

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

Guide 4: Perioperative management of patients with medical comorbidities and additional needs.

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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 last in a series of four implementation guides, produced in collaboration between GIRFT and the National Eye Care Recovery Transformation Programme (NECRTP) 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 last 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.

Perioperative management of patients with medical comorbidities and additional needs.

Patients requiring cataract surgery are usually from an older cohort (with associated multi-morbidity and frailty). The [GIRFT-RCOphth high flow all complexity cataract surgery guidance](#), and the associated [GIRFT-NECRTP pathway](#), define how providers and commissioners should offer cataract surgery by applying high flow principles. Multimorbidity and frailty do not automatically preclude patients from benefiting from high flow cataract surgery.

Excellent patient experience in high flow surgery stems from carefully planned perioperative management of *all* risk factors that may affect outcome, not just the clinical status of the eyes.

Currently, unwarranted variation in the management of patient factors and comorbidities lead to unnecessary delays in surgery, on the day cancellations, or unnecessary exclusion from high flow all complexity operating lists. Cataract surgery is highly clinically and cost effective; nationally, over 95% of patients have cataract surgery performed under local anaesthetic and, for the majority, the procedure is completed in less than 20 minutes. It is imperative that we use resources wisely and improve access to cataract surgery to provide patients with timely visual restoration and the best outcome.

This document provides guidance on how patient's medical comorbidities and additional needs should be managed perioperatively to reduce unwarranted variation in the application of the high flow all complexity cataract surgery pathway. There is also a series of Frequently Asked Questions (FAQs) incorporated into this guide to support pathway implementation. The guidance will support the transformation of services and ensure adoption of best practice. Current perioperative practices in your department which deviates from this guidance should be discussed at departmental level to determine if the deviation is warranted. **This guidance pertains to patients undergoing cataract surgery under local anaesthetic (LA) only.**

For high flow cataract surgery, it is essential that underlying comorbidities are appropriately managed/controlled as routine observations etc. are not conducted on the day of surgery.

Summary table

Issue	Advice summary
Anticoagulant and antiplatelet medication	Antiplatelet and anticoagulation medication, including dual antiplatelet therapy, should not be altered peri-operatively for patients undergoing cataract surgery under topical or sub-Tenon's block LA. Patients who are well established on warfarin will have their INR measured routinely at minimum every 12 weeks. Reasonable evidence from the patient's anti-coagulation record (yellow book) that the INR is likely to be within its therapeutic range is sufficient and no extra measurement of INR is required perioperatively.
BMI	There is no specific BMI cut-off for high flow cataract surgery performed under LA.
Bradycardia Tachycardia	As part of the pre-operative assessment, a baseline set of observations including heart rate should be measured. Usually, a heart rate below 40 beats per minute is termed bradycardia and above 100 beats per minute, tachycardia. If a heart rate outside of the normal range cannot be explained or is unmanaged, surgery must be postponed.
Cardiac Implantable Electronic Devices (CIEDs)	In phacoemulsification surgery, diathermy is not used and therefore the risk of CIED malfunction is very low. CIEDs are not a contraindication to high flow cataract surgery. PPMs must have been checked within the last 12 months and ICDs within the last 6 months. Evidence of the CIED check should also be available in the notes in preparation for the day of surgery.
Diabetes mellitus	There is no requirement to measure HbA1c pre-operatively in patients who have diabetes. On the day of surgery point of care blood sugar measurements are not required unless the patient is unwell, or it is part of the patient's routine blood sugar management.
Epilepsy	Epilepsy is not an absolute contraindication to undergoing cataract surgery under local anaesthesia provided that the patient is well established on antiepileptic medication and has not experienced a seizure for at least two years.
Hypertension	At pre-assessment: if the blood pressure is elevated but less than 180/110mmHg, surgery should not be delayed as there is no evidence to suggest adverse medical or surgical outcomes. On the day of surgery: If the patient's blood pressure recorded at pre-assessment was less than 180mmHg systolic and 110mmHg diastolic, then it does not need repeating at any point on the day of surgery.
Infections outside the eye	Patients with an acute active infection should have their elective cataract surgery delayed until it has fully resolved due to the risk of endophthalmitis. Routine testing of urine with dipsticks in pre-operative assessment clinics in asymptomatic patients is not recommended.
Mental capacity	Patients lacking capacity to consent for surgery should undergo a best interest meeting pre-operatively.

<u>Mobility issues</u>	Patients who require increased support with moving and positioning should be booked onto a non-high flow (8 or less patients) list. The ward team should facilitate positioning patients onto the operating trolley just ahead of their theatre slot.
<u>Myocardial infarction, angina, and transient ischaemic attack</u>	Elective cataract surgery should be postponed for three months following myocardial infarction, cardiac therapeutic intervention (e.g., stent or angioplasty), stroke or transient ischaemic attack.
<u>Pre-operative tests</u>	No routine pre-operative blood tests or ECG need to be conducted, and no medication needs to be altered or stopped pre-operatively.
<u>VTE</u>	Patients undergoing cataract surgery do not need to undergo a routine VTE risk assessment.
<u>MRSA screening</u>	Only patients previously identified as colonised with or infected by MRSA require mandatory MRSA screening prior to elective cataract surgery.

The summary in this table should be read in conjunction with the full explanation for each condition which can be found in the next section of this guide.

Conditions

Anticoagulant and antiplatelet medication

Antiplatelet and anticoagulation medication, including dual antiplatelet therapy, should not be altered perioperatively for patients undergoing cataract surgery under topical or sub-Tenon's block LA due to the low risk of haemorrhage and increased risk of harm to the patient from systemic thromboembolism. Sharp needle (retrobulbar, peribulbar) block LA should be avoided. Joint Royal College of Ophthalmologists and Royal College of Anaesthetists guidance states that cataract surgery can proceed if the INR is within the patient's therapeutic range; **note the therapeutic range varies from patient to patient and is recorded in their yellow book**. There is no single "safe" cut off INR level for patients on warfarin. Reasonable evidence from the patient's anti-coagulation record (yellow book) that the INR is likely to be within its therapeutic range is sufficient and no extra measurement of INR is required perioperatively.

Patients who are well established on warfarin will have their INR measured routinely every 12 weeks or sooner as per NICE guidance. The most recent INR result can be reviewed at the pre-operative assessment (patients should be reminded to bring their INR record to the pre-operative assessment appointment). The patient's normal INR therapeutic range and routine INR testing schedule should be documented during the pre-operative assessment. Remind patients to maintain their regular INR checks, so that they make sure they have their INR measured within 12 weeks of their scheduled cataract procedure and bring their yellow book (or other evidence of latest INR) on the day of surgery. If at any point the INR is above the therapeutic range, the patient should be advised to contact the hospital so their surgery can be rearranged. Some units find it helpful to supply patients with a standard "warfarin letter" stating requirements to share with their anticoagulation clinic.

The effects of direct oral anticoagulants (DOACs) cannot be easily assessed pre-operatively and no further investigations or changes to dosing are required.

References

- [Safety of continuing warfarin therapy during cataract surgery: a systematic review and meta-analysis - PubMed \(nih.gov\)](#)
- [2012-SCI-247-Local-Anaesthesia-in-Ophthalmic-Surgery-2012.pdf \(rcophth.ac.uk\)](#)
- [Novel oral anticoagulants in cataract surgery - moving towards a national consensus regarding perioperative continuation \(nature.com\)](#)

Body Mass Index (BMI)

There is no BMI cut-off for high flow cataract surgery performed under LA. It is important to check all equipment used (e.g., trolleys and wheelchairs) are appropriate and safe for the patient's weight. Patients who require more time for positioning are often better booked onto a non-high flow (8 or less patients) list where greater time is allowed. All patients must be able to lie flat and still for the duration of the procedure when performed under LA.

Bradycardia and tachycardia

As part of the pre-operative assessment, a baseline set of observations including heart rate should be measured. Usually, a heart rate below 40 beats per minute is termed bradycardia and above 100 beats per minute, tachycardia. A heart rate outside of this range could be normal but may indicate serious underlying pathology such as an arrhythmia or infection. This range is provided as a guide to 'stop and think' rather than an absolute cut-off resulting in cancellation. Pre-assessment staff should always seek out an obvious cause for a heart rate abnormality e.g., side effect of a beta-blocker. If a heart rate outside of the normal range cannot be explained or is unmanaged, then advice should be sought from an anaesthetist or the acute medical team as appropriate. In these cases, surgery must be postponed until investigation and optimisation is complete.

Cardiac Implantable Electronic Devices (CIEDs)

There are several different types of CIED including:

- Permanent pacemakers (PPMs)
- Implantable cardiac defibrillators (ICDs)
- Cardiac Resynchronisation Pacemakers and Defibrillators (CRTPs and CRT-Ds)
- Implantable Loop Recorders (ILRs) – no additional precautions are required.

Perioperatively, if a CIED is exposed to electromagnetic interference through diathermy it may cause the device to inappropriately function causing loss of cardiac output, life threatening arrhythmia or death. In phacoemulsification surgery, diathermy is not used and therefore the risk of CIED malfunction is very low. CIEDs are not a contraindication to high flow cataract lists. PPMs must have been checked within the last 12 months and ICDs within the last 6 months to ensure they are functioning appropriately. If the device was recently inserted, then the patient must have attended a follow-up appointment where the device was interrogated before their cataract operation.

At pre-operative assessment, it must be clearly documented on the patient's notes that they have a CIED. The following information should be clearly documented in the notes from the device information card: type of device, manufacturer, model and serial number, date of insertion, indication for insertion and underlying rhythm, hospital responsible for follow-up, location of device, and contact details of hospital responsible

for pacemaker. Evidence of the CIED check should also be available in the notes in preparation for the day of surgery. If these steps have been followed pre-operatively no further checks are required on the day of surgery.

References

- [Guidelines for the peri-operative management of people with cardiac implantable electronic devices \(wiley.com\)](http://wiley.com)

Diabetes mellitus

Pre-operatively

Instruct patients to eat and drink normally on the day of surgery, this is important for insulin dependent diabetics and patients taking oral antidiabetic agents that can lead to hypoglycaemia if the patient skips meals. This should be carefully reiterated to all patients in appointment letters. There is no need to change or omit any diabetic medications perioperatively for patients undergoing cataract surgery under local anaesthetic.

There is no requirement to measure HbA1c pre-operatively for cataract surgery in patients who have diabetes. There is currently no evidence to support a harmful outcome in patients undergoing cataract surgery with a raised HbA1c. Measurement of HbA1c is a frequent cause of delayed surgery which ultimately may cause greater risk to patients.

As part of normal GP care, patients with diabetes should have their HbA1c measured in accordance with National Institute for Health and Care Excellence (NICE) guidance and diabetic treatment titrated accordingly.

On the day of surgery

Point of care blood sugar measurements are not required on the day of surgery unless the patient is unwell or reports that they have not taken their medication or eaten and drunk as instructed. As patients are not starved for the procedure and don't have diabetic medications altered, the risk of blood glucose instability is reduced; furthermore, patients will be awake throughout and able to report symptoms relating to blood glucose irregularity. The Royal College of Ophthalmologists supports the view that diabetic patients undergoing cataract surgery should have their blood sugar controlled but does not consider there is enough evidence to cancel cataract surgery above any one level of blood sugar or HbA1c. There is no published evidence on the adverse effects of high intraoperative blood glucose on outcome after cataract surgery.

If the patient is feeling unwell, this should trigger blood sugar measurement that will guide further management aimed at preventing cancellation wherever possible. It would be advisable to discuss ongoing management of patients who are unwell, with a blood sugar out of range, with the acute medical team or anaesthetic team.

Patients who are insulin dependent and routinely measure their blood sugar throughout the day should be reminded to continue this throughout their admission.

References

- [Ophthalmic Safety Alert – Diabetic control and safe cataract surgery | The Royal College of Ophthalmologists \(rcophth.ac.uk\)](https://www.rcophth.ac.uk)
- [Peri-operative management of the surgical patient with diabetes 2015 - - 2015 - Anaesthesia - Wiley Online Library](#)
- [Glycaemic control during cataract surgery under loco-regional anaesthesia: a growing problem and we are none the wiser - British Journal of Anaesthesia \(bjanaesthesia.org\)](https://bjanaesthesia.org)
- [The Association Between Glycaemic Control, Renal Function and Post-operative Ophthalmic Complications in People With Diabetes Undergoing Cataract Surgery-A Single-Centre Retrospective Analysis - PubMed \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov/)

Epilepsy

Epilepsy is not an absolute contraindication to undergoing cataract surgery under local anaesthesia provided that the patient is well established on antiepileptic medication and has not experienced a seizure for at least 2 years. If patients have poorly controlled epilepsy or aren't compliant with antiepileptic medication, then the surgery should be completed under general anaesthetic. The decision to proceed under local anaesthetic should be done on a case-by-case basis by a consultant ophthalmologist. The patient's neurologist should be consulted to help make this decision, especially regarding patients with photo sensitive epilepsy.

Hypertension

Pre-operatively

As per Association of Anaesthetists & British Hypertension Society guidance, blood pressure measurement should be taken or confirmed, and a decision made on any actions required if raised, prior to the day of surgery.

Normotension is defined as a blood pressure below 140/90mmHg. If the blood pressure is elevated but less than 180/110mmHg, patients should be advised to see their GP, but surgery should not be delayed as there is no evidence to suggest adverse medical or surgical outcomes. If the systolic and/or diastolic blood pressure is 180/110mmHg or higher, then patients should be referred rapidly to their GP or medical team, and surgery delayed until this is optimised. Blood pressure should be measured in pre-operative assessment clinic according to the method outlined in the above guidance.

This guidance also states blood pressure does not need to be measured pre-operatively in patients who have evidence of a blood pressure less than 160mmHg systolic and 100mmHg diastolic documented by primary care in the last 12 months. This facilitates phone or virtual pre-operative assessment. If this evidence is not available, blood pressure should be performed as part of the pre-operative patient assessment.

On the day of surgery

On-the-day measurements of blood pressure are often a reflection of patient anxiety and not a true measure of blood pressure or risk. If the patient's blood pressure recorded at pre-assessment was less than 180mmHg systolic and 110mmHg diastolic, then this does not need repeating at any point on the day of surgery. Blood pressure readings are only required on the day of surgery if the patient becomes acutely unwell.

Rationale for decision

It is safe and acceptable to not check BP on the day of the operation when satisfied there is reasonable BP control pre-operatively, because there is no evidence it affects the systemic or ocular outcome and it's a common cause of distressing cancellations on the day and consequent delays in accessing surgery for patients. Expulsive haemorrhage is much less common since the advent of phacoemulsification. Most of the literature examining the relationship between hypertension and expulsive haemorrhage relates to previous extracapsular cataract extraction or early phacoemulsification. There is no high-quality evidence demonstrating an increased risk of expulsive haemorrhage for patients with uncontrolled on the day blood pressure when the pre-operative blood pressure was within recommended limits.

References

- [Hypertension and cataract surgery under loco-regional anaesthesia: not to be ignored? | BJA: British Journal of Anaesthesia | Oxford Academic \(oup.com\)](#)
- [The measurement of adult blood pressure and management of hypertension before elective surgery \(anaesthetists.org\)](#)

Infections outside the eye (including leg ulcers)

Patients with an acute active infection should have their elective cataract surgery delayed until it has fully resolved due to the risk of endophthalmitis. Patients must be advised to contact their surgical team if they are started on antibiotics or develop an infection anywhere in the body prior to their surgery to avoid on the day cancellations. Routine testing of urine with dipsticks in pre-operative assessment clinics in asymptomatic patients is not recommended.

Some patients have chronic low-level infections such as leg ulcer infections and urinary tract infections which are not self-limiting and cannot be easily treated. In these instances, we suggest a frank discussion with patients about the risks and benefits of proceeding with elective cataract surgery. We support performing elective cataract surgery in patients with chronic infection outside the eye if the patient fully understands and consents to the potential additional risk posed and high quality endophthalmitis prophylaxis is undertaken in line with RCOphth guidance. However most chronic leg ulcers are not infected, and surgery may safely proceed.

References

- [RCOphth Managing an outbreak of postoperative endophthalmitis.](#)

Mental capacity

Patients lacking capacity to consent for surgery should undergo a best interest meeting pre-operatively. When it is in the patient's best interest to proceed with surgery, a consent form 4 should be used. These patients will likely require more time and support peri- and intraoperatively and should be booked onto a non-high flow (8 or less patients) list. Some patients may require sedation or GA. Some units do not put such patients on pooled lists and ensure the consultant who was involved in the pre-operative clinic and best interests meeting performs the surgery. If pooled lists are used, it is important that the consultant involved in the best interests meeting liaises directly with the surgeon who will perform the surgery before the day of the operation to ensure appropriate handover of information.

Mobility issues and hoisting

Some patients may require increased support with moving and positioning and therefore are usually best booked onto a non-high flow (8 or less patients) list where there is more time available. Issues can be reduced by having a high-quality operating trolley allowing a wide range of body, head and neck positions and a theatre team experienced in cataract surgery. The ward team should position patients onto an operating trolley or complete hoisting outside of the theatre room, just ahead of their theatre slot to limit disruption to the operating list.

A small number of surgeons are able to perform cataract surgery for patients in the sitting up position when they are unable to lie flat.

References

- [J Cataract Refract Surg 2011;37:805-9. doi: 10.1016/j.jcrs.2011.03.023.](https://doi.org/10.1016/j.jcrs.2011.03.023)

Myocardial infarction, angina, stroke, and transient ischaemic attack

Elective cataract surgery should be postponed for three months following myocardial infarction, cardiac therapeutic intervention (e.g., stent or angioplasty), stroke or transient ischaemic attack (TIA). Patients who have experienced one of these conditions in the last three months are American Society of Anaesthesiologists (ASA) physical classification grade IV and are at high-risk of a subsequent event in the immediate post event period.

Patients with angina should be advised to bring their usual angina medication and have this available to use throughout their admission including in theatre. Any patient with new or un-investigated chest pain should be sent for immediate review prior to elective cataract surgery.

References

- [Perioperative management of adult patients with a history of stroke or transient ischaemic attack undergoing elective non-cardiac surgery \[CMJv16n6-Mehd.indd \(nih.gov\)\]](#)

Frequently asked questions

What tests need to be performed pre-operatively?

No routine pre-operative blood tests or ECG need to be conducted, and no medication needs to be altered or stopped. Due to the nature of the procedure, the local anaesthetic and the short duration of time in a hospital setting, a focused pre-operative assessment can be undertaken. This must include careful documentation of the patient's medications, allergies, and underlying health conditions pertinent to patient safety.

References

- [The Value of Routine Preoperative Medical Testing before Cataract Surgery | NEJM](#)

How long does a medical pre-operative assessment remain valid for?

There is no specific time cut off for the validity of a pre-operative assessment if the following measures are in place. On the day of surgery, there should be an assessment of whether the health, medications, or allergies of the patient have changed since their pre-assessment. Alternatively, these questions can be asked over the telephone a few days prior to admission to avoid any on the day cancellations. Trusts with an electronic patient record can use this to check remotely for changes to a patient's medical history, for example, recent admission to hospital.

However, experience from units who are increasing their cataract list to higher flow report much greater confidence and efficiency on the day where there is a short time period between the pre-operative assessment and the operation date. Providers should therefore aim to schedule surgery for a few weeks (no more than 3 months) after the one-stop pre-operative assessment clinic. Unnecessary long delays between the one-stop assessment clinic and surgery increase the risk of changes to the patient's condition/circumstances. These changes subsequently increase the risk of cancellation on the day of surgery.

Is venous thromboembolism (VTE) risk assessment required?

NICE guidance states "Do not routinely offer pharmacological or mechanical VTE prophylaxis to people undergoing a surgical procedure with local anaesthesia by local infiltration with no limitation of mobility." As cataract surgery under local anaesthesia is a short operation with immediate mobilisation, patients undergoing cataract surgery do not need to undergo a routine VTE risk assessment and this should be incorporated into local providers' VTE policies.

References

- [Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism. NICE guideline NG89 2018](#)

Is MRSA screening required?

National guidance stipulates that the only patients previously identified as colonised with or infected by MRSA require mandatory MRSA screening prior to elective cataract surgery.

References

- [MRSA screening guidance \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/421212/mrsa-screening-guidance.pdf)
- [MRSA and cataract surgery - reflections for practice \(Clin Ophthalmol.\)](#) 2010; 4: 1223–1227. doi: [10.2147/OPTH.S12027](https://doi.org/10.2147/OPTH.S12027)

Which cases need an anaesthetist present in theatre?

All patients requiring a general anaesthetic (GA) will require the presence of an anaesthetist and a more extensive pre-operative assessment compared with LA patients. Patients requiring sedation will also require the presence of an anaesthetist unless other clinical staff have been trained and are competent in providing procedural sedation. National audit data suggests that less than 5% of patients require a GA or sedation for cataract surgery, therefore the majority of elective cataract surgery can be performed without an anaesthetist present. ASA I, II and III patients are all suitable for elective surgery without the presence of an anaesthetist as long as their comorbidities are stable and managed.

ASA grade IV is defined as a patient with severe systemic disease that is a constant threat to life. Examples include but are not limited to: recent (less than 3 months) myocardial infarction, stroke; TIA; ongoing cardiac ischemia; severe heart failure; sepsis; and renal failure with no regular dialysis. Clearly, elective cataract surgery should be postponed in ASA IV patients or any patient with an unstable or unmanaged condition to allow for optimisation as far as reasonably possible. However, if optimisation is not possible and surgery is in the best interests of the patient, a thorough pre-operative assessment should be completed, and a senior anaesthetist available on the day of surgery to provide immediate medical assistance.

References

- [ASA Physical Status Classification System | American Society of Anesthesiologists \(ASA\) \(asahq.org\)](https://www.asahq.org/ASA-Physical-Status-Classification-System)
- [Chapter 13: Guidelines for the Provision of Ophthalmic Anaesthesia Services 2020 | The Royal College of Anaesthetists \(rcoa.ac.uk\)](#)

Acknowledgements

Project Team:

Dr Josh Wall	National Medical Director's Clinical Fellow, Specialist Registrar in Anaesthesia
Miss Melanie Hingorani	Consultant Ophthalmologist at Moorfields Eye Hospital and Chair of the UKOA
Prof Tim Briggs	GIRFT Programme Chair and National Director of Clinical Improvement for the NHS

GIRFT Clinical Leads:

Miss Alison Davis	GIRFT co-lead for Ophthalmology
Mr Jonathan Bhargava	GIRFT co-lead for Ophthalmology
Miss Lydia Chang	GIRFT co-lead for Ophthalmology
Dr Chris Snowden	GIRFT co-lead for Anaesthesia and Perioperative Medicine
Dr Mike Swart	GIRFT co-lead for Anaesthesia and Perioperative Medicine

Contributors:

Centre for Perioperative Care

Royal College of Ophthalmologists Clinical Leads Group

Mr Graham Lomax	GIRFT National Director of Implementation
Mrs Karen Skelton-Hough	GIRFT Senior National Implementation Manager
Mrs Ndi John	GIRFT Senior Content Development Manager

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