Clinical policy for non-medical practitioners to manage patients within a HCP-led glaucoma service – level 2

{Insert} Name of Trust

Summary
This document describes the processes required for non- medical staff to assess and manage patients in a non-medical healthcare professional led glaucoma service for patients with ocular hypertension (OHT), suspected glaucoma or diagnosed glaucoma who are on treatment and have been stable for 6 months.

Version: X.0
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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:	Nurses, orthoptists, optometrists, ophthalmologists, ophthalmology managers

Version History

Version	Date Issued	Brief Summary of Change	Author

{Insert} Name of Trust

Clinical policy for non-medical practitioners to manage patients in the glaucoma service.

UKOA clinical policy packs are based on already developed documents used in hospital trusts across the UK for advanced practice and extended roles for health care professionals (HCP), combined with expert consensus views from UKOA professional members.

They are **not** designed to be used without any change but are designed to be a starting point for trusts and professionals to create their own documents to support HCPs in this role. These packs should be reviewed, edited and changed as required to fit the provider's and professionals' particular service requirements and the organisation's processes. Areas which are particularly like to need consideration as to local needs are in grey text.

Queries, comments or feedback to the UKOA on this document are very welcome.

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Please delete this page before use in trusts and health boards.

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. There is a growing need for greater diversity of knowledge and skills within the ophthalmology workforce in order to cope with significantly rising demand for eye care. This is supported by the Royal College of Ophthalmologists (RCOphth) and other HCP professional organisations as well as the NHS England National Elective Care High Impact Intervention and Getting it Right First Time (GIRFT). The development of non medical and allied health professionals to deliver more multidisciplinary care is key objective as set out in the long-term plan and interim people plan.

2. Purpose

This policy sets out the process required for designated HCP to train for and to successfully assess and manage patients with:

- Ocular hypertension (OHT)
- Glaucoma suspects
- Mild treated primary open angle glaucoma
- Mild treated normal tension glaucoma
- Chronic angle closure patients treated with peripheral iridotomy or lens extraction.

This will contribute to the efficient delivery of the ophthalmology service and will enhance and develop patient-centred care, which fulfils national safety and service delivery targets. Service provision will be more flexible and resilient, with the potential for increased 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 policy and outcomes.

3. Scope

This policy applies to all trust / health board sites where HCP's are assessing and managing patients with glaucoma-related conditions and low risk glaucoma alongside consultants or in independent clinics and is relevant to ophthalmic nurses, orthoptists and optometrists who are working, or wish to work, as advanced practitioners in these HCP-led glaucoma clinics. Ophthalmologists including consultants and those managing ophthalmology services should have a good understanding of this policy if it is to be implemented locally.
It should be read in conjunction with other relevant trust/national documents:

- Consent policy
- Clinical governance/risk policy
- NG81 National Institute for Clinical Excellence NICE Guidelines (2017)
- Ophthalmic common clinical competencies framework (OCCCF) 2019

- Infection control policy
- Ophthalmology/glaucoma care guidelines.

To be eligible for delivering this procedure, HCP staff must have a minimum time 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 and the glaucoma lead as competent to commence training.
- Registered orthoptist at band 6 or above who has sufficient ophthalmic experience to be judged by their manager and the glaucoma lead as competent to commence training
- Registered optometrist at band 6 or above who have sufficient ophthalmic experience to be judged by their manager and the glaucoma lead as competent to commence training.

4. Duties and responsibilities

4.1 Advanced/Extended practice HCP responsibilities

HCP's undertaking the training are responsible for:

- Compliance with local healthcare organisation 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 Standard Operating Procedures (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 regularly audit their patient records and care as part of their annual appraisal / individual performance review. HCPs must attend regular relevant continuing professional development including clinical update sessions on glaucoma, and its associated treatment options.

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

4.2 Consultant ophthalmologist's and trainer's responsibilities

It is the trainers' responsibility 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.

Appropriate delegated trainers include:

- HCP with more than 2 years' experience who is a named glaucoma advanced trainer and who has been signed off or is working at (OCCCF level 3)
- A fellow or ST 6 and above ophthalmic trainee
- Experienced SAS doctor with subspecialty glaucoma expertise

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 knowledge, skills and procedural technique.

The consultant will arrange that they or another suitably qualified ophthalmologist or highly experience glaucoma HCP are available to support the HCP during clinics whilst training and also once qualified. The doctor or senior professional should either be present on site or by phone with a pathway in place for the patient to see a doctor urgently with the appropriate safe timescale if required.

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

4.3 Managers responsibility

The manager(s) [lead nurse, lead orthoptist, lead optometrist or ophthalmology department manager] will keep a record of all competencies and a register or list of trainers and HCPs eligible to perform glaucoma assessment and management.
Managers must only endorse practice if such development is in line with the practitioner`s job description and existing healthcare organisation 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 Employers 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. Training & Assessment

HCPs can only commence training after approval by their line manager.

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:

- Assessing patients with ophthalmic conditions
- Applanation tonometry
- Slit lamp operation

For these baseline skills and knowledge/experience, the trainer / ophthalmologist and line manager will need to agree if there is any basic training or clinical experience required to bring the HCP to a level where the advanced glaucoma 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 advanced practice training.

Glaucoma extended/advanced scope 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 such as Higher certificate in glaucoma or equivalent
- Informal in-house training or sessions with the consultant or other trainer
- Additional reading around the subject area in books and journals
- Reading of NICE guidelines and operating manuals
- E-learning modules such as the RCOphth OCCCF modules on e-learning for health.

The HCP will maintain a portfolio of the above. As they progress, further records of their cases and experience, a log of discussions and unfamiliar conditions, reflective learning on a smaller number of cases, further reading and workplace based assessments, and discuss with the trainer as part of their competency assessment. The level of glaucoma care competency should be able to demonstrate equivalence to the Glaucoma Level 2 RCOphth OCCCF competency framework.

The HCP will need to know:

- Anatomy and physiology of the eye particularly in relation to glaucoma, aqueous production and outflow, mechanisms of reduced or inhibited outflow.
- Risk factors for glaucoma including narrow angle glaucoma (such as age, race, gender and refractive status)
- Classification of glaucoma including:
    - Open angle glaucoma
    - Angle closure / narrow angle glaucoma
        - Acute
        - Chronic
    - Secondary glaucoma
        - Pseudoexfoliative
        - Pigmentary
        - Traumatic
        - Uveitic

- Management options for open and closed angle glaucoma including:
    - Topical IOP lowering drugs
    - Laser therapy
        - Selective laser trabeculoplasty/ Argon laser trabeculoplasty (SLT/ALT)
        - Peripheral Iridotomy (PI)
        - Argon Iridoplasty
        - Ciliary body Cyclodiode laser
- The HCP should also have an awareness and basic understand of common surgical options:
    - Trabeculectomy
    - Lens extraction
- Able to take a targeted history and ensure drop compliance and correct administration technique
- Pharmacology to include:
    - All relevant topical anti glaucoma drugs
    - Systemic treatment options for glaucoma
    - Interactions with systemic medications
- Side effects of topical medication and benefits of treatment and how to counsel and ensure compliance
- Recognition of side effects and allergy and what actions to take
- Is aware of any possible red flags and how to escalate concerns
- Awareness of DVLA visual standards
- Risk and legal issues around extended role development
- How to audit HCP practice

Technical skills competency

The HCP must be able to accurately assess all elements of ocular anatomy ocular function related to glaucoma including:

- Assessment of visual acuity
- Assessment of pupils
- Assessment of central corneal thickness
- Assessment of anterior segment angle using van Herick and Smith's method
- Assessment of intraocular pressure by use of Goldmann applanation tonometry
- Assessment of anterior segment structures including; cornea, iris, lens
- Interpretation of visual fields
- Assessment of the optic nerve
- Basic exam of the fundus
- Interpretation of optic nerve imaging including:
    - Stereodisc images
    - OCT
    - HRT
- Visual standards for the DVLA

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 but continue to have their consultations observed in all cases with the trainer. This period will usually last at least 2 months, before the final assessment as competent by their trainer with competencies recorded as detailed in the appendices. There should be at least 2 successfully completed work based assessments for each element listed in the technical competency framework as per the OCCCF glaucoma curriculum structure.

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 ophthalmologist after three to six months of independent practice.

5.1 Assessment

Assessment may be carried out by the trainer, however where possible it would be best practice for the assessor to be different from the trainer. Assessment will take the form of 2 work placed based assessments (WpBAs) for each element of the technical skills.

These are pre-identified cases in which the assessor observes the HCP from start to completion of two cases. The assessment should analyse all aspects of examination and treatment including soft skills such as communication as well as technical skills with particular attention being paid to the skill being examined.

Successful completion of two WpBAs with sufficient training and knowledge as deemed by the assessor and trainers will lead to sign-off for competency to carry out that particular portion of the examination independently.

6 Frequency of practice

HCP glaucoma clinics will be carried out according to service need. Once a practitioner has been signed off as competent, they should be performing procedures 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 this policy and associated protocol, case management and record keeping in conjunction with trainer
- Regular audits on outcomes and success of procedures
- 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. Stakeholder Engagements and Communication

The ophthalmology team developed this policy 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. Approval and Ratification

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

10. Dissemination and Implementation

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

This policy will be published on the healthcare organisation intranet site.

11. 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 regarding HCP delivery of glaucoma care or any trust serious incidents will trigger a review of this document.

12. Document Control and Archiving

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

13. 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 Glaucoma Consultant	Audit	Every 12-24 months	Ophthalmic or glaucoma clinical lead
HCP	Senior ophthalmology clinicians and line manager	Appraisal and individual performance review - portfolio of audit, practice and knowledge	Annually	Line manager and ophthalmology trainer
Complications or adverse events to be recorded	All staff	Incident reporting	On-going	Ophthalmology Clinical Governance (CG)
Complaints	Complaints team	Complaints process	On-going	Ophthalmology CG

14. Supporting References / Evidence Base

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3. Opthalmologists, T. (2019). *Ophthalmic Common Clinical Competency Framework - The Royal College of Ophthalmologists*. [online] The Royal College of Ophthalmologists. Available at: https://www.rcophth.ac.uk/professional-resources/new-common-clinical-competency-framework-to-standardise-competences-for-ophthalmic-non-medical-healthcare-professionals/ [Accessed 24 Jul. 2019].
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5. Langley, D. (2019). *Standards*. [online] Optical.org. Available at: https://www.optical.org/en/Standards/ [Accessed 25 Jul. 2019].
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8. Rcophth.ac.uk. (2019). Commissioning Guide: Glaucoma (Long Version). [online] Available at: https://www.rcophth.ac.uk/wp-content/uploads/2016/06/Glaucoma-Commissioning-Guide-Long-June-2016-Final.pdf [Accessed 6 Aug. 2019].
9. Nice.org.uk. (2019). Glaucoma: diagnosis and management. [online] Available at: https://www.nice.org.uk/guidance/ng81/resources/glaucoma-diagnosis-and-management-pdf-1837689655237 [Accessed 7 Aug. 2019].

Local documents

Ophthalmology department guidelines
Consent policy
Clinical record keeping policy
Clinical governance / Risk policy
Infection control policy

Appendix 1 Competencies

For **New HCP Practitioners** who are:

- undertaking glaucoma practice as a new skill or,
- unable to present their manager with proof of continuing competency.

The HCP must complete all relevant training specific to the role requirements and then ensure all competencies signed off not only by their trainer, but also by the ophthalmology consultant before they practice independently. The HCP must be confident that they are performing within their sphere of competency.

For **Current HCP Practitioners** who have:

- Completed the HCP training programme previously and have been assessed and signed off as competent against the HCP competencies but have had a gap in service (≥6months).
- 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.

They must be assessed as competent at the discretion of the supervising consultant ophthalmologist or experienced HCP trainer. This can include:

- HCP observing in clinic
- Open discussion to ensure theoretical competence
- Observed practice
- Case discussion
- Successful completion of 2 work placed based assessments (wpBA's).

All HCP must ensure that successful completion of the competencies occur on time and that this is fully discussed and signed off by the trainer. Practitioners must ensure that copies of the signed competency are sent to their manager, and they should retain a copy for their own portfolio.

The assessor

The assessor must be a competent consultant ophthalmologist with special interest in glaucoma or a specialty trainee ophthalmologist (ST6 or above) designated as a trained by the consultant ophthalmologist or an HCP who is on the list of approved trainer/assessors. The assessor must only sign the competency when all aspects of the competency standards have been demonstrated by the practitioner. The assessor may be the same person as the trainer, ideally staff permitting it would be good practice for the assessor to be a different person.

Appendix 1.1 Glaucoma procedures: Competency checklist

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

Aims and Objectives The Clinician is able to demonstrate supporting knowledge, understanding and has been observed as competent to adhere to the policy for extended role work in the laser treatment clinic.	The HCP is able to demonstrate supporting knowledge, understanding and has been observed as competent to effectively examine and deliver treatment to patients in the glaucoma subspecialty of the ophthalmology service
Knowledge. education	Prior to this assessment the practitioner has successfully completed the following: **Theoretical knowledge via courses, e-learning or local training such as Higher certificate in Glaucoma.** **Background reading, learning and theory portfolio** **Observational work based training** **Supervised practice training**
HCP Responsibility	HCP staff should ensure they keep their knowledge and skills up to date through local policies, standard operating procedures and guidance. It is the responsibility of the individual to work within their own scope of competence relevant to their job role and follow their professional bodies Code of Conduct.
Employee signature/print name: …….. Assessor signature print name: …… Date: ……..	
Policies, Guidelines and Protocols:	**Date policy read by** HCP **and initials**
Local policies or documents x	
Local policies x	
Local policies etc.	
Local healthcare organisation laser treatment procedure / guideline	

	Underpinning knowledge and understanding	**Date and assessor initials**
Local clinical policies or guidelines	• Demonstrates x local policy • Demonstrates x local policy etc. • (key policies such as infection control and consent)	
National policies and guidelines	• NG81 NICE guidelines • RCOphth Glaucoma commissioning guidelines	

Knowledge specific to extended/advanced glaucoma practice	• Anatomy and physiology of the eye particularly in relation to glaucoma, aqueous production and outflow, mechanisms of reduced or inhibited outflow.
	• Risk factors for glaucoma including narrow angle glaucoma (such as age, race, gender and refractive status)
	• Classification of glaucoma including:
	  ○ Open angle glaucoma
	  ○ Angle closure / narrow angle glaucoma
	  ▪ Acute
	  ▪ Chronic
	  ○ Secondary glaucoma
	  ▪ Pseudoexfoliative
	  ▪ Pigmentary
	  ▪ Traumatic
	  ▪ Uveitic
	• Management options for open and closed angle glaucoma including:
	  ○ Topical IOP lowering drugs
	  ○ Laser therapy
	  ▪ Selective laser trabeculoplasty/ Argon laser trabeculoplasty (SLT/ALT)
	  ▪ Peripheral Iridotomy (PI)
	  ▪ Argon Iridoplasty
	  ▪ Ciliary body Cyclodiode laser
	• The HCP should also have an awareness and basic understand of common surgical options:
	  ○ Trabeculectomy
	  ○ Lens extraction
	• Able to take a targeted history and ensure drop compliance and correct administration technique
	• Pharmacology to include:
	  ○ All relevant topical anti glaucoma drugs
	  ○ Systemic treatment options for glaucoma
	  ○ Interactions with systemic medications
	• Side effects of topical medication and benefits of treatment and how to counsel and ensure compliance
	• Recognition of side effects and allergy and what actions to take
	• Is aware of any possible red flags and how to escalate concerns
	• Awareness of DVLA visual standards	

Professionalism	• Demonstrates a working knowledge of own responsibilities and accountability in relation to current policies and procedures as well as national standards of professionalism such as Health Care Professions Council, British and Irish Orthoptic Society, General Optical Council and Nursing and Midwifery Council standards. • Demonstrates an in depth understanding of their duty to maintain professional and ethical standards of confidentiality • Risk and legal issues around extended role development • How to audit HCP practice	
Performance Criteria	**Date of assessment and assessor initials (see OCCCF Glaucoma Curriculum for WpBAs)**	
WpBA undertaken and passed **x2**		

(CA2 Assess vision)	
WpBA undertaken and passed **x2 (CA6 Pupils)**	
WpBA undertaken and passed **x2 (PI2 Corneal Pachymetry**	
WpBA undertaken and passed **x2 (BCS1 Anatomy)**	
WpBA undertaken and passed **x2 (CA17 Angles)**	
WpBA undertaken and passed **x2 (CA8 IOP)**	
WpBA undertaken and passed **x2 (PI13 Fields)**	
WpBA undertaken and passed **x2 (CI10 Fundus examination)**	
WpBA undertaken and passed **x2 (PM10 visual standards)**	
WpBA undertaken and passed **x2**	

(PM3 Use of Drugs)	

Appendix 2. Record of observed / supervised / independent cases

Name, designation of HCP:

Date	Pt hospital Number	Comments e.g. observed/supervised/independent	Signature of HCP	Signature of Assessor/trainer

Appendix 3. Reflective practice template

Name, designation and signature of HCP:

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

Appendix 4. Clinic protocol

Protocol for assessing and managing OHT, glaucoma suspect and low risk glaucoma patients by non-medical practitioners

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 glaucoma extended/advanced practice up to level 2 of the OCCCF curriculum or equivalent.

2. Purpose

The purpose of this protocol is to describe the process for advanced/ extended role practitioners to assess and manage low risk glaucoma patients in the healthcare organisations eye care service and related care and to ensure consistency, safety and best practice

3. Eligible cases

Patients with:

- Ocular hypertension
- Suspected glaucoma
- 'Stable' low risk primary open angle glaucoma
- Pseudoexfoliation (without glaucoma)
- Pigment dispersion syndrome (without glaucoma)
- Treated chronic angle closure glaucoma with open angles

4. Exemptions and exclusions

Patients with:

- Advanced glaucoma
- Secondary glaucomas:
    - Pigmentary glaucoma
    - Pseudoexfoliative glaucoma
    - Traumatic glaucoma
    - Rubeotic glaucoma
    - Uveitic glaucoma
    - Phacolytic glaucoma
- Primary angle closure suspects
- Primary angle closure
- Angle closure glaucoma
    - Acute
- Childhood forms of glaucoma

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
- Patient has difficulties keeping still e.g. Parkinsons or nystagmus
- Patient has co-morbidities which increase the risk of progression or the implications of progression on visual outcome such as diabetic retinopathy (DR), age-related macular degeneration (AMD), only one functional eye (i.e. previous vascular occlusion, optic neuropathy or dense amblyopia)
- High risk patient in low risk independent clinic.

5. Process

Prior to commencing consultation the HCP will

- Review the patient's healthcare record and ensure the following:
    - The patient is in the appropriate clinic
    - No comorbidities
    - No new general health problems which may impact on their glaucoma control
    - That they have had a goniosocopy documented in the last 5 years

Assess the history

- Take a directed history relevant to the condition and whether previously treated patient
- Enquire about symptoms and side effects if on treatment
- Enquire about allergies
- Enquire about impact on lifestyle
- Take a directed social history
- Ensure adequate drop technique and compliance
- Review systemic medication

Conduct the examination

- The examination may vary depending on whether visual fields and or optic nerve head imaging are carried out on the day of the appointment:
- Best corrected visual acuity
- Anterior segment examination:
    - Examination of cornea
        - Epithelial integrity
        - Endothelial layer to rule out krukenberg spindle
    - Iris

        - Retro-illumination
        - Look for signs of pigment near angle
    - Angle
        - Estimate the angle depth using Van Herick's method and if required Smith's technique
    - Lens
        - Look for age related changes, e.g. cataract
        - Examine anterior surface dilated to rule out pseudoexfoliation
- Pachymetry (if not previously completed)
- IOP
- Interpretation of visual fields (document interpretation in healthcare record)
- Slit lamp examination of optic nerve head
    - Note the following:
        - Cup-to-disc ratio
        - Neuro-retinal rim integrity (any notching, thinning, palor, note whether ISNT rule obeyed or not)
        - Retinal nerve fibre layer (wedges, generalised loss/thinning)
        - Vasculature (note any baring, bayoneting, attenuation, or evidence of any abnormal development or visibility of vessels such as collaterals, new vessels etc.)
        - Peripapillary area (note down any peripapillary atrophy, nerve fibre haemorrhages)

Treatment and management

If the patient requires any <u>new</u> management/treatment or <u>change</u> to existing management/treatment (provided the HCP holds a relevant prescribing qualification they should make the necessary changes to topical therapy in accordance with any local guidance. Alternatively they may list the patient for laser therapy in accordance with local policies and treatment algorithms.

If the HCP does not hold a relevant prescribing qualification, they may amend treatment within agreed local arrangements or if there are no local arrangements in place they should discuss the case with a suitable member of the ophthalmology team who can prescribe medication:

- A member of the medical ophthalmology team

<u>Or</u>

- A HCP trained to level 3 of the OCCCF competency framework with a suitable prescribing qualification.

If the patient has evidence of significant progression or a significant breach in eye pressure their case should be discussed (on the day) with a member of the ophthalmology medical team such as the on-call ophthalmologist or eye casualty doctor or a very senior HCP glaucoma practitioner.

If the patient is stable and all of their clinical examination and investigations remain within locally agreed parameters to suggest no evidence of disease progression then the patient should be booked a review appointment in accordance with the updated NICE guidance (2017) on review frequency. See table below.

Patients with OHT

Conversion from OHT to COAG	**Control of IOP**	**Time to next assessment[1]**
Not detected or uncertain conversion[2]	No	Review management plan and reassess between 1 and 4 months
Uncertain conversion[2]	Yes	Reassess between 6 and 12 months
No conversion detected	Yes	Reassess between 18 and 24 months
Conversion	No or yes	See recommendations on the diagnosis and reassessment of COAG
[1]Use clinical judgement to decide when the next appointment should take place within the recommended interval. [2]Uncertain conversion includes having insufficient accurate information (perhaps because the person was unable to participate in the assessment).		

Patients with suspected glaucoma

Conversion to COAG	**Control of IOP**	**Time to next assessment[1]**
Not detected or uncertain conversion[2]	No	Review management plan and reassess between 1 and 4 months
Uncertain conversion[2]	Yes	Reassess between 6 and 12 months
No conversion detected	Yes	Reassess between 12 and 18 months
Conversion	No or yes	See recommendations on the diagnosis and reassessment of COAG
[1]Use clinical judgement to decide when the next appointment should take place within the recommended interval. [2]Uncertain conversion includes having insufficient accurate information (perhaps because the person was unable to participate in the assessment).		

Patients with glaucoma

Conversion to COAG	**Control of IOP**	**Time to next assessment[1]**
Not detected	No	Review management plan and reassess between 1 and 4 months

Uncertain progression[2] or progression	No	Review treatment plan and reassess between 1 and 2 months
No progression detected and low clinical risk	Yes	Reassess between 12 and 18 months
No progression detected and high clinical risk	Yes	Reassess between 6 and 12 months
Uncertain progression2 or progression	Yes	Review treatment plan and reassess between 2 and 6 months
[1]Use clinical judgement to decide when the next appointment should take place within the recommended interval. [2]Uncertain conversion includes having insufficient accurate information (perhaps because the person was unable to participate in the assessment).		

Preparation of room and equipment

- Check that the appropriate agreed level of cover (ophthalmologist present or ophthalmologist contactable) is available.
- Review the consultation room facilities, ensuring it is clean and safe for use and that all safety equipment is in working order.
- Check all equipment is ready for the session.
- Ensure all topical drugs are present and in date

Documentation

- GP letter to be completed on local system, filing a copy in the patients' healthcare record
- 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.

Appendix 6. Risk Assessment

<table>
<tr><td>Department / Directorate</td><td colspan="3">Ophthalmology</td></tr>
<tr><td rowspan="2">Description of risk</td><td colspan="3">This risk assessment is to assess any risks associated with non-medical practitioners expanding their role and undertaking advanced practice care for patients being managed in a HCP-led glaucoma service within the ophthalmology department.

Assessment for glaucoma carries associated risks such as:

• Potential for missed unusual cause / diagnosis
• Very rarely permanent damage to eye or vision
• Miscommunication with patient/carer.

The above could occur for all competent practitioners whether medical or non-medical professional. Serious complications are rare. However some are 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.

Risks associated with a non-medical HCP carrying out this care include:-
• Perception by patient/family that problem was due to care not performed by doctor
• Failure of HCP to detect problem
• Having the experience and ability to identify or manage problems which may occur;
• Not enough staff or time to undergo training
• Not enough senior staff or consultant time to supervise and sign off training
• Capacity issues creating pressure to have excessive numbers on clinics
• Insert any others here or amend the above
•</td></tr>
<tr><td colspan="3">• The guidelines from the Royal College of Ophthalmologists, BIOS and College of Optometrists are followed.
• Compliance with consent, infection control and other key trust policies
• Ready availability of an ophthalmologist by phone or on site.
• Adherence to the extended role laser practice policy.
• Ophthalmic consultant leadership and supervision of service.
• An Incident Reporting process in place for adverse events.
• An audit of the service is regularly carried out.
• Regular patient feedback is sought.
• Governance structures in place where issues / concerns can be raised.
• A complaints system is in place where these are reviewed and lessons are learned and shared.</td></tr>
<tr><td>Existing controls in place when risk was identified</td><td colspan="3"></td></tr>
<tr><td rowspan="3">Initial Risk Score i.e. with existing controls in place</td><td>Consequence (1-5)</td><td></td></tr>
<tr><td>Likelihood (1–5)</td><td></td></tr>
<tr><td>Risk Score (1 – 25)</td><td></td></tr>
<tr><td colspan="4">Actions to reduce the risk to an acceptable level</td></tr>
</table>

Description of actions	Cost	Responsibility (Job title)	Completion Date
Register risk on DATIX or similar reporting system (for all risks > 3) if appropriate	nil		
Existence of Policy compliant with RCOPhth,GOC , BIOS, NMC 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 urgent phone access to doctor for advice and pathway to send patient			
HCPs trained and competent to diagnose and/or provide immediate treatment for complications or unexpected issues			
Insert details of any staffing number or availability adaptations or other mitigations			
Maximum number of patients on HCP clinics at X			

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

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