Quality Standard Self-Assessment Tool

The ROYAL COLLEGE of OPHTHALMOLOGISTS

Medical Retina Disease 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 answer 'Yes' to all of the question, and the results should be used in conjunction with other methods of quality assessment to support learning and improvement.

Please send feedback on the form and how you have used it to assess and change your services to Beth Barnes, Head of Professional Support beth.barnes@rcophth.ac.uk.

Disorders of the retina which are treated non-surgically are very common (age related macular degeneration, diabetic retinopathy, retinal vascular occlusions etc.) and, if mild or long standing, may be dealt with in primary care, primary care ophthalmology, screening services and general ophthalmic services.

Medical retina (MR) disease standards in this document apply to care of the common conditions at the severe or acute end of the spectrum, those requiring invasive procedures and more serious or unusual conditions such as posterior uveitis or unusual retinal vasculopathies, which are more appropriately managed in a dedicated MR service.

1. Consultant leadership.
   There is at least one consultant with subspecialist MR training delivering MR care:

   YES ☐ NO ☐

   There is a nominated lead for MR disease, or for AMD and for diabetic/vascular retinopathy, with this role specified in their job plan / job description:

   YES ☐ NO ☐

   Evidence / comments:

2. There is a MR/AMD/diabetic retinopathy clinic coordinator or failsafe officer to ensure high risk patients are seen and managed on time:

   YES ☐ NO ☐

   Evidence / comments:

3. Patients affected by significant or serious MR disorders are seen within a dedicated MR service:

   YES ☐ NO ☐

   Evidence / comments:

4. Patients with MR disease are routinely supplied with information in an accessible format on their diagnosis, treatment and medication:

   YES ☐ NO ☐

   List available MR disease leaflets:

   Evidence / comments:

5. LogMar visual acuity testing is in routine use (defined as over 75% of the time) for patients**:**

   YES ☐ NO ☐

   Evidence / comments:

6. Specialist investigations are available:
   - Retinal photography YES ☐ NO ☐
   - Retinal OCT YES ☐ NO ☐
   - Fundus fluorescein angiography YES ☐ NO ☐
   - Indocyanine green angiography YES ☐ NO ☐
   - Autofluorescence YES ☐ NO ☐
   - Wide-field imaging / angiography YES ☐ NO ☐
   - Electrodiagnostics (in most units via referral) YES ☐ NO ☐

   Evidence / comments:

   Imaging, particularly fluorescein angiography, is available:
   - Usually without another attendance required (same day) YES ☐ NO ☐
   - Frequently enough that treatment is not delayed YES ☐ NO ☐

7. A local rapid referral proforma and pathway for suspected wet AMD for optometrists and general practitioners is available:

   YES ☐ NO ☐

   Evidence / comments:

8. The Information Technology infrastructure allows networked viewing of all relevant ophthalmic clinical images on workstations in all relevant ophthalmic clinical areas providing the AMD and vascular retinopathy services:

   YES ☐ NO ☐

   Evidence / comments:

9. Medical retina conditions are managed by appropriately trained clinical staff, or trainees under the supervision of fully trained staff, and appropriate protocols are adhered to:

   YES ☐ NO ☐

   Where nonmedical staff see MR patients appropriate governance arrangements should be in place including regular in-house training, extended role protocols and recorded competency standards:

   YES ☐ NO ☐

Intravitreal injections are undertaken by fully trained clinical staff, or trainees under the supervision of fully trained staff, and appropriate guidelines are adhered to:

YES ☐ NO ☐

Where nonmedical staff undertake intravitreal injections, appropriate governance arrangements should be in place including regular in-house training, extended role protocols and recorded competency standards:

YES ☐ NO ☐

Evidence / comments:

10. Follow up.
    The service consistently reviews patients regularly in line with College and NICE Guidelines on AMD and vascular retinopathies and adheres to clinician requested timing of appointments:

YES ☐ NO ☐

The service regularly monitors adherence to clinician requested timing and has no significant "follow up backlog" or delay:

YES ☐ NO ☐

There are no serious incidents of visual harm due to delayed follow up reported in the last 6 months:

YES ☐ NO ☐

Evidence / comments:

11. There is an agreed policy covering do not attend (DNA) patients, cancellations and rescheduling that takes into account visual disability, the needs of vulnerable adults, communication with patients and primary care physicians and also ensures clinician input into decisions on timing of rebooking or discharge:

YES ☐ NO ☐

Evidence / comments:

12. There is easy access to an Eye Clinic Liaison Officer or patient support officer who has close links to social services and relevant third sector organisations (e.g. Macular Society, RNIB) and has received training in psychological/mental health implications, including the Charles Bonnet syndrome, and social aspects of loss of vision in the elderly?

YES ☐ NO ☐

Evidence / comments:

13. There is access to low vision aid (LVA) services within the 18 weeks referral to treatment time:

YES ☐ NO ☐

Evidence / comments:

14. The service has a policy/strategy for providing smoking cessation advice and or signposting to such cessation services relevant patients:

YES ☐ NO ☐

The service has a policy/strategy for providing information or advice on diet and or micronutrient supplementation to relevant AMD patients:

YES ☐ NO ☐

Evidence / comments:

15. Audit. Care and outcomes are audited, using recognised standards, and used for quality assurance and to improve services.

- Adherence to protocols and guidelines including NICE guidelines YES ☐ NO ☐
- Visual acuity loss after intravitreal injections YES ☐ NO ☐
- Visual acuity gain after intravitreal injections YES ☐ NO ☐
- Endophthalmitis rates and other complications of intravitreal injections YES ☐ NO ☐
- Audit data is used for appraisal / performance management of ophthalmologists YES ☐ NO ☐

Evidence / comments:

Action Plan

Issue identified	Action to be taken	Who will lead action	Date for completion