

Quality Standard



The ROYAL COLLEGE of
OPHTHALMOLOGISTS

Ophthalmic A&E/ Urgent Care Services

The Royal College of Ophthalmologists champions excellence in care. In order to provide the best care for patients, and to generate improvements in care, it is important to be able to measure the quality of clinical services provided. In addition, measuring quality provides quality assurance data for patients, regulators and commissioners. There are many possible ways of measuring service quality including clinical audit, outcome measures and patient surveys.

The College's Quality and Safety Group provides a set of simple self-assessment tools for a number of clinical services: cataract, glaucoma, adnexal, medical retina (including age-related macular degeneration [AMD]), diabetic retinopathy, vitreoretinal surgery, neuro-ophthalmology, children and young adults and adults with learning difficulties. The tools focus on service provision not outcomes, and do not attempt to assess every aspect of service but try to focus on a small number of key areas. It is not expected that most clinical services will achieve a perfect score, and the results should be used in conjunction with other methods of quality assessment to support learning and improvement.

Please send feedback to Beth Barnes (beth.barnes@rcophth.ac.uk), Head of Professional Standards.

There is increasing demand for all urgent and emergency care in the UK, including ophthalmic care. Patients requiring ophthalmic urgent and emergency care are common, and the incidence of new eye casualty attendances has been estimated at 20-30 per 1000 population per year and eye emergencies are thought to make up 1.46-6% of accident and emergency (A&E) attendances. The standards in this document apply to urgent and emergency secondary ophthalmic care, and how that links up to community and primary care, to ensure safe care and adherence to national guidelines.

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1. Leadership

There is a nominated eye unit clinical lead for the urgent service with the role defined in their job plan. The job description includes liaison with non-ophthalmic A&E staff and community / primary care colleagues.

YES NO

The eye unit provides training and support to the trust's non-ophthalmic A&E doctors, nurses and AHP staff who may be required to deal with ophthalmic conditions.

YES NO

Comments/reasons for non adherence:

2. Arrangements for 24/7 urgent care

There is a plan for emergencies and urgent care 24/7, and there is a formal agreement in place with the receiving provider to accept cases if sent off site, covering all categories of potential urgent care demand. *

YES NO

All internal colleagues and all relevant external colleagues (main A&E, GPs, optometrists, commissioners, other eye units in region, NHS111) are aware of this plan.

YES NO

Patients who have had treatment are given written and verbal information to enable contact with a competent professional so that they can immediately access emergency advice or treatment.

YES NO

Comments/reasons for non adherence:

3. Networks

If the unit usually or routinely directs emergency patients elsewhere, there are agreed reliable administrative and clinical arrangements with the receiving unit for efficient referral/transfer, for on-going follow up including repatriation, and information sharing.

YES NO

If part of an urgent care network, there are systems for obtaining details on the unit's emergency complications seen in other units, used to assess rates of postoperative endophthalmitis or retinal detachment.

YES NO

4. Consultant and senior decision maker availability

There is a consultant ophthalmologist or equivalent senior specialty doctor (SSD), such as a highly experienced and independently practicing associate specialist, with ultimate clinical responsibility for emergency patients, available to provide advice at all times, and able to come into the hospital to see patients as required.

YES NO

The consultant/SSD sees all emergency admitted patients, and confirms the care plan, within a maximum of 12-14 hours from the time of arrival at hospital. If not, these cases are managed by senior (ST6 and above or fellow) doctors, and discussed with the consultant within a maximum of 2-3 hours if urgent surgery is being considered.

YES NO

Surgeons with private practice commitments make arrangements for their private patients to be cared for by another surgeon/team when they are on-call for emergency admissions or surgery, on leave or otherwise unavailable.

YES NO

There is a senior decision maker (clinician who can establish a diagnosis, define a care plan and discharge a patient without routine reference to a more senior clinician e.g. ST3 and above) who can arrive within 30 minutes and be available by telephone for advice to more junior or AHP colleagues.

YES NO

The senior decision maker reviews all unplanned returns within 72 hours of an A&E condition.

YES NO



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All emergency admitted patients are discussed daily (including at weekends) with the responsible consultant /SSD and a daily early morning ward conducted by the senior decision maker to discharge.

YES NO

Comments/reasons for non adherence:

5. Equipment and facilities

There is a dedicated ophthalmic A&E room equipped with the essential equipment: standard visual acuity testing chart; near vision and colour vision testing equipment; slit lamp with tonometer; gonioscope lens; indirect ophthalmoscope; 20 dioptre and 90 dioptre lenses; exophthalmometer; ideally also trial frames and a trial lens set.

YES NO

There is access to the other equipment and investigations outlined in the College A&E service guidance? **

YES NO

There is an adequate stock of medications which may be required to treat emergency conditions where there is no pharmacy service immediately available**

YES NO

There are facilities for resuscitation plus available trained staff for systemic emergencies such as cardiac arrest.

YES NO

There is urgent access to a hyperacute stroke unit (HASU) for TIA/stroke with an agreed defined referral pathway and to acute neurology services.

YES NO

There are beds available for ophthalmic emergency admissions and staff with enough experience of nursing ophthalmic cases to allow the appropriate treatment e.g. frequent topical medication

YES NO

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6. Protocols, guidelines and staffing

There are departmental protocols / guidelines for the management of common emergencies such as acute glaucoma and endophthalmitis based on College, NICE or other recognised national guidance.

YES NO

There are triage guidelines for staff taking calls or providing initial assessment.

YES NO

For nursing and AHP staff delivering extended role A&E care there are:

Training and sign off against the College common competency framework	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Guidelines / protocols including for ophthalmologist involvement	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Supervision of practice by an ophthalmologist	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Audit and appraisal of performance	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Comments/reasons for non adherence:

7. Theatre

There is a theatre to perform emergency ophthalmic procedures where necessary. If provided within a network of care, that pathway is clear and agreed by all providers.

YES NO

The theatre is equipped to allow intraocular and extraocular surgery and lid repair including operating microscope and the equipment and instruments necessary for cataract, corneal and squint surgery, and vitreo-retinal equipment if that surgery is provided.

YES NO

Out of hours emergency ophthalmic surgery is only performed by medical staff sufficiently experienced to manage the case, assisted by theatre staff with enough expertise in ophthalmology to be able to provide safe support and use of equipment.

YES NO

There is sufficient anaesthetic cover available to allow out of hours surgery in the evening or during the day at weekends without having to operate between 10pm-8am because of pressure of other more non-ophthalmic cases.

YES NO

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A consultant surgeon or senior fellow is present where possible for all unscheduled returns to theatre.

YES NO

Comments/reasons for non adherence:

8. Clinical governance

There is a clinical governance structure with meetings to examine outcomes, audit and regular review of practice for emergency and urgent care.

YES NO

Clinical audit on urgent and A&E ophthalmic care is undertaken regularly.

YES NO

Lessons are learned from patients with poor outcomes and appropriate steps taken to reduce the chance of recurrence e.g. education or training issues addressed.

YES NO

If care is delivered in a network, there is regular network review of patient outcomes, incidents and experience; there are processes in place to identify and monitor network risks and critical incidents with the provision for joint investigation and learning for serious and moderate harm incidents. Clinical audit can be conducted across the network.

YES NO

If care is delivered in a network, there are regular joint training and governance meetings.

YES NO

If seeing ophthalmic emergencies in an A&E seeing, which of the following key metrics are assessed and used to manage performance? (circle each)

- Left department before being seen for treatment rate
- Re-attendance rate
- Time to initial assessment
- Time to treatment
- Total time in A&E
- Measures of patient satisfaction (e.g. friends and family test).
- % of patients who should be discharged at first visit who were discharged at first visit
- % of patients diagnosed and managed accurately (consultant retrospective case note audit)

Comments/reasons for non adherence:

9. Communication

All attendances result in a printed discharge summary/letter to GP (and where relevant optometrist) with a copy given to the patient (90% of discharge summaries should be sent to the patient's GP within 48 hours).

YES NO

There is a stock of leaflets on common urgent and emergency eye conditions.

YES NO

Written information or an advice leaflet for the patient is provided for most attendances where relevant.

YES NO

Comments/reasons for non adherence:

***Question 2 notes.** Urgent care demand can include:

- Urgent and emergency advice and care for patients who have received care from the unit
- Patients who come to or contact the hospital or the eye unit with an urgent problem
- Urgent and emergency care of patients who are already in the hospital or unit for some other reason (e.g. an in-patient in a medical ward) who then develop an eye problem
- Acutely unwell patients in eye settings

****Question 5 notes.** Other equipment and investigations to be available:

- Equipment for obtaining microbiology and virology specimens including culture plates and glass slides for corneal scrapes and equipment for AC and vitreous taps
- Equipment and medications for intravitreal injections for endophthalmitis
- Instruments plus suture material to deal with injuries to the globe and periocular tissues where immediate repair is appropriate
- Equipment necessary for removal of foreign material from the ocular surface and the necessary facilities to perform irrigation of the ocular surface in the case of chemical injury
- Facilities to obtain urgent blood tests such as erythrocyte sedimentation rate or plasma viscosity (CVP)



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- Microbiology service to receive and process specimens for culture and provide immediate interpretation of gram stains obtained in infective conditions
- Ophthalmic ultrasound B scan and ideally an OCT
- Ideally access to formal visual field tests e.g. Goldmann or automated perimetry
- The appropriate topical medications to perform ophthalmic examination, including: Minims of topical anaesthetic, mydriatics, and fluorescein dye
- Access to X-ray and neuro-imaging facilities
- Access to Argon and YAG lasers and/or cryotherapy so that emergency cases such as retinal tears and acute angle closure glaucoma can be treated without delay

Medications to be available for emergency conditions where there is no pharmacy service immediately available:

- Topical steroids, topical antibiotics (ointment and drops), mydriatics, topical anti-hypertensives (beta-blocker, apraclonidine, pilocarpine), aciclovir ointment, aciclovir tablets, non-steroidal anti-inflammatory tablets, prednisolone tablets, intravenous steroids (methylprednisolone and hydrocortisone), intravenous acetazolamide, acetazolamide tablets, anti-histamine tablets, oral and intravenous antibiotics (including alternatives to penicillin), amikacin vancomycin and moxifloxacin, systemic intraocular pressure lowering agents, mannitol and glycerol.