

Cataract audit: 50 consecutive cases (completed during ST4-7)

Please note: all CCT applications received after 30 August 2017 must be supported by an audit where the surgery is performed within three calendar years of the CCT date.

Please refer to the RCOphth Ophthalmic Services [guidance chapter on audit and clinical effectiveness](#) and the [OST curriculum](#)
Cataract National Dataset, Eye (2009) 23, 38–49.

The following data should be recorded for each cataract case:

Date of surgery
Hospital or NHS number
Pre op VA (best measured) in the eye to be operated
Pre op co-pathology/reasons for a guarded visual prognosis/complications (as per Table 5*)
Operative complications (as per Table 7*)
Post-operative complications (as per Table 8*)
Best measured post-operative VA
Spherical equivalent refractive aim spherical equivalent post-operative refraction

For cases with complications you must include outcome data (final refraction, complications such as cystoid macular oedema, etc.)

Your audit needs to be presented as an audit paper (preferably saved as a PDF file) and should include the following:

- Title
- Background
- Aim
- Setting
- Standards
- Method (including approach to sampling)
- Results
- Interpretation of findings
- Adjustments to practice
- Date for re-audit

The following should be provided for the audit:

% of eyes achieving post-op visual acuity 6/6 or better and 6/12 or better with and without ocular co-pathology (as per Table 10*)
% of per-operative complications (in particular PC rupture with and without vitreous loss)
% of post-operative complications
% of eyes within 0.5 D of the refractive aim and within 1D of the refractive aim

*Refer to the Cataract National Dataset, Eye (2009) 23, 38–49.