Postgraduate Handbook Ophthalmology

East Surrey Hospital

August 2017
Health Education Kent Surrey and Sussex

OPHTHALMOLOGY FACULTY HANDBOOK: A GUIDE FOR POSTGRADUATE DOCTORS AND STAFF AT SURREY AND SUSSEX NHS TRUST

This handbook is mapped to HEKSS’s Graduate Education and Assessment Regulations (GEAR).

Introduction

Welcome to the Eye Department at East Surrey Hospital.

This booklet is for your information about how your programme works, who the key people are who will be working with you and to help you to settle in and to explain how the Department works.

For ST trainees this document should be read in conjunction with your curriculum, which can be found at http://curriculum.rcophth.ac.uk/.

We hope you find it useful and that you enjoy and profit from your time with us.

This handbook is updated annually based on feedback to the Faculty Group from you as a Postgraduate Doctor and from your Supervisors.

Brief Profile

Ophthalmology Outpatient Clinic (ground floor, West Wing) includes:
- Fields
- Orthoptics
- Minor operations
- Lasers
- OCT scanning

Some textbooks are kept in the clinic for reference only.

Limpsfield Ward (first floor, West Wing) includes:
- Ophthalmic Day Surgery Unit
- Clean room for intravitreal injections
- Slit lamp examination room
- Fluorescein angiography and fundus photography
- Biometry and pre-assessment
- Microsurgical skills facility with microscope, microinstruments and suturing material

Theatre 5 in the main theatre complex is located further down the main corridor on the first floor and is used for GA lists for most consultants.

Some Ophthalmic operating lists and clinics are performed at Crawley Hospital, West Green Drive, Crawley RH11 7DH. Tel 01293 600300.
Clinics are held at Horsham Hospital, Hurst Road, Horsham Rh12 2DR tel 01403 227000
Post Graduate Education Centre (ground floor, Trust Headquarters):
- Seminar rooms for teaching
- The library is located adjacent to the PGEC

Key People

There are several key people who will support you during your time with us:

Director of Medical Education
Medical Education Manager
Medical Resourcing Manager
LFG Administrator

Dr Sarah Rafferty
Tina Suttle-Smith
Louise Wilson
Claire Parsonage

Consultants

Mr Roger Wilson (Clinical Supervisor)
Ms Fiona O’Sullivan (Educational Supervisor)
Acting College Tutor

Mr Luke Herbert (Educational Supervisor)
Mr Ijaz Sheikh (Educational Supervisor)

Miss Lucia Pelosini (Clinical Lead)
Miss Sengal Nadarajah (Clinical Supervisor)
Miss Kapka Nenova (Clinical Supervisor)

Associate Specialists

Miss Kamona Nkanza (Clinical Supervisor)

Staff Grade

Mr D Boghani (Clinical Supervisor)

Nursing Staff (Ward & Clinic)

Theatre Sister Caroline Conlon
Theatre Sister Caroline Davies
Clinic Sister Annah Muringani

Sn Bahar Rahimi
Sn Louella Burgess
RN Shimray Melita
RN Mary Simpson
RN Sumauang Susan
Sn Gugulethu Maposa (mat leave)
NA Jackie Wateridge
NA N Chinyerere
NA J Brun
RN Sharon Bethell

NA Manfred Mayo
NA Rochelle Laikhram
NA Maningo-Holloway Rebecca
RN Concepcion(Connie) Sousa
RN Kunjumol Roy
RN Lola Esho
RN Donnalene Cumabatch
Rn N Hashmi
RN RN Verity Nicholas

Departmental Manager

Malgorzata Higley (x 2150)

Ward Clerks
Carol Hanlan

Admissions Clerks
Jane Willis

ESH Trainees’ Guide
25/07/2016


**Secretaries**

Fiona Herson (Mr Wilson)
Sharon Given (Mr Herbert)
Julie Roberts (Miss O’ Sullivan)
Catherine Kosta (Mr Sheikh)
Karen Pearce (Miss Pelosi)
Alex Fidalgo

**Patient Tracker Manager**

Jane Osman

**Orthoptists**

Caroline Stamp (Head Orthoptist)
Lydia Mathews (mat leave)
Kathy Parker
Mun-Wei Kan

Claire Howard
Sabrina Kathapermall
Katie Warner

**Medical Photographer**

Max Brown

**Technicians**

Monika Papp
Kitti Kamsaladeevi
Leo Rolim
Outpatient Clinics

1. Timings:
   a. Morning clinics start at 9:00am.
   b. Monday, Tuesday and Thursday afternoon clinics start at 1:30pm
      Wednesday afternoon clinics start at 2:00pm

2. You will have your own list of patients to see (except in Mr Herbert’s clinics). Try to
   see them at the time of the appointment or as soon after as possible. If your list is short
   and another doctor in the clinic is under pressure please help with seeing their patients.
   In Mr Wilson’s clinic the post-op follow-up patients are shared out to all doctors unless
   specified.

3. Each patient should have accurate visual acuities checked at each visit. The nurses in
   the clinic do many of the VA checks but if not please always check it yourself. If there has
   been a significant change in VA since the last visit, recheck it yourself.

4. Please write down what the problem is with the patient. If there are multiple eye
   problems, attempt to make a clear list of them. At the end of your clinic entry
   please attempt a diagnosis and/or plan of action to show what your thoughts are.

5. Write down clearly the medication you have prescribed or the operation you have
   listed the patient for (See Appendix 4 for instructions on listing patients). State when
   the next appointment is planned or if the patient has been discharged.

6. Always check that the date and consultant name are accurate and sign your own
   entry legibly.
Important clinical points

1. **Always ask for help if you are out of your depth clinically or if the patient is unhappy.**

2. Do not use Chloramphenicol drops with other antibiotics.

3. Do not start or stop steroid drops in a patient with herpes zoster ophthalmicus or herpes simplex eye disease without checking with the consultant.

4. When listing a patient for cataract surgery, please check that a current refraction is recorded in the notes. Fill in the first page of the cataract pre-assessment forms. Please see Appendix 2 regarding listing patients for surgery.

5. When listing patients for surgery, ensure you have discussed with the relevant consultant any cases which are deemed "Consultant/Senior to do", particularly complex cataracts and any subspecialty procedures. Do not list any difficult cases without prior discussion with the Consultant in charge. See appendix 3 for further details on this subject.

6. When seeing patients for a check 2 weeks after cataract surgery, record the refraction in the operated eye. For routine phaco cataract cases, taper the Maxitrol drops over 2-4 weeks. Please list for the second eye at this visit if clinically appropriate, if CCG criteria are met. If both cataracts have been successfully removed and there is no other ocular pathology, discharge the patient to their GP and optician’s care.

7. **Warfarin:**

   a. For patients undergoing cataract surgery, they should not stop their warfarin but should have their INR checked 24 hours before surgery and should bring their warfarin book with them on the day of surgery. For sub-Tenon’s anaesthesia, INR should be ≤ 3.

   b. For glaucoma surgery, REMEMBER TO ASK IF THE PATIENT IS ON BLOOD THINNERS. Please discuss with the consultant. In general, INR should be ≤ 2. Aspirin and clopidogrel should be stopped 2 weeks pre-operatively if medically safe to do so.

8. If a patient presents with visual loss which you judge will affect their ability to work or to drive please seek confirmation of this from the Consultant before saying anything to the patient. These situations have serious implications for patients and it is important that the information given to them is absolutely accurate.
Letters

A letter has to be sent for each visit of every patient. Ensure that your letters are completed BEFORE leaving the clinic or casualty.

All letters are dictated using the hospital’s Dictate IT system. Every dictation must start with the patient’s medical record number and DOB (name not necessary) otherwise the letter will be returned to your electronically for verification. All letters require e-approval before they are sent out to the patients/GPs. Please ensure you regularly e-approve all letters using the online system, to ensure letters are promptly sent out.

The minimum information in your letters should include the following items:

Dear Dr X:
Re: Mrs Y..Z,
date of birth,
MRN

Diagnoses
1. Bilateral chronic open angle glaucoma
2. Left cataract

Current treatment
1. G. Latanoprost ON to both eyes

Vision
Right 6/9 Left 6/60

Comments
*Brief summary of additional important information and plan including any follow-up. DO NOT REPEAT ANYTHING ALREADY STATED ABOVE.*

Yours sincerely

For Letters on patients with Medical Retinal Conditions

*Minimum Information must include:*

- Diagnosis
- Number of injections (if patient is on treatment)
- VA, IOP (once every 6/12)
- Fundus examination findings
- OCT findings
- Management plan
Diabetic Patient Letters
– coding.

The following is tedious, but if you don’t do it you will find lots of notes in your in-tray asking for you to fill in forms.

Please ensure you include in dictation the DRSS coding e.g. R0, M0. Ask the secretary to copy the letter to the relevant Screening Service depending on the GP location. If you do not carry out slit lamp biomicroscopy on a patient with diabetes please dictate “not screened” and copy letter to DRSS. Please tick the “DR” box on the outcome form.

Glaucoma Clinic Letters
When dictating letters on glaucoma patients, please ensure the following minimum information is included

1 Diagnosis.
2 Intra-ocular pressure at that visit.
3 Drop treatment or other treatment prescribed for glaucoma.
4 The interval to the next appointment.

Coding of Glaucoma and Ocular hypertensive patients at the end of every consultation:

All glaucoma patients must be coded either GL1 if condition is stable or GL2 if the condition is deemed not controlled. Similarly patients with Ocular Hyper-tension are coded OH1 if deemed stable whether on treatment or not and OH2 if deemed uncontrolled. Please mark the code on the clinic outcome form.
1. Diagnosis.
2. Intra-ocular pressure at that visit.
3. Drop treatment or other treatment prescribed for glaucoma.
4. The interval to the next appointment.
5. **All glaucoma patients must be coded either GL1 if condition is stable or GL2 if the condition is deemed not controlled. Similarly patients with Ocular Hyper-tension are coded OH1 if deemed stable whether on treatment or not and OH2 if deemed uncontrolled. Please mark the code on the clinic outcome form.**

**For Letters on patients with Medical Retinal Conditions**

*Minimum Information must include :*

- Diagnosis
- Number of injections (if patient is on treatment)
- VA, IOP (once every 6/12)
- Fundus examination findings
- OCT findings
- Management plan

**Communicating With Patients**

- Always introduce yourself at the beginning of each consultation.
- Try to give ALL your attention where possible to the patient.
- Be polite even when under pressure; courtesy helps with aggressive patients.
- Explain to the patient in simple terms what can be done next.
- Ask for help from your Clinical Supervisor or other doctor in clinic if you are unable to diagnose or formulate a plan of management.
Pre-assessment, Operating Lists and Ward Work

Nurses do most of the cataract pre-assessment on the Day Care Unit. You are responsible for checking that consents are signed and that the patient understands the risks and benefits of the proposed intervention. You must check the biometry measurements and arrange a repeat measurement if they are inaccurate; also ensure there is a recent refraction for both eyes written in the pre-assessment form. You should also ensure that the patient is suitable for the chosen anaesthetic.

PLEASE SEE Appendix 1 REGARDING PRE-OPERATIVE INVESTIGATIONS FOR EYE CASES FOR GENERAL ANAESTHETICS.

Theatre Lists

Check with the consultant in charge regarding the order of theatre lists.

General principles for the running order of theatre lists:

1. Day cases before inpatients (where applicable)
2. Put intra-ocular cases before extra-ocular cases.
3. Always put an infected case at the end of the list.
4. Patients with latex allergy should be scheduled first on the list if possible.

For Miss O’Sullivan’s trabeculectomies, always check if they are to have peroperative 5-FU or Mitomycin and state this clearly. Also write up the 5-FU or Mitomycin prescription on Mondays and submit to Pharmacy that day to ensure the drug is available in good time for the list on Friday morning.

If any changes are made to the list, make sure the following people are informed: (a) the surgeon, (b) the anaesthetist, (c) the theatre staff and (d) the relevant ward staff.

Ensure patients are consented, marked and the paperwork is completed in time for the patient to be ready for the theatre start time (8:30am / 1:30pm). Please ensure the WHO safety checklist for cataract surgery is followed precisely (see Appendix 10).

The IOL chosen for the patient must be written on the consent form. Be sure the correct lens has been selected and is in the operating theatre before scrubbing. Implanting the wrong lens is a Never Event.

Observe carefully and record fully what is done during each operation.

From 2017, Medilight will be used to record the surgical notes, discharge information and letter to GP.

Prescribe post-op drops and analgesia. G Maxitrol QDS 2/52, BD 2/52 is used for all routine cataract cases. Some surgeons prescribe post-operative Acetazolamide 250mg.

Speak carefully especially if the case is done under local anaesthetic.

After the list check that all instructions are clear to the ward staff and go to Outwood Ward to discharge any paediatric day cases.
Please do not fill out discharge summaries or operation notes in advance. Complete them after the procedure. It is embarrassing if a letter is sent in error when the patient has not had the operation!

Casualty Clinic

MONDAY- FRIDAY 9:00AM – 5:00PM

There is a Casualty Clinic each weekday morning. All new referrals from that day as well as casualty follow-ups will be seen by the team assigned to Casualty that day.

If a GP asks you to see a patient never refuse. Arrange to see the patient promptly.

- Let the nursing staff know the name of the patient and the expected arrival time.
- See the patient yourself if at all possible.
- For a chronic problem, bring the patient back to that Consultant’s clinic. Arrange follow-up by passing the Eye Casualty notes to the relevant consultant so they can grade the urgency of appointment.
  - Mr Herbert is happy to accept direct referrals of patients with vitreoretinal problems, make a request for clinic on the notes and pass to Mr Herbert’s secretary. Explain to the patient that Mr Herbert will check the notes and arrange an appropriate review. Do not tell them they will be seen in x, y or z days as this leads to conflict between your assessment of urgency and that of the Consultant.

Casualty Follow Ups

- We do not encourage multiple reviews in Casualty:
  - Suitable cases for Casualty follow-up should be those requiring review within 2 weeks (e.g. trauma, corneal ulcers and severe iritis).
  - Patients who need more than two reviews or review in > 2 weeks’ time must be booked into and seen in a Consultant clinic. See Appendix 4 on how to refer a Casualty Follow up patient to a consultant clinic.
- If you cannot see the patient yourself, it is courteous to inform your fellow trainee who will be seeing the casualty of the patient and their problem.

Out of Hours (On Calls)

After 5:00pm all casualties will be accepted and seen initially by the doctor on call. The location for seeing out-of-hours patients is a dedicated Emergency Eye Room in the Emergency Department on the ground floor. Clinical notes and discharge summaries should be recorded electronically on Cerner for every out-of-hours patient seen.

Please see the Patient Flow Pathway and Powerchart Guide for Out of Hours Ophthalmology under appendix 2. This will be explained in more detail during induction.

Swipe access is needed to enter the ED Department. Please therefore contact Jackie Sandford in the Estates Department ASAP after induction to arrange this.
Ophthalmic medications are kept in a drug cupboard within the ED Eye Room; the keys for this are kept in ED Minors in a locked cupboard which you will be shown (code C1966).

It has come to the Consultants’ attention that some patients who have presented as casualties to the Eye Department after 5:00pm have been told that they will not be seen by the ophthalmology doctor on call on that evening. They have been asked to return to the Eye Department the following day to be seen as a casualty. This is not appropriate. When you are on call you are contracted to see patients who present with eye problems. These patients may come from a variety of sources such as direct referrals from a GP, optometrist, the ED Department or Minor Injuries Units in the hospital but also these patients may present as a walk-in with an acute eye problem.

If it is necessary to admit a patient, inform the on-call Consultant. If admitting a patient after midnight who does not need advice or immediate surgery you may inform the Consultant first thing next morning. However, if you need advice do not hesitate to ask for it. Please inform the trainee for that firm first thing next morning of any patients you have admitted during your period on call.

If you bring back casualty patients for review after a weekend on call, either see them yourself, or add their names to the casualty appointments book (which is kept in the eye clinic by the nursing station) either on the weekend in advance or on the Monday morning. As a courtesy please inform the trainee who will be in casualty clinic and make arrangements for the relevant Casualty notes to be available to them.

At weekends it is essential that every inpatient is seen each day by the on call trainee. Check with your colleagues on Friday afternoon so that you know how many patients are staying in. Check with Limpshire nursing staff who will tell you where the patients are being transferred to. If the plan of management for the weekend is unclear, please ask.

Please note the following points:

Duty and Work Hours

The normal working day is from 8:30am to 5:30pm for all junior staff. The on-call rota is managed by Dr Sundas Maqsood for the year Aug 17- Aug 18. It is accessible online as a Google calendar.

The doctor who is on call for a week day should remain in the hospital from 5:00pm until 8:00pm and arrange to see all casualties referred to them well before 8:00pm. It is also important that any inpatients on the ward are sorted out prior to your leaving the hospital at 8:00pm. In particular, requirements for IV antibiotics, intra-ocular pressure
lowering treatment after surgery, pain relief and any other medications must be written up and confirmed with the nursing staff prior to you leaving the hospital at 8:00pm. After 8:00pm you may go home but must be available for telephone advice.

The weekend arrangements are that the doctor on call for Saturday and Sunday must be available for telephone advice from 9:00am and hand over between the doctor on call on Friday and Saturday must occur. At the moment the hours you are scheduled to work in the hospital on Saturday are from 11:00am to 5:00pm but depending on demand from our local referrals it may be necessary to move these hours slightly. On Sunday the hours are from 12:00pm to 4:00pm and again after these hours you may be at home but available to give telephone advice. Please note also that these total hours are well below the normal 48 hour working week and if there is an urgent case outside of the schedule hours which does need to be reviewed by an ophthalmologist and cannot wait until the following morning there are sufficient hours in your timetable to allow you to return to the hospital and see such an acute patient. These situations would include acute angle closure glaucoma, penetrating eye injuries, serious complications following ophthalmic surgery such as endophthalmitis or severe bleeding, severe alkali burns compromising vision or a patient with multiple injuries who needs an urgent eye assessment, or any other potentially sight-threatening situation. Please discuss these cases with the on-call Consultant.

Retinal Detachments, Urgent Ultrasound
Please contact Mr Herbert 07956 226276 before referring these out of the hospital. If he is not available discuss with the on-call Consultant.

Complex Lid or Orbital Trauma
Please inform the oncall consultant and then discuss with the Oculoplastics Fellow at Queen Victoria Hospital, East Grinstead.

Corneal Scrapes, Intravitreal/AC Taps
These must be sent to the Microbiology on-call technician based at Crawley. Phone them in advance via Switchboard to arrange safe receipt and processing.

Contact Numbers:
Please note that it is the junior doctors’ responsibility to have a working phone on their person at all times during the day time working hours, and also during the time when you are scheduled to be on call. When you are on call at 5:00pm it is your responsibility to let the switchboard know the mobile phone number you are available on whilst you are in the hospital. Some trainees find it is useful to have two mobiles on them whilst on call, in case one runs out of battery or has no signal – switchboard should be informed of both numbers. Similar arrangements apply to weekends.

On call swaps need to be notified to the trainee who is on-call rota co-ordinator. The rota will be updated accordingly and switchboard will be emailed with the new details of who is on call. Please note, a minimum of 48 hours' notice is required for this. If the rota coordinator is on leave and you swap on call duties with another colleague, it is your responsibility to ensure that switchboard, nursing staff on the ward and casualty know about the swap. Please also email the rota co-ordinator so a record can be kept. It is also your responsibility to hand over to your colleague when you finish an on call period of duty and it remains your responsibility to see inpatients and write up their notes on each of your on call days, if there are any Ophthalmology inpatients.
**Incident Reporting and Clinical Governance**

Any critical incidents are reported using the online DATIX System. This will be described during the trust induction. The website can be accessed through the Favourites on the trust intranet. The link address is http://datx1/datix/live/index.php

Half day Clinical Governance sessions are held 10 times in the year. All Clinical activity is cancelled and attendance is mandatory for all doctors. Doctors are required to participate in audit in the Department; the topics for audit are agreed with doctors at the September meeting or at other times if needed. The dates for monthly governance meetings up to March 18 are in the appendices at the end of this document.

**Teaching Programme**

**Regional Teaching**
Each week there is a Regional Teaching half day on Friday afternoons at the Sussex Eye Hospital, Brighton, all clinical commitments for trainees are cancelled. Attendance is compulsory and trainees should be released from their morning clinical activity by 12:30pm.

**Local Teaching**
Monday AMs (8:30am) Glaucoma Teaching/Case Presentation
Fiona O’Sullivan

Tuesday AMs (8:30am) weekly sessions
Ijaz Sheikh

Thursday PMs (after clinic) Paediatric teaching
Roger Wilson

**Skills Training**

We provide ST1 trainees with ½ day training opportunities each week to improve practical skills, including biometries, orthoptics, refraction, OCT scanning, low vision clinics. You should perform at least 25 biometries yourself and understand the theory behind it and how different machines work.

If you are a Year 1 trainee you must attend at least one basic microsurgery skills course. These are run regularly by the Royal College of Ophthalmologists.

Mr Herbert does B scanning every Tuesday lunchtime in the Radiology department at ESH and all trainees are welcome to attend these sessions.

**Clinical Leadership**

This is an important part of your training. A useful resource for on-line training and information is the e-LfH website, clicking on the Medical Leadership option. It is recommended that all trainees undertake equality and diversity training online. All trainees will be set individual targets in Clinical Leadership at appraisal meetings and it is important that at least 2 of your CbDs are focused on clinical leadership issues.
Leave

You are entitled to 27 days (ST1-2) or 32 days (ST3+) annual leave and 15 other days study leave per year. You should take the same number of leave days on each day of the week so that you are not repeatedly missing one particular clinical activity and therefore take in blocks of one-week. Exam leave is at the discretion of the department. When multiple exams are taken by one individual we may ask that some of this time is taken from your annual leave.

- You must give at least 7 weeks’ notice of any leave.
- Prior to arranging leave you must check your fellow trainees’ leave arrangements and ensure that you have arranged cover for all your on-call commitments. You must confirm this with the rota coordinator who will need to sign your leave form.
- If you share a clinic with another trainee, only one trainee may be away at a time unless in exceptional circumstances when you must check with the consultant in charge of the clinical activity.

All leave requests must be agreed with your Educational Supervisor and Malgorzata Higley, Departmental Manager.

Once agreed, you must send out a leave notification form and clinic cancellation form to all relevant parties. The list of email addresses and examples of the leave notification form and clinic cancellation forms will be emailed to you by the rota coordinator. The forms must include the exact clinic name and instructions as to whether they are to be cancelled, reduced or covered by a locum, the later applies specifically to eye casualty which cannot be cancelled.

- Do not assume your clinical activity has been cancelled once the leave form has been sent,

It is your responsibility to check that these clinic alterations have been enacted BEFORE you go on leave at least 10 days in advance. If your clinic has not been altered appropriately, you must notify Malgorzata Higley immediately and in her absence Miss Lucia Pelosi.

SICK LEAVE

If you are sick and unable to come to work you must report your absence on the first day of sick leave via the First Call system and update your sick leave notification and/or return to work as required. This system will be explained to you at Trust Induction.

If you are off work please also notify on the first day Miss Pelosi, clinical Lead, Malgorzata Higley Manager and Sundas Maqsood so that arrangements to cover your daytime and on calls can be arranged. Please keep them informed of when you will be returning to work.
Educational Supervision/ARCPs/E-Portfolio

Your Educational Supervisors are responsible for overseeing your training and ensuring that you make the necessary clinical and educational progress. You should arrange to meet your Educational Supervisor within two weeks of joining the Trust so that they can discuss your Personal Development Plan for the year with you. Please ensure that your last ARCP outcome form and your last ES report from your previous unit are available to your ES at Redhill IN ADVANCE of the first meeting. This may not be applicable to ST1 trainees starting on the programme. You should have regular feedback from your ES. If you have any concerns please do not hesitate to speak promptly to your ES or College Tutor so these can be addressed.

Clinical Supervisors are responsible for your day-to-day supervision in clinic or theatre.

You are required to complete your e-portfolio on a regular basis. All WBAEs for the year of training and supervisor reports must be uploaded onto your e-portfolio. Please follow the RCPOthphth instructions on this accurately – it is your responsibility to inform yourself of these requirements but Ms O’Sullivan is happy to give advice.

You also need to be available for your interim review and ARCP, which is usually an annual event. You must book leave for these dates by giving at least 7 weeks’ notice in writing. These days are not taken from your study leave or annual leave allowance and attendance is mandatory. Sometimes you will later be informed that you do not need to attend the ARCP in person and then you should cancel the leave booked and re-instate your clinical activity.

Local Faculty Groups

Local Faculty Groups (LFGs) hold a Quality Control remit within the system of educational governance operational in HEKSS.

The Ophthalmology LFG’s remit is threefold: to ensure that the local ophthalmology programme is fit for purpose and in line with the ophthalmology curriculum requirements, to quality control the local ophthalmology programme and to ensure that trainee progression is tracked, supported and audited. The Ophthalmology LFG meets three times a year, in March, June and November. The Local Faculty’s work is quality controlled by the HEKSS Standards for the Local Faculty GEAR.

With 4 trainees in the department, you are all invited to attend the LFG meetings and to provide feedback so you can bring to the attention of the LFG any issues arising during your training at ESH promptly.
Local Academic Board

There is a Local Academic Board (LAB) in each Trust, which has the responsibility to ensure that postgraduate medical trainees receive education and training that meets local, national and professional standards. The LAB undertakes the quality control of postgraduate medical training programmes. It receives Annual Audit and Review Reports from the LFGs.

What if you need help?

Most Postgraduate Centres operate an ‘Open Door’ approach and here you can find information about local Trust policies, e.g. Grievance, Bullying and Harassment and Equal Opportunities.

HEKSS also offer support for trainees in difficulty (TiD). Details of the HEKSS Trainees in Difficulty Guide can be found on their website: http://kss.hee.nhs.uk

If you have any problems at all, issues with stress, bullying or are unhappy to come to work please discuss with your Educational Supervisor or the College Tutor, or if you feel they are part of the problem contact the Director of Medical Education (Dr Sarah Rafferty) or the Medical Education Manager (Tina Suttle-Smith).
GUIDELINES FOR INVESTIGATIONS PRIOR TO ANAESTHESIA IN GENERAL
SURGERY, OPHTHALMOLOGY (not cataract surgery), ORTHOPAEDICS,
GYNAECOLOGY AND UROLOGY PATIENTS.

1 The general principle is to only carry out investigations which are clinically indicated
or when there is a reasonably high expectation of abnormality.

2 Do not repeat recent investigations if the results were normal and the clinical
situation has not changed in the last 6 months.

FBC – Age of 55 years or any patient who has:
Clinical anaemia, systemic disease, poor general condition, blood loss > 500 ml
anticipated, medication associated with blood loss or decreased red cell production
(cytotoxics, anti-epileptics or NSAIDS). Major surgery to provide baseline.
An Hb below 10 g/dl is generally considered undesirable for elective surgery. A cause
should be sought for anaemia if it is not obviously due to the presenting condition.

Urea & Electrolytes – Age over 55 years or any patient who has:
Intravenous fluid therapy, vomiting or diarrhoea, drug administration affecting
electrolytes (steroids, diuretics, lithium). Poor general condition, systemic disease –
especially diabetes, retinal or cardiac disease. Major surgery to provide baseline.

ECG – Age over 55 years or any patient who has:
Known cardiac disease suspected cardiac disease or high risk of cardiac disease, eg
hypertension, peripheral vascular disease, cerebrovascular disease, respiratory
disease, diabetes of longstanding, heavy smoker, poor general condition.
Do not repeat if normal within 3 months and condition stable. If performed a normal
ECG does not exclude heart disease, as many patients suffering from angina have a
normal ECG at rest. Patients at low risk of heart disease (ASA 1 or 2) do not require a
preoperative ECG.

Chest x-ray – any patient who has:
Cardiac or respiratory disease, chronic respiratory disease with no recent chest x-ray
(last 3 months), possible metastases, recent chest trauma, heavy smoker.
Routine pre-operative chest x-ray is not justified, there should always be a clinical
indication.

Clotting Screen – any patient who has:
Anticoagulant therapy, eg Warfarin (not peri-operative LMAH), bleeding or bruising
tendency, liver disease.
Routine clotting screen prior to surgery very rarely picks up abnormalities. Aspirin does
not affect the INR or PTT.

Blood Sugar – any patient who has:
Known or suspected diabetes, patient on steroids prior to vascular surgery.

Urinalysis – all patients: This investigation is mostly used to pick up unsuspected
diabetes and should be routine for all admissions.
APPENDIX 3
CRITERIA FOR JUNIOR DOCTORS LISTING PATIENTS FOR SURGERY

Listing criteria for cataract surgery

1. Meets the criteria set by local CCGs for surgery.- see next page.

2. The patient wants surgery after they have been given a realistic appraisal of how much difference it could make and the risks involved

3. They are using new glasses or have an optometrist’s letter showing the failure to improve with refraction to better than 6/12 in the last year

List directly:-

• Routine second eye surgery which meets the above criteria.

• Second eye surgery with vision and pathology equivalent to first eye, for example mild macular degeneration and no complex nature to the surgery

• First eye surgery with no additional pathology and vision of 6/12 or worse

Cases which must be discussed with a senior colleague:-

• Ophthalmic procedures where complexity suggests the operation should be carried out consultant or senior surgeon

• Surgery on patients with additional known pathology

• Vision better than 6/12

Cases which should not be listed at all but referred for a senior opinion for potential listing should include:-

• Only eye patients

• First eye patients with complex surgical issues

• Any patient for subspecialist procedure including squint, glaucoma, retinal, oculoplastic or corneal surgery

• Patients who cannot give informed consent e.g. adults with learning disability or significant memory loss

PLEASE BE AWARE OF EACH CONSULTANT’S ANAESTHETIC PREFERENCES.

ESH Trainees’ Guide
CATARACT SURGERY GUIDELINES IN WEST SUSSEX

Extract from the attached PDF
“Cataract threshold policy West Sussex CCG” July 2013
First Eye Surgery
Patients can only be referred where best corrected visual acuity as assessed by high-contrast testing (Snellen) as being:
Binocular visual acuity of 6/10 or worse for drivers, OR
Binocular visual acuity of 6/12 or worse for non-drivers, OR
Reduced to 6/18 or worse in one eye irrespective of the acuity of the other eye, OR
The patient wishes to/is required to drive and does not meet Driving and Licensing Authority (DVLA) eyesight requirements, OR
The cataract is preventing the management of other co-existing eye conditions, OR
The cataract is substantially affecting the patient’s ability to work (paid employment)

Second Eye Surgery
Patients can only be referred for second eye surgery when their visual acuity meets the above criteria, OR
Difference in visual acuity between 1st and 2nd eye is so significant that it is preventing driving

CATARACT SURGERY GUIDELINES IN SURREY

Extract from page 19 of the attached PDF

“Surrey thresholds of procedures, restrictions and policies” 2013
Any suspicion of cataracts in children should be referred urgently.
Adults with a visual acuity of 6/9 or better in either eye are considered a low priority for cataract surgery.
Referrals from community services should only be made after an assessment by an optometrist unless there are exceptional reasons why this is not possible. Optometrists should take into account the referral thresholds and the impact of the cataract(s) on the patient’s life.
Referral of patients to ophthalmologists should be based on the following indications:
1. Best corrected visual acuity must be worse than 6/9 (6/9.5 and worse) in the first affected eye OR the patient wishes to/is required to drive and does not meet the Driving & Licensing Authority (DVLA) eyesight requirements.
2. AND impairment of lifestyle such as; The patient is at significant risk of falls. Or the patient’s vision is substantially affecting their ability to work. Or the patient’s vision is substantially affecting their ability to undertake. leisure activities such as reading, recognising faces or watching television.
3. AND willingness to have cataract surgery; The referring optometrist or GP has discussed the risks and benefits and ensured the patient understands and is willing to undergo surgery prior to referral.
Patients should only undergo surgery of the second eye when that eye meets the thresholds of 6/18 or worse visual acuity.
Exceptions
Cataract surgery can continue to be performed for medical reasons such as glaucoma and diabetes and on patients with severe anisometropia who wear glasses. The clinical reason for the surgery should be clearly documented.
Appendix 4. Form for referring casualty patient to a consultant – please use if patient has chronic problem or has been seen in Casualty for two follow ups and needs further follow up.

Please Forward Patient Notes to:

☐ Mr Herbert
☐ Mr Sheikh
☐ Mr Wilson
☐ Miss O’Sullivan
☐ Miss Pelosini
☐ Miss Nadarajah
☐ Miss Nenova

For advice regarding follow-up in their clinic as appropriate

With Regards
Rolling Audit Half Days April 2017 to March 2018

No audit day in April

Tuesday 23rd May 2017

Thursday 22nd June 2017

Tuesday 18th July 2017

No audit day in August due to junior doctors’ change over

Wednesday 13th September 2017

Thursday 19th October 2017

Tuesday 14th November 2017

No audit day in December due to Christmas

Tuesday 16th January 2018

Wednesday 14th February 2018

Thursday 15th March 2018
Appendix 2

Out of Hours Ophthalmology – Powerchart system

In seeing a patient out of hours there are 5 administrative steps to complete.

1. Finding a patient on your Powerchart Out of Hours list.
2. Adding a new clinical note.
3. Adding a discharge letter (GP letter)
4. Printing your notes the discharge letter through power chart
5. Checking the patient out of powerchart.

Bare in mind the following points.

- In order to find any patient through Powerchart they must have an appointment that you can view through the scheduling facility (Ring 1, picture below).
- You will already have received a printed front sheet and stickers regarding any patient that has an appointment for your Out of Hours list from the ED minors reception.
- Upon accepting any extra patients, a new appointment must be made by ED minors reception.

Step 1 Finding a patient on your Powerchart Out of Hours List

a) Open Powerchart

As per the picture above

b) Click on the scheduling button (ring1).
As per the picture above
  a) A new panel will open. If this your first time, you will need to enter the words “RTP Out of Hours OPH” in the RESOURCE free text panel (ring 1).
  b) You will see all the patients booked in for the evening in time order. Patients that are in green have been checked in by the ED reception and are waiting for you in the ED waiting room (Ring 2).
  c) Select your first patient by double clicking their row. In our case, the test patient is “RTPESTMAP, MAP.” (Ring 2)
    • The next you time you wish to select the resource, you can use the RECENT dropdown menu as per below (Ring 3, picture below).
Step 2 Adding New Notes

As per the picture above
1. Select “Clinical Notes” (ring 1)
2. Then click “Add note” button (star 1)
   - Ring 2 will show all the notes and documents for this patient in a folder cascade.
   - Ring 3 will show the text of a selected document.

As per the picture above
3. A new window pops up.
4. In Ring 1, there are two options. Please select General clinical note and fill the subject as “OPH OOH” for the correct coding. (NB we will use the “ ED Depart Summary” selection for the next task – Discharge letter)
5. Write your notes (Ring 2)
6. Click “sign” (Ring 3)
As per the picture above
7. Another window pops up asking if you want to view the document, Click “No”.
8. Congratulations, you're done with your notes for now. Next step, the discharge letter

Step 3. Discharge letter

per the picture

As per the picture above
1. In the same manner, add a new note, but this time select “ED Depart Summary” (Ring 1). This will produce a pre-written template which you can fill.
2. You must fill the subject as “OPH OOH GP Letter” for easy coding (Ring 1).
3. Edit the letter as you see fit (Ring 2).
4. Click “Sign”
6. Another window pops up asking if you want to view the document, Click “No”.
7. Congratulations, you’re done with your discharge letter for now. Next move to printing your notes and discharge letter.

Step 4: Printing Notes and the Discharge Letter.

As per the picture above
1. As shown in ring 1, find and double-click on your completed note from the cascade folders.
2. Click the print button (ring 2).
3. Repeat the same process to find and print the discharge letter.
4. Print 3 copies of the discharge letter, 1 copy for the patient, 1 copy for the GP, 1 copy for the notes.
5. Gather together your printed notes and discharge letter intended for filing in the notes and place them in the filing cabinet drawer named “OPH OOH Notes”
Step 5. Checking the patient out of Powerchart

As per the picture above
1. Go back to clicking the scheduling button (ring 1)
2. Right click on your patient (ring 2) and select “check out” from the drop down list (ring 3)

As per the picture above
3. A new window pops up.
4. Always select the same options in each field in Ring 1.
5. Always leave the comments here blank (Ring 2)
6. Click ok (Ring 3)
7. The patient’s row will now be grey, signifying that they are checked out.
Patient Flow Pathway 9am-5pm Monday to Friday for Out of Hours Ophthalmology (OHO)

Key

Nurses and OPD2 reception duties

ED reception duties

On call Eye Doctor duties

Limpsfield ward clerk duties (Lena + Carol)

Patient accepted by OHO Doctor
- Details gathered by OPD nurses and registered by OPD Reception 2 and given a slot in OHO (Out of Hours Ophthalmology) Clinic list.
- Referral letters and transferred to locked cupboard in ED eye room, by OPD nursing staff.
- NB Accepted referral letters should be placed in the “Expected patients” slot in the filing cabinet or given to the oncall doctor.

Patient given seating in waiting area by ED reception

- Patient arrives at ED reception and
- states “I am here for the OHO EYE Dr.”
- Patient checks in at ED reception - encounter open

Dr examines, investigates (+/-ED staff help) and
- Manages patient in eye room and
- determines the following outcomes:

Discharge + SOS to eye clinic.

- Discharge letter + notes printed and kept together in OHO filing cabinet. 2 copies of the discharge letter both for patient and GP printed and handed to patient
- Dr checks patient out of Powerchart – encounter closed.

Follow up (F/U) in Eye Casualty

- Discharge letter + notes printed and kept together in OHO filing cabinet.
- Dr checks patient out of Powerchart – encounter closed.
- For next day F/U, leave notes in the “next day F/U” sleeve in the filing cabinet, ready for collection.
- Inform patient of the time to arrive. Be sure to write this in the notes plan as well.

F/U in Ophthalmology OPD - Consultant Vetting

- Discharge letter + notes printed and kept in OHO filing cabinet
- Consultant vetting covering letter for Consultant to be attached to notes.
- Dr checks patient out of Powerchart – encounter closed
- Notes to be sent for vetting to the appropriate

Notes collected by Lena + Carol the next available working day and filed back in main notes.

- Limpsfield ward clerks Carol or Lena action the F/U using the timescale from notes or discharge letter and book into eye Casualty as appropriate.
- Next day F/U in eye casualty will need to be checked in by ED reception or OPD 2 reception depending on the day of F/U

Ver YH Tham 30.6.15

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