

High flow, all complexity, local anaesthetic cataract surgery implementation support guides:

Guide 3: Designing effective perioperative data collection tools to support high flow cataract surgery, (includes example proforma for local adaptation)

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NECRTP



In collaboration with

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Introduction

Cataract surgery is the most performed operation in the NHS, accounting for 6% of all operations. Due to the pandemic, the elective surgery backlog has increased, and cataract operations make up a large proportion of that waiting list. Demand for cataract surgery is predicted to continue to increase over the next 10 years ([The Way Forward](#)), and delays to surgery result in prolonged visual impairment which contribute to mental health issues, worsening dementia, falls, loss of independence, the inability to work, and an overall poor quality of life.

Guidance on the development of cataract hubs and high flow cataract lists was produced jointly between Getting It Right First Time (GIRFT) and The Royal College of Ophthalmologists (RCOphth) in March 2021. Since the publication of these documents there has been significant transformation of hospital cataract services and further learning. The continued roll out of high flow cataract surgery is an essential step in tackling the elective backlog and providing patients with timely access to cataract surgery.

This is the third in a series of four implementation guides, produced in collaboration between GIRFT and the National Eye Care Recovery Transformation Programme (NECRTP) to provide additional support and guidance for providers implementing the GIRFT-RCOphth [high flow all complexity cataract surgery pathway](#) and [guidance](#). The cataract pathway defines the high flow principles providers and commissioners should offer for cataract surgery.

'It is the view of the RCOphth and GIRFT that high flow cataract surgery principles are applicable to all but the most highly complex cases and high flow approaches should be used in all cataract surgery settings'

The content of these implementation support guides is based on current literature and existing national guidance, expert consensus (including anaesthetists, non-medical clinical and managerial colleagues in addition to ophthalmologists), learning from GIRFT and East Lancashire Hospital's NHS Trust (ELHT), supported by the NECRTP implementation of the high-flow all-complexity cataract surgery pathway. ELHT successfully ran a five-day elective cataract drive where 121 cataract procedures were completed and cemented changes so that the number of cataract procedures completed weekly is expected to increase by 46%, tackling the elective backlog to deliver sight changing surgery to patients more quickly.

This is the third in a series of [four guides](#) covering different aspects of high flow cataract pathway implementation:

- **Guide 1:** How to deliver a high volume cataract theatre list
- **Guide 2:** How to setup a 'one-stop' cataract pre-assessment clinic
- **Guide 3:** Designing effective perioperative data collection tools to support high flow cataract surgery, (includes example proforma for local adaptation)
- **Guide 4:** Perioperative management of patients with medical comorbidities and additional needs.

A key piece of learning from the successful implementation of high flow cataract surgery at ELHT was the importance of bespoke perioperative data collection and an associated data collection tool (in ELHT's case a paper proforma but in many trusts this would be part of an Electronic Patient Record [EPR]) to support the surgical journey. **Many providers currently use generic data collection tools for local anaesthetic ophthalmic procedures which are not adequately adapted to include the unique steps of the cataract pathway** e.g., risk stratification and collect data on many irrelevant aspects such as venous thromboembolism (VTE), falls risk and Creutzfeldt-Jakob disease (CJD) assessment. A temptingly quick solution is to add additional proformas to the generic one; however, this can make processes more convoluted, increase the risk of error and does not reap the efficiency benefits of eliminating the collection of unnecessary data. Presenting just the relevant data in a clear manner increases safety, enhances flow, and reduces the patient journey time.

For ease of language, "proformas" refer to electronic and paper data collection tools and the related data set appropriate for local anaesthetic cataract surgery.

Perioperative proformas used in cataract surgery need to guide healthcare professionals efficiently through the high-flow all-complexity cataract surgery pathway to ensure consistency in patient management and guarantee critical steps/processes are highlighted and followed. The proformas should also support healthcare professionals in the provision of care by highlighting appropriate actions, for example, what to do when a patient is on warfarin. A well designed proforma is fundamental to ensure clinical practice mirrors the pathway and variation is minimised.

High flow cataract surgery depends on nurses and other non-medical healthcare professionals performing critical steps perioperatively, such as confirming consent and marking the eye on the day of surgery, following appropriate training. To facilitate changes to traditional practice, proformas need to be updated to reflect these new roles and responsibilities.

High flow cataract surgery is achieved by working smarter and not harder; an example would be the removal of the unnecessary completion of VTE forms for every patient undergoing cataract surgery, which is still performed widely around the country. The burden of unnecessary data collection and completion of 'paperwork' for healthcare professionals reduces the time available for direct patient care, slows the patient journey and the key clinical data pertinent to cataract gets "lost" within reams of other, non-pertinent information. It is therefore critical that proformas are designed to support the high-quality documentation of the necessary information only. **The level of documentation before and on the day of surgery needs to be appropriate for a procedure that is expected to take less than 20 minutes and where the patient should be discharged within 60 minutes.**

Creating new proformas is labour intensive and time consuming, and local debates on what data is crucial and what can be divested can be lengthy. Therefore, **this implementation guide provides an example, which can be modified to suit local practice having already been tested and agreed with expert ophthalmology and anaesthetic colleagues from GIRFT and around England.** There are also accompanying explanatory notes to detail key design concepts. The example proforma set out in this guide illustrates the essential required information that should be recorded for each cataract patient and has eliminated the unnecessary steps. Following local modifications, it has been implemented at ELHT and successfully supports the provision of high flow cataract surgery.

Explanatory notes

Pre-operative assessment

1. This proforma/data set is **NOT APPROPRIATE** for patients requiring a general anaesthetic. Patients requiring a general anaesthetic will need an in-depth medical assessment. Furthermore, these patients will require observations on the day of surgery, a modified WHO checklist, different pre-operative preparation (e.g., ensuring starvation status) and different post-operative care (e.g., monitoring conscious level in recovery). We recommend using a provider's standard general anaesthesia (GA) proforma for these patients. However, this proforma's pre-operative ophthalmic assessment, risk stratification and operation record **can** be used for patients requiring a GA.
2. Red flags are provided to support the decision-making process during the medical pre-operative assessment. When a red flag is identified it may indicate the patient is not fit for surgery or not appropriate for surgery under local anaesthetic or that extra action is required. The identification of red flags should prompt a discussion with an ophthalmologist to explore the actions required. The list of red flag conditions is provided to support decision making and are not intended to represent a definitive list.
3. For detailed guidance on assessing and managing medical co-morbidities see our associated guide [here](#). Some key points to remember are:
 - a. For patients taking warfarin, ensure their therapeutic range and testing frequency is documented. Remind patients to have their international normalised ratio (INR) tested within 12 weeks of surgery. If it is out of range, they need to contact the ophthalmic department to rearrange their surgery.
 - b. Any patient with a cardiac implantable electronic device needs a clear summary of the type of device, and confirmation of a recent check of the device attached to the notes.
4. Patients must be provided with high-quality advice at the one-stop clinic to educate patients and adequately prepare them for what to expect on the day of surgery and post operatively. For example, as no medications are altered or stopped prior to cataract surgery, it is imperative diabetic patients are reminded to eat and drink as normal.
5. There should be a set protocol for the investigations required for each patient. Every patient will require biometry pre-operatively; however, it must be clearly defined for the whole team the criteria which determine which patients will require additional investigations e.g., optical coherence tomography (OCT) macula, corneal topography. The appropriate tests can then be

completed for each patient prior to review by an ophthalmologist, thus improving efficiency and ensuring standardisation of practice.

6. The summary sheet and surgical plan summarises which list a patient should be booked on. This is a critical step as high flow cataract surgery depends on booking patients with similar levels of complexity on the same list.
7. Intraocular lens (IOL) selection should follow [RCOphth-UKOA guidance](#). **Transcription of IOL details is a significant risk factor for wrong IOL never events. Therefore, where possible IOL choice should be recorded and signed for directly on the biometry sheet or pulled through from the biometry onto the EPR** where that functionality exists. If there is IOL transcription, it is **ABSOLUTELY MANDATORY** that all IOL confirmation checks, and relevant WHO safety checks **include the original biometry data**.

The example proforma (and WHO checklist) should be modified to reflect local protocols for IOL selection prior to the day surgery, confirmation of the IOL selection on the day of surgery and checking of the lens immediately prior to surgical intervention.

8. Ophthalmologists or non-medical prescribers should complete all prescriptions required for the day of surgery and post-operatively at the one-stop clinic if this cannot be delivered via a Patient Group Direction (PGD) or similar arrangements. All perioperative and post-operative medications should be standardised with different but consistent regimens for higher risk patients as per [GIRFT-RCOphth guidance](#). To take out (TTO) ordered ahead of time and kept on the ward can help to avoid delays on the day of surgery.

Day of surgery admission

1. All areas for systemic observations on the day have been removed from the proforma as they are not routinely required as part of the high flow cataract pathway.
2. It should be made possible for nurses to administer medicines on the day of surgery under a PGD.
3. The RCOphth modified WHO checklist must be used and adapted to reflect the lens selection protocol in place in your trust.

Disclaimer: This resource has been developed to support the transformation of elective cataract services. We welcome providers to use, adapt and modify this document to suit their local needs. However, all content used needs verification and approval according to local governance processes prior to use with patients.

Example LA Cataract Surgery Pathway Proforma

To be completed for ALL High Flow & Standard LA Cataract Elective Admissions

All sections must be complete or marked N/A if not relevant to patient

(Attach patient sticker here)
 First name: Last Name:
 DOB: M/F:
 Address:

 NHS No:
 Hospital number:

List allergies & reaction

Date:

Patient Details	
Patient prefers to be addressed as:	
Home Tel No:	Mobile Tel No:
Interpreter: Y / N If Y, language:	
GP Address:	
Post Code:	Tel:

NEXT OF KIN / EMERGENCY CONTACT
Name
Address
Home Tel No
Mobile Tel No
Relationship

SOCIAL HISTORY	Yes	No	Details
Do you live alone?			
What is your occupation?			
Do you drive?			
Are you a carer for someone?			

Attach Patient Sticker here

Hospital No:	DOB:
First name:	M/F:
Last Name:	GP:
Address:	
NHS No:	RXR

Pre-operative Assessment: Ophthalmic History

	Yes	No	Details
Eye conditions such as glaucoma, diabetic retinopathy, AMD, intravitreal injections, uveitis			
Previous eye injury			
Previous eye surgery			
Refractive laser/surgery			
Amblyopia or patching as child			
Contact lens wearer*			

*Check contact lens have been left OUT for the correct length of time if appropriate

Pre-operative Assessment: Medical History and Fitness for Surgery

Date:					
Pulse red flag: ≤40 or ≥100		SpO2 red flag: ≤94% or requires home oxygen		Weight	
Blood Pressure red flag: BP ≥180/110mmHg		Height		BMI red flag: > 40	

	Red flag	Yes managed	No	Details
High blood pressure (red flag: ≥180/110mmHg)				
Previous heart attack (red flag: MI or cardiac intervention within last 3 months)				
Angina (red flag: chest pain at rest or uninvestigated chest pain)				If yes, patient to bring anti-angina meds on day of surgery.
Pacemaker or ICD (red flag: symptomatic and/or pacemaker requires a 12mth check / ICD 6mth check)				If yes, date of last pacemaker/ICD check: Attach IECD info to notes.
Epilepsy (red flag: seizure in last 2 years, photosensitive fits or non-compliance with meds)				All cases to be discussed with ophthalmologist +/- neurologist
Previous stroke or mini stroke (TIA) (red flag: stroke or TIA within last 3 months)				
Asthma, COPD or cough (red flag: breathing will prevent lying flat)				
Mental illness or dementia or learning disability (red flag: might need best interests or cannot keep still for operation)				If yes, detail any power of attorney; if uncertain, doctor to assess mental capacity

	Red flag	Yes managed	No	Details
Active infection (red flag: active chest, urine, skin infection or leg ulcers)		N/A		
Other health conditions not covered above (red flag: if unmanaged or untreated or ASA 4)				Please list:
Have you ever been notified you are at increased risk of CJD? (red flag: yes)		N/A		If yes notify IPC and undertake full CJD assessment
Red flag: Unable to lie flat and keep still for 30 mins? (e.g., cooperation, breathing, spine or neck problems)		N/A		
Red flag: problems with being awake for surgery? (e.g. claustrophobia / anxiety / tremor)		N/A		
Mobility problems?	N/A			If yes, consider standard list
Does the patient need a hoist?	N/A			If yes, book on standard list
Communication problems e.g., language barrier, hard of hearing	N/A			If yes, make appropriate arrangements

If any red flags, please alert ophthalmologist as patient may not be fit for surgery or for LA.
Options may include: postponing surgery, further investigations / medical optimisation, full assessment for GA or very high risk patient.

Pre-operative Assessment: Drug History

Securely affix GP drug history print out to this page, if not available, complete table below
Tick box if patient is not on regular medications

Medication	Dose	Frequency	Medication	Dose	Frequency

If patient is on warfarin, advise to continue checking INR as per their usual testing frequency and bring evidence on day of surgery. The INR needs to be within patient's therapeutic range at the last scheduled check for surgery to go ahead. This check should be no more than 12 weeks prior to surgery.
If out of range prior to surgery patient to call hospital ASAP before day of surgery.

Therapeutic range:

Testing frequency:

Attach Patient Sticker here

Hospital No:	DOB:
First name:	M/F:
Last Name:	GP:
Address:	
NHS No:	RXR

Pre-operative Assessment: Advice and Readiness for Surgery

Preparation for day of surgery	Yes	No
Does the patient have appropriate travel arrangements for the day of surgery?		
Will the patient be using Patient Transport for the day of surgery? If yes don't list first		
Informed patient to take medicines as usual on day of surgery?		
Informed patient to eat and drink as usual on day of surgery?		
Informed patient to bring any medication normally taken at time of surgery or PRN meds?		
Informed patient not to bring valuables and limit to 1 small bag?		
Informed patient about current COVID-19 testing and isolation?		
Informed patient not to wear makeup or lashes on day of surgery?		
Information provided about what to expect post-operatively?		
Has patient been provided with cataract leaflet and read it? If not, provide.		
Significant concerns for first night post-op e.g., those living alone with little support and one eyed patient or frail elderly patient.		
Is the patient able to self-administer or have a carer/relative administer eye drops post procedure? If not arrange district nurse		
Is the patient able to self-administer (or by relative / carer) eye drops pre-procedure?		
If yes, provide self-dilating drops, leaflet and instructions, warnings e.g., blurred vision / no driving		

Notes (if red flag identified please detail the action or outcome):

Staff signature:

Reg No:

Print name:

Date:

Pre-operative Ophthalmic Assessment

Attach Patient Sticker here

Hospital No:	DOB:
First name:	M/F:
Last Name:	GP:
Address:	
NHS No:	RXR

Please attach biometry print out to this page


Pre-operative Ophthalmic Assessment

Check/confirm previous ocular history [\[Click here to view pg2\]](#)

Check/confirm medical history [\[Click here to view pg 2\]](#)

Attach Patient Sticker here

Hospital No: DOB:
 First name: M/F:
 Last Name: GP:
 Address:
 NHS No: RXR

Symptoms					
Blurred Vision		Daily Activities		Glare	
Difficulty Driving		Difficulty Reading		Halos	
Duration and other details of symptoms:					
Examination					
Lids					
Conjunctiva					
Cornea					
Ant Chamber					
Pupil					
Lens					
PXF					
Fundus					
					
Outcome					
Discussion on material risks, benefits, alternative options with shared decision making undertaken					
If suitable, ISBCS discussed/offered					
Patient happy to proceed with surgery					
Consent form completed and copy provided to patient					
Refractive aim discussed and agreed with patient					
Biometry reviewed and IOL selected					

Operative Risk Factors

Attach Patient Sticker here

Hospital No: DOB:
 First name: M/F:
 Last Name: GP:
 Address:
 NHS No: RXR

Patient factors	Mild	Significant
Compliance factors e.g., anxiety / claustrophobia / very hard of hearing / limited English / reduced mental capacity or learning difficulties / severe psychiatric disease		
Positioning / mobility factors: e.g., very limited mobility / difficulty lying flat or positioning / tremor / (needs hoist = significant)		
Refractive or globe size		
Axial length / AC depth, very high refractive errors	AL <22 or >26; ACD<2.5	AL <20 or >30; ACD<2.0
Toric IOL		
Eye factors		
Only eye		
Active diabetic retinopathy or AMD		
Glaucoma surgery	e.g., PI	e.g., trabeculectomy /tube
Vitrectomised or multiple IV injections		
Previous corneal graft		
Posterior capsule rupture other eye		
Previous significant trauma / phacodonesis / pseudoexfoliation		
Corneal opacity limiting view		
Small /poorly dilated pupil	<6mm / minor synechiae unlikely to need hooks/ring	<4mm or synechiae likely to need hooks/ring
Endothelium / Fuchs	Guttata	Guttata & pachymetry >600
Difficult access eye e.g., deep set, blinking during examination		
Absent fundal view brunescient / white cataract / hypermature		
Posterior polar cataract		
Systemic and drugs		
Alpha blockers (e.g., doxazosin, tamsulosin)	Doxazosin	Tamsulosin

Now please sign prescriptions for the day of surgery.

Summary sheet and surgical plan

Planned Operation: Right/Left/Both Phacoemulsification and IOL

Attach Patient Sticker here

Hospital No: DOB:
 First name: M/F:
 Last Name: GP:
 Address:
 NHS No: RXR

Anaesthetic (circle): LA Topical / LA Subtenons

Outcome (Please circle correct responses)				
Which eyes need Phaco / IOL		Both	Right	Left
If both eyes			ISBCS	Sequential
Guarded visual prognosis: State why				
On the day dilatation method	Mydrane on the table	Self-dilatation	Mydriaserit	Day case drops

Grade	Description	Surgeon Roles	List Type
1: Routine 0 risk factor)	Straight forward case which should cause no difficulties	Registrar, Junior Fellow	High flow list
2: Low complexity 1-2 risk factor)	Straight forward case which should cause an experienced surgeon no difficulties, no special patient needs	Registrar, Junior Fellow	High flow list
3: High complexity 3 risk factors or PXF, iris hooks, graft/trabeculectomy, very difficult access or positioning, very high refractive errors/small or large globe)	More challenging case for an experienced surgeon, likely to take longer and carrying a high risk of complication OR ISBCS OR higher patient needs e.g., severe dementia, best interests, hoist, significant positioning difficulties	Consultant, Senior Fellow	Standard list
4: Very high complexity phacodonesis, black cataract, nanophthalmia, posterior polar cataract, previous significant trauma	A very challenging case with a very high risk of major complication	Consultant with Specialist interest	Named consultant list
Needs GA or sedation OR patient ASA 4 or medically unstable			Anaesthetist list

Biometry check and intraocular lens selection – performed against printed biometry sheet			
Correct patient details		Correct setting optical or ultrasound	
Correct formula		Target refraction (if different from emmetropia)	
Correct eye		Correct A constant	
IOL selection on the biometry sheet *			
Does the lens require special order? If yes, please make adequate arrangement			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name:		Signature:	
Reg No:		Date:	

*This should be documented as per local protocol

WHO Cataract Checklist

SIGN IN (read out loud by Theatre Practitioner with patient and ward nurse)

TIME OUT (read out loud by circulating Theatre Practitioner to whole team). All other activities and conversations cease.

SIGN OUT (read out load by Theatre Practitioner to whole team)

In anaesthetic room

Theatre Practitioner with patient and ward nurse:

- "Hello my name is I am your Can you please tell me your name and date of birth?"
- Check against wristband, notes and consent with the ward nurse.**
- "Do you have any allergies?"
- Check against wristband and notes**
- "Can you tell me what operation you are having and which eye we are operating on?"
- "Is the correct surgical site marked?"
- Check against consent for correct procedure and side. Check consent is signed and dated by patient and surgeon.**
- "Is the biometry in the notes and does it have the correct patient details?"
- LA and Iodine eye drops can now be administered

Theatre Practitioner with surgeon

- "Is lens power and model documented, counter signed and dated by the surgeon?"
- Check against biometry & IOL choice documented in the records**
- "Is the patient taking warfarin or other anticoagulants?"
 - No Yes, last INR available
- "Is the patient taking tamsulosin or other alpha blocker?"
 - No Yes, surgeon notified

Before start of surgical intervention

To patient:

- "Hello my name is We are going to check your details again. Can you please tell me your name and date of birth?"
- Check against wristband, records, mark and consent with scrub nurse.**
- "There are no allergies / they are allergic to..."
- Check against colour of wristband**
- "We are performing "name of procedure" on the right/left/both eyes"
- "This matches the consent and the surgical mark. The consent form is signed by the patient and the surgeon."

If intraocular lens to be implanted

- Scrub practitioner and surgical team to confirm lens box against the biometry and records (2+ person check):**
- "The lens is a 'n' dioptre 'type of lens' for the right/left eye and matches the side and patient identity for: the mark on the patient; the consent form and the IOL selected on the biometry sheet. This matches the ONLY lens selected and available in theatre."
- Check the lens power and type is written and signed on the source biometry**
- "Is an alternative lens available if needed?"
- To surgeon:** Are there any specific equipment or medication requirements, additional steps or patient-specific needs?
- To Scrub Nurse:** Has the sterility of instruments been confirmed? Are there any equipment issues or concerns?

Before any member of the team leaves the operating room

To surgeon:

- Please confirm what procedure has been performed and which site/side.
- Are there any variations to standard recovery and discharge protocol for this patient?

To scrub:

- Are the instrument, swabs and sharps count complete (or not applicable)?
- If applicable: Have any equipment issues been identified?

Patient Details

Last Name	
First Name	
DOB	
NHS Number	
Date of Procedure	

The checklist is for Cataract Surgery performed under Local Anaesthetic ONLY*

This modified checklist must not be used for other surgical procedures

*This checklist should be modified to reflect local practice surrounding the confirmation and checking of the IOL prior to surgical intervention

Attach Patient Sticker here

Hospital No: DOB:
 First name: M/F:
 Last Name: GP:
 Address:
 NHS No: RXR

Intraoperative Care

(To be completed by Ophthalmologist & Theatre Practitioner)

Eye drops administered in Anaesthetic Room as per prescription (Tick to confirm)	Yes	Time
Eye drops given and prescription chart updated		

Mydriasset Pellet (Tick to confirm)	Yes	N/A
Mydriasset pellet removed where applicable		
Signature: _____ Print Name: _____ Date: _____		

Intra Operative Care			Tick
Method of Transfer	Transfer independently onto operating trolley		
	Transfer onto operating trolley with assistance of people		
	Other method		
Position on Operating Trolley	Supine		
	Other:		
Pressure Relieving Aids	Reubens Pillow		Arm Support
	Gel Mat		Head Ring
	Knee / Heel Supports		

Notes

Intra-operative Care

(to be completed by Theatre Practitioner)

Attach Patient Sticker here

Hospital No: DOB:
First name: M/F:
Last Name: GP:
Address:
NHS No: RXR

Notes for scrub team

PLEASE ATTACH ALL STERILE CODE LABELS HERE:

Scrub Practitioner Signature:

Print Name:

Date:

Circulating Practitioner Signature:

Print Name:

Date:

Operation Record

Attach Patient Sticker here

Hospital No: DOB:
 First name: M/F:
 Last Name: GP:
 Address:
 NHS No: RXR

Date					
Surgeon				Grade	
Supervisor or assistant				Grade	
Please circle to record					
Eye	Right	Left	1 st Eye	2 nd Eye	
Anaesthesia	Topical		Subtenon		
Prep	Povidone iodine 10% to skin + 5% to conj			Chlorhexidine 4%	
Co-morbidity	Uncooperative patient		Uncontrolled eye movement		Deep-set eye
	Pupil Medium (manipulation not required but increased surgical difficulty)			Pupil Small (surgical manipulation necessary)	
	Posterior Synechiae	Atonic Pupil	Floppy iris	Pseudoexfoliation	Phacodonesis
	Corneal Opacity		Poor View	Other	
Incision	Corneal	Limbal	Scleral	Axis	degrees
Viscoelastic	Healon	HealonGV	Viscoat	Other	
Capsulotomy	CCC	Can Opener	Vison blue	Other	
Nucleus	D&C	Stop & Chop	Phaco chop	Phaco aspiration	ECCE
Cataract Grade	1	2	3	4	
Additional linear phaco power					
SLM	Bimanual	Coaxial	Manual	None	
IOL	P/C Bag	Sulcus	AC	Iris fixed	No IOL
	Toric IOL	Sphere:	Cyl:	Axis:	
Iris	Iris hooks	Mechanical dilation		Synechiolysis	
Suture	None	No:	10-0 Vicryl	10-0 Nylon	Other
Meds	I/C Cefuroxime 1mg in 0.1ml	Subconj cefuroxime	Subconj dexamethasone	Subconj gentamicin	Other
Topical meds					
Intra Cameral Drugs Used	Lidocaine 1%	Phenylephrine 2.5%		Miochol	Triamcinolone
Other	Mydriaserit removed				

Complications	<input type="checkbox"/> None	
	<input type="checkbox"/> Phaco wound burn	<input type="checkbox"/> Corneal oedema
	<input type="checkbox"/> Iris damage/trauma	<input type="checkbox"/> Iris prolapse
	<input type="checkbox"/> Hyphema	<input type="checkbox"/> Simple Zonule dialysis
	<input type="checkbox"/> Zonule rupture no vitreous loss	<input type="checkbox"/> Zonule rupture with vitreous loss
	<input type="checkbox"/> PC rupture no vitreous loss	<input type="checkbox"/> PC rupture with vitreous loss
	<input type="checkbox"/> Lens fragments into vitreous	<input type="checkbox"/> Decentred IOL
	<input type="checkbox"/> IOL into vitreous	<input type="checkbox"/> IOL exchange
	<input type="checkbox"/> Other IOL problem haemorrhage	<input type="checkbox"/> Choroidal / expulsive
	<input type="checkbox"/> Operation cancelled	<input type="checkbox"/> Other please detail
Dressing	<input type="checkbox"/> Cartella <input type="checkbox"/> Pad <input type="checkbox"/> None	
Extra details		

Follow Up Setting (can be more than one)	Hospital doctor	Hospital nurse/optometrist led	Primary Care Optometrist (optician) enhanced	Primary Care Optometrist (optician) Sight test only
Timing				
Please complete post op prescription and discharge letter				

Signature:

GMC No:

Print Name:

Date:

Post-operative Care

Attach Patient Sticker here

Hospital No: DOB:
 First name: M/F:
 Last Name: GP:
 Address:
 NHS No: RXR

(to be completed by Theatre Practitioner)

Handover to Day Case ward	Confirmed	Comments
Procedure performed		
Type of anaesthesia		
Post-operative instructions		
All theatre documentation complete		
TTOs are written for the correct eye and prescription signed		
Mydriasset was removed and recorded		

Receiving nurse:

Signature:

Print Name:

Date:

Please use space below to record any further details relating to post-operative care

Discharge

(to be completed by Day Case Nurse)

Attach Patient Sticker here

Hospital No: DOB:
 First name: M/F:
 Last Name: GP:
 Address:
 NHS No: RXR

Discharge checklist	Yes	No	Comments
Patient alert and orientated			
Patient feeling well			
Wound clean and dry			
Operation note reviewed for special post-operative instructions			
Explain the importance of post-operative eye drop treatment			
Provide information on post-operative care and danger signs to watch out for			
Post-operative advice leaflet given			
Copy discharge summary and any letter for optometrist given			
Post-operative eye drops given to patient / carer			
Eye drop instillation has been taught to patient			
EPR discharge completed			
Follow-up arrangements explained			
Suitable escorted transport home			<i>Own or hospital transport?</i>
Contact number / out of hours helpline given			
Outpatient appointment booked if required			
Day case patient fit for discharge			
If district nurse needed, all arranged			

NO OBS REQUIRED UNLESS PATIENT IS UNWELL

Please use space below to record any further details relating to discharge

Patient discharge checklist competed by:

Signature: RMC No: Print Name: Date:

Time ready for discharge _____ Time patient left ward _____

Appendices

Appendix 1: Prescriptions

Attach Patient Sticker here

Hospital No: DOB:
 First name: M/F:
 Last Name: GP:
 Address:
 NHS No: RXR

Pre-operative self-dilating drops

Prescription: Dilating Eye Drops dispensed to patient for self-administration on day of surgery			
Drops	Cyclopentolate 1%		
Dilate	Right eye	Left eye	Both eyes
Number of drops			
Drops	Phenylephrine 2.5 %		
Dilate	Right eye	Left eye	Both
Number of drops			
Prescribed By:	Name:		Signature:
	GMC No:		Date:
TTO Given & explained by:	Name:		Signature:
	Reg No:		Date:

Drops for the day of surgery drops

Prescription: Eye Drops administered in Anaesthetic Room on day of surgery			
Drops	Oxybuprocaine 0.4%		
Dilate	Right eye	Left eye	Both eyes
Number of drops	3 drops total at 90 second intervals		
Drops	Povidone 5% Minims		
Dilate	Right eye	Left eye	Both eyes
Number of drops	1 drop total		
Prescribed By:	Name:		Signature:
	GMC No:		Date:
Administered By:	Name:		Signature:
	Date:		

Local standardised prescription for post-operative drops can be inserted here

Appendix 2 – Alternative Risk Stratification Tool

Attach Patient Sticker here

Hospital No: DOB:
 First name: M/F:
 Last Name: GP:
 Address:
 NHS No: RXR

Patient factors	Mild	Significant
Compliance factors e.g., anxiety / claustrophobia / very hard of hearing / limited English / reduced mental capacity or learning difficulties / severe psychiatric disease	1	2
Positioning / mobility factors: e.g., very limited mobility / difficulty lying flat or positioning / tremor / (needs hoist = significant)	1	2
Refractive or globe size		
Axial length / AC depth, very high refractive errors	AL <22 or >26; ACD<2.5	AL <20 or >30; ACD<2.0
	1	2
Toric IOL	1	
Eye factors		
Only eye		2
Active diabetic retinopathy or AMD	1	2
Glaucoma surgery	e.g., PI	e.g., trabeculectomy /tube
	1	2
Vitrectomised or multiple IV injections		2
Previous corneal graft		2
Posterior capsule rupture other eye		2
Previous significant trauma / phacodonesis / pseudoexfoliation	2	3
Corneal opacity limiting view	1	2
Small /poorly dilated pupil	<6mm / minor synechiae unlikely to need hooks/ring	<4mm or synechiae likely to need hooks/ring
	1	2
Endothelium / Fuchs	Guttata	Guttata & pachymetry >600
	1	2
Difficult access eye e.g., deep set, blinking during examination	1	2
Absent fundal view brunescient / white cataract / hypermature		2
Posterior polar cataract		3
Systemic and drugs		
Alpha blockers (e.g., doxazosin, tamsulosin)	Doxazosin	Tamsulosin
	2	2
Total score		<input style="width: 100px; height: 20px;" type="text"/>

Appendix 2: Alternative risk stratification tool

Attach Patient Sticker here

Hospital No:	DOB:
First name:	M/F:
Last Name:	GP:
Address:	
NHS No:	RXR

Score	Description	Roles	Surgical Complexity	List Type
0-3	Straight forward case which should cause an experienced surgeon no difficulties ISBCS – needs consultant present	Registrar, Junior Fellow	Low	High flow list
4-7	More challenging case for an experienced surgeon, likely to take longer and carrying a high risk of complication OR higher patient needs e.g., severe dementia, best interests, hoist, significant positioning difficulties ISBCS – needs consultant present	Consultant, Senior Fellow	High	Standard list
8 or more	A very challenging case with a very high risk of major complication	Consultant with Specialist interest	Very High	Named Consultant List
NA	Needs GA or sedation OR patient ASA 4 or medically unstable			Anaesthetic list

Scoring should assist with identifying the appropriate list type for each patient; however, clinical judgement takes priority.

Acknowledgements

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We would like to thank everyone at East Lancashire Hospitals NHS Trust who worked with us to transform their cataract surgery pathway and implement high flow cataract surgery. The learning from this project has inspired this national guidance and will help providers across the country transform their services.

Contact girft.academy@nhs.net if you have feedback or questions.