis may improve over 6 months
	Chronic (over 6 months) with superior field defect or and cosmetically unacceptable	Routine referral to adnexal service after discussion with medic
<b>Conjunctiva</b>		
Conjunctival injection	Injection around subtenons entry site and/or sub-conjunctival haemorrhage	Reassure, expect resolution within 6 weeks
	Circumlimbal injection (ciliary flush) usually indicative of anterior uveitis	Check anterior chamber activity and manage accordingly – see anterior chamber
	Diffuse injection	
	– Drop toxicity or allergy	Manage appropriately
	– Blepharitis	Manage appropriately
	– Consider uveitis, TASS, endophthalmitis with associated signs and symptoms	Show to doctor
<b>Cornea</b>		
Superficial punctuate keratopathy/keratitis	Dry eye	Dry eye symptoms are common after cataract surgery and can take up to 3 months to resolve. Lubricate and reassure
	Blepharitis	Manage appropriately
	Drop toxicity (usually diffuse keratopathy/keratitis)	See associated guidance Manage appropriately
Descemet's membrane	Mild: common after cataract surgery	If cornea clear and expected visual outcome achieved, reassure.

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folds		Postpone local refraction until resolution after six weeks if possible
	Moderate to severe: significant corneal oedema and/or inflammation	Show to doctor
Descemet's membrane tear or detachment	No corneal oedema	If expected visual outcome achieved and cornea clear, no action required
	Associated corneal oedema	Show to doctor
Sutures	Buried	If non-absorbable (i.e. nylon) discuss with doctor and remove if competent to do so If absorbable (i.e. vicryl) no action required
	Loose	Remove is competent to do so, if not call doctor/competent HCP to remove
<b>Anterior chamber</b>		
Shallow	<ul style="list-style-type: none"> <li>– Wound leak, Seidel positive (often associated with low IOP)</li> <li>– Serous choroidal effusion (often associated with low IOP)</li> <li>– Pupil block: Severe uveitis, capsular block syndrome (associated with high IOP)</li> <li>– Haemorrhagic choroidal effusion (suprachoroidal haem) (often associated with high IOP)</li> </ul>	Show to doctor
Cells	Use 1x1mm slit beam	Differentiate between cells and pigment
	Grade 0 (no cells) Grade 0.5+ (1 to 5 cells)	No action required
	Grade 1+ (6 to 15 cells)	Discuss with doctor
	Grade 2+ (16 to 25 cells) Grade 3+ (26 to 50 cells) Grade 4+ (> 50 cells)	Show to doctor Note severe post op inflammation is endophthalmitis until proven otherwise
Flare	Use 1x1mm slit beam (SUN grading) Grade 0 (none) Grade 1+ (faint) Grade 2+ (moderate, iris and lens details clear) Grade 3+ (marked, iris and lens	Flare can be difficult to grade clinically If grade 3+ or 4+, show to doctor Otherwise manage on the basis of AC cells

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	details hazy) Grade 4+ (intense, fibrin or plastic aqueous)	
Hypopyon/Hyphaema	Severe uveitis, endophthalmitis, TASS, trauma	Show to doctor
Vitreous	Vitreous strand incarcerated in wound – peaked pupil	Show to doctor
Retained lens fragments	Corneal oedema, anterior uveitis	Show to doctor
Anterior chamber IOL	Document haptic position, check patency of PI, check for pigment dispersion	Show to doctor
<b>Iris</b>		
Trauma	Mild intraoperative iris trauma - may result in prolonged postoperative uveitis	Manage on the basis of AC cells
	Iris transillumination	If significant trauma and/or patient suffering with glare, show to doctor
Prolapse	Iris prolapse to wound	Show to doctor
<b>IOL and capsule</b>		
Anterior capsular phimosis	Mild with no associated uveitis and visual axis clear	No action required
	All other cases	Show to doctor
Posterior capsular opacification or plaque	Patient asymptomatic	No action required
	Patient symptomatic	YAG laser safe to perform 4 months after surgery –list accordingly
Capsular block syndrome (CBS)	Entrapment of fluid between the IOL and posterior capsule – Refractive surprise (myopic shift) – Shallow AC	Show to doctor and consider YAG capsulotomy if indicated
<b>Vitreous</b>		
Cells	Anterior uveitis may cause spill-over of a few cells into the anterior vitreous	Manage on the basis of AC cells
	Vitritis: significant infiltration of vitreous cavity with inflammatory cells/vitreous haze - suspect endophthalmitis	Show to doctor
Weiss ring	Posterior vitreous detachment common after cataract surgery	Search for retinal breaks (dilate) and give retinal detachment advice
Pigment	Shafer’s sign: assume retinal break	Search for retinal break (dilate) and show to doctor
<b>Retina</b>		

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Pseudophakic cystoid macular oedema (PCMO)	<p>Symptoms</p> <ul style="list-style-type: none"> <li>– Decreased visual acuity. Near disproportionately worse than distance</li> <li>– Metamorphopsia: demonstrate on amsler</li> <li>– Possible central scotoma/micropsia</li> </ul> <p>Signs</p> <ul style="list-style-type: none"> <li>– Use of a narrow slit beam (with indirect viewing) and/or examination with red-free light to help to outline cystic spaces</li> <li>– Loss of foveal reflex</li> </ul> <p>Confirm with OCT if available</p>	<p>Discuss with doctor</p> <p>Highlight to doctor any susceptibility to corneal epithelial breakdown or previous drop toxicity before prescribing topical ketorolac (acular)</p> <p>Never prescribe ketorolac in combination with maxitrol</p> <p>See PCMO guidance</p>
Diabetic retinopathy	Mild non-proliferative	No action if under retinopathy screening service. Otherwise refer to GP for screening
	Moderate to Severe non-proliferative	Refer to medical retina for review
	Proliferative	Urgent referral to medical retina. Show to doctor
	Diabetic maculopathy with no macular oedema (confirmed on OCT)	Manage according to retinopathy grade
	Diabetic maculopathy with macular oedema	Show to doctor and consider treating any pseudophakic component Refer to medical retina
	No diabetic maculopathy with CMO	Manage as per PCMO guidance and refer all patients with diabetes and PCMO to medical retina
Retinal detachment (RD)	<p>Examination of vitreous and peripheral retina in any patient presenting with symptoms</p> <p>Give RD advice to any patients at increased risk</p> <ul style="list-style-type: none"> <li>– High myopes (axial length <math>\geq 26\text{mm}</math>)</li> <li>– History of RD in fellow eye</li> </ul>	<p>Urgent referral to VRE if retinal tear/detachment detected</p> <p>Show to doctor</p>
Choroidal effusion	Serous or haemorrhagic	Show to senior doctor
<b><i>Steroid responders</i></b>		
IOP < 32mmHg	Continue topical medications as prescribed	Recheck IOP 2 weeks after stopping topical steroid. If IOP still > 21mmHg refer appropriately
IOP > 32	Continue topical medications as prescribed	Discuss with doctor
<b><i>Visual outcome</i></b>		

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Unexpectedly poor	Best corrected visual acuity worse than expected	Formally refract and consider further investigations (eg OCT, corneal tomography, visual fields) and discuss with doctor
Dysphotopsia	Unwanted images associated with IOL Negative: temporal darkness, crescent, shadow, black line Positive: light flicker, arc, flash, flare, starburst, haloes	Rule out any other ocular cause Reassure patient and allow for adaptation Try correcting any residual refractive error Do not list for YAG capsulotomy Discuss with doctor
<b>Refractive outcome</b>		
Refractive surprise	More than 1 dioptre spherical equivalent from refractive target	Ensure no capsular block Accurate refraction Check biometry/IOL details Discuss with doctor
Refractive upset	Px unwilling to accept refractive outcome	Discuss with doctor
Toric IOL	Any patient unhappy with refractive outcome or presenting with more than one dioptre of astigmatism on refraction	Formally refract, dilate and compare IOL axis with planned axis Discuss with doctor

## Drop toxicity or allergy

- Chemical irritation of ocular and/or adnexal tissues by a topically applied drug/preservative or hypersensitivity response to a topically applied drug/preservative
- Signs and symptoms include Irritation, pain, stinging, burning, photophobia, blurred vision, lid swelling, conjunctival injection, diffuse punctate staining of cornea and/or conjunctiva
- Toxicity to preservatives most likely cause which can be managed by switching to unpreserved drops
- Consider stopping topical NSAIDs (e.g ketorolac/acular) in any patients presenting with any epitheliopathy (rarely leads to corneal melt) and start intensive preservative free lubricants with review in 1-2 weeks. Note patients with diabetes, rheumatoid arthritis or any corneal pathology susceptible to epithelial breakdown are at increased risk
  - Note Maxitrol and ketorolac should never be prescribed in combination
- In any severe cases show to doctor

## Postoperative uveitis

- Patients at increased risk of significant postoperative uveitis include: dark irides, diabetes, history of uveitis, intraoperative complications, retained lens matter, iris trauma/chafing

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- Rebound uveitis should be treated with an increased frequency and longer tapering course of topical anti-inflammatories
- Patients presenting with a second episode of rebound uveitis require gonioscope angle examination to determine the presence/absence of retained lens matter – refer to doctor if not competent

## **Toxic Anterior Segment Syndrome (TASS)**

- Sterile postoperative inflammatory reaction caused by a non-infectious substance that enters the anterior segment and results in toxic damage to intraocular tissues
- Rare, incidence unknown
- Clinical picture similar to endophthalmitis but inflammatory reaction limited to anterior chamber and presents early with onset 12-24hrs after surgery
- Show to doctor

## **Endophthalmitis**

- Rare, occurring in approximately less than one in a thousand cases
- Acute postoperative endophthalmitis presents up to six weeks following surgery but usually presents within the first two weeks
- Chronic endophthalmitis can present after six weeks
- Signs and symptoms include pain, visual loss, lid swelling, marked anterior chamber inflammation with hypopyon, vitritis and often no fundal view (conjunctival injection and corneal oedema with other associated signs)
- Show to senior doctor immediately
- See guidelines for management of endophthalmitis

## **Pseudophakic cystoid macular oedema (PCMO)**

- The incidence of clinical PCMO, defined as symptomatic vision loss 6/12 or worse, is approximately 0.1% to 2.35%. PCMO as seen on OCT after modern phacoemulsification may range from 4% to 11%
- PCMO most often develops 4-6 weeks after cataract surgery. The peak incidence of PCMO occurs at 6 weeks after surgery. Acute PCMO occurs within 6 months postoperatively; chronic PCMO is present more than 6 months after cataract surgery
- Incidence increases in patients with high-risk characteristics including diabetes mellitus, retinitis pigmentosa, history of central retinal vein occlusion, recent history of uveitis, pre-existing epiretinal membrane, or following complicated cataract surgery
- Most patients with PCMO have spontaneous resolution of the macular oedema within 3-4 months. One year after surgery a small minority of patients (<1%) in the absence of treatment may still have decreased visual acuity from PCMO.
- Once PCMO is confirmed by clinical findings and/or OCT, initial treatment includes the use of topical steroidal and nonsteroidal anti-inflammatory medications (NSAIDs) e.g. g dexamethasone 0.1% four times daily and g ketorolac four times daily for 6-8 weeks followed by tapering

## **5.3 Documentation**

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- Record assessment, treatment and all discussions clearly in the patient's health records as per trust records policy
- Complete the consent form and record provision of the relevant written leaflets.
- GP letter to be completed on records, filing a copy in the notes
- If an unexpected event occurs, document and complete and report the incident. This is necessary to facilitate communication within the team, meet legal requirements of practice and enable monitoring over a time period.
- Complete any documentation for listing the patient

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## Appendix 7 Risk Assessment

Department / Directorate	Ophthalmology	
Description of risk	<p><b>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 cataract ophthalmology service.</b></p> <p>All eye care carries associated risks such as :-</p> <ul style="list-style-type: none"> <li>• Safeguarding issues</li> <li>• Potential for missed diagnosis</li> <li>• Potential for associated systemic disease</li> <li>• Potential for affecting vision</li> <li>• Complications of treatment</li> <li>• Miscommunication with patient or family.</li> </ul> <p>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 of the patient and family in the care and the trust especially if any problem is not spotted or acted upon in a timely manner.</p> <p>Risks associated with a non-medical HCP carrying out this care include:-</p> <ul style="list-style-type: none"> <li>• Perception by patient/family that problem was due to care not performed by doctor]</li> <li>• Failure of HCP to detect problem</li> <li>• Having the experience and ability to identify or manage problems which may occur;</li> <li>• Non enough staff or time to undergo training</li> <li>• Not enough senior staff or consultant time to supervise and sign off training</li> <li>• Capacity issues creating pressure to have excessive numbers on clinics</li> <li>• Insert any others here or amend the above</li> <li>•</li> </ul>	
	Existing controls in place when risk was identified	<ul style="list-style-type: none"> <li>• The guidelines from the Royal College of Ophthalmologists, BIOS and College of Optometrists are followed..</li> <li>• Compliance with consent, safeguarding and other key trust policies</li> <li>• Ready availability of an ophthalmologist by phone or on site.</li> <li>• Adherence to the advanced practice policy.</li> <li>• Ophthalmic consultant leadership and supervision of service.</li> <li>• An Incident Reporting process in place for adverse events.</li> <li>• An audit of the service is regularly carried out.</li> <li>• Regular patient feedback is sought.</li> <li>• Governance structures in place where issues / concerns can be raised.</li> <li>• A complaints system is in place where these are reviewed and lessons are learned and shared.</li> <li>• Regular mandatory training in issues such as mental capacity, infection control and safeguarding for all staff</li> </ul>
Initial Risk Score i.e. with existing controls in place	Consequence (1-5)	
	Likelihood (1-5)	

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		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 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				
<b>Maximum number of patients on HCP clinics at X</b>				
Target Risk Score i.e. after <b>full</b> 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		

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