

# **Handbook in Ophthalmology for New Registrars and Locum Doctors**

**East Surrey Hospital**

**MAY 2019**

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

## Introduction

Welcome to the Eye Department at East Surrey Hospital.

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

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

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:**

- Visual Fields
- Orthoptics
- Minor operations
- Lasers
- OCT
- Some textbooks are kept in the clinic - for reference only.

### **Limpsfield Ward (First floor, West Wing) includes:**

- Ophthalmic Day Surgery Unit, including cyclodiode laser.
- Clean room for intravitreal injections
- Slit lamp examination room
- Fluorescein angiography and fundus photography
- Biometry and pre-assessment
- Microsurgical skills facility with microscope, micro-instruments and suturing material

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 clinics are performed at:

### **Crawley Hospital**

West Green Drive, Crawley, RH11 7DH. Tel 01293 600300.

*Parking is difficult in Crawley hospital. There is some paid parking on the road outside the hospital which only accepts coins and also nearby Orchard street car park which can accept card payments.*

### **Horsham Hospital**

Hurst Road, Horsham, RH12 2DR. Tel 01403 227000.

*Parking remains issue at Horsham hospital, there is limited paid parking outside the hospital which only accepts coins.*

## Key People

There are 4 Deanery trainees, a Glaucoma Fellow and MR Fellow as well as Specialty doctors. All consultants are RCOphth approved clinical supervisors/portfolio assessors.

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

Director of Medical Education - Dr Sarah Rafferty  
Medical Education Manager - Tina Suttle-Smith  
Medical Resourcing Manager - Louise Wilson  
LFG Administrator - Claire Parsonage

### Consultants (Sub-specialty)

Miss Sengal Nadarajah (MR: diabetes)	<b>(Clinical Lead, Educational Supervisor)</b>
Mr Roger Wilson (Paeds, Glaucoma)	
Ms Fiona O’Sullivan (Glaucoma)	<i>(Educational Supervisor)</i>
Mr Luke Herbert (VR, MR)	<i>(Educational Supervisor)</i>
Mr Ijaz Sheikh (MR: AMD)	<i>(Educational Supervisor)</i>
Miss Kapka Nenova (MR: uveitis, RVO)	<b>(Eye Casualty Lead, Educational Supervisor)</b>
Miss Kelly Weston (Paeds, Strabismus)	<b>(College Tutor, Educational Supervisor)</b>
Mr Minas Georgopoulos (Glaucoma)	<b>(Clinical Audit Lead)</b>

### NB

Cornea and oculoplastics are covered by Queen Victoria Hospital.  
MR consultants will all see patients with acute MR problems

### Staff Grade

Mr D Boghani *(Clinical Supervisor)*  
Dr Shukri

### Locum Doctors

Dr Sleiman  
Dr Shala’ta

### Nursing Staff (Ward)

Theatre Sister Caroline Conlon  
Theatre Sister Caroline Davis  
Sister Louella Burgess

RN Donnalene Cumabatch  
RN Naheed Hashmi  
RN Shimray Melita  
RN Eleanonora Di Micilli  
RN Sumauang Susan  
SN Bahar Rahimi

NA Manfred Mayo  
NA Rochelle Laikhram  
NA Maningo-Holloway Rebecca  
NA Safnat Gill

### Nursing Staff (Clinic)

Clinic Sister Annah Muringani (x6658 or clinic x2540)

RN Concepcion(Connie) Sousa  
RN Kunjumol Roy  
SN Gugulethu Maposa  
SN Lola Esho  
SN Maria Pires  
SN Caroline Gill

NA Alina Tenhe  
NA Jackie Wateridge  
NA Claire Coppard

#### Management Team

Christopher Treloar  
Malgorzata Higley  
Catherine Thomas

Service Manager  
Service Delivery Coordinator (x 1242)  
Ophthalmology Team Leader (x 2150)

#### Ward Clerks

Carol Hanlan  
Lena McCarthy (x1672)

#### Admissions Clerks

Angelina Ross (x1731)  
Andrea Mason (x1832)  
Ed Mitchell (Injection W/L x1832)  
Preeta Varghese - W/L Team Leader (x6574)

#### Secretaries

Sharon Given (x1761)  
Julie Roberts (Horsham x7302)  
Karen Pearce (x1280)  
Rebecca Richmond (x1752)  
Mandy Lavery (x6926)  
TBA (x6760)

(Mr Herbert and Miss Nadarajah)  
Horsham Clinics and Dictate IT  
(Miss Weston and Mr Wilson)  
(Mr Boghani, Locums, PCC/eye cas admin)  
(Miss O' Sullivan and Mr Georgopoulos)  
(Mr Sheikh and Miss Nenova)

#### Patient Tracker Manager

Jane Osman

#### Retinal Coordinator

Albertino Dujardin

#### Orthoptists

Caroline Stamp (Head Orthoptist) (x6678)  
Lydia Mathews  
Sabrina Kathapermall (*RCOphth assessor*)  
Alia Harrison

Claire Howard (Horsham)  
Katie Warner (Horsham)  
Katy Parker (Crawley/Horsham)

#### Optometrists

Sarah Leppard (Paediatric refraction clinics, Crawley)  
Caroline O' Brien (Horsham)

#### Contact Lens Practitioner

Mary Golding

#### Medical Photographer

Max Brown

#### Technicians

Monika Papp  
Kitti Kamsaladeevi  
Leo Rolim  
Alison Pleschett

## Work Hours

The normal working day is from 8:00am to 5:00pm.

### Contact Numbers:

Please note it is the junior doctors' responsibility to have a working phone on their person at all times, during daytime working hours and when you are scheduled to be on call. It is your responsibility to let switchboard know the mobile phone number you are available on.

## Outpatient Clinics

ESH:

- Morning clinics start at 8:30am and afternoon clinics start at 1:30pm

Horsham and Crawley Hospitals:

- Morning clinics starts at 8.30am and afternoon clinics start at 2.00pm

You may have your own list or it will be a pooled clinic list. You will be supernumerary to begin with in the paediatric clinics. If your own 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.

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.

## Important clinical points

1. **Always ask for help if you are out of your depth clinically, or if the patient is unhappy.**
2. When listing a patient for cataract surgery, please check that a current refraction is recorded in the notes, taken from the opticians letter, focimetry or autorefraction. Fill in the first page of the cataract pre-assessment forms. **Please see Appendix 1: listing patients for surgery.**
3. When listing patients for cataract surgery, ensure you have discussed with the relevant consultant any cases which are deemed "Consultant to do", particularly complex cataracts and any 'cataract plus' subspecialty procedures. Do not list any difficult cases without prior discussion with the Consultant in charge. **See appendix 2 for further details on this subject.**
4. Do not list patients for subspecialty procedures without prior discussion with the consultant in charge of that patients care.
5. When seeing patients for post-operative check following cataract surgery, record the refraction in the operated eye (autorefraction). Please list for the second eye at this visit **if clinically appropriate** (see appendices 1 and 2). If both cataracts have been successfully removed and there is no other ocular pathology, discharge the patient to their GP and optician's care.
6. 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 information given to them is absolutely accurate.
7. If you order a CT/MRI or blood test please check the results yourself. If this is not possible ensure you hand over to a colleague to do so, and follow up at your earliest opportunity.

8. If you have any clinical queries please speak to consultant in charge first if available on that site, if not please call Mr Dipen Boghani via switch board for further advice.
9. Please sign your entry legibly

### Outcome Form and Coding at the end of every consultation (see Appendix 3)

All patients must have an outcome form completed at the end of each clinic visit, which must be given to the patient to take to the outpatient reception. Make it clear to the patient that this is essential in order for them to receive another appointment.

The purpose of the outcome form is:

1. To record any investigations and procedures performed during the appointment – please circle any on the form that apply.
2. To code the condition of glaucoma and retinal patients. All patients with glaucoma to be coded either GL1 if condition is stable or GL2 if the condition is deemed poorly controlled i.e. needs follow up within 3 months. Similarly, patients with OHT are coded OH1 if deemed stable (whether on treatment or not) and OH2 if not, and require earlier follow up. Please mark on the clinic outcome form.
3. You must mark on the outcome form when the patient is to attend next. Write:
  - a. the interval in weeks or months for the next follow up visit clearly in the relevant box at the bottom of the outcome form,
  - b. in which clinic (write the initials of the named consultant who's clinic they are to return to),
  - c. whether the patient can be seen by 'any' doctor or must see the 'consultant'.

### FFA

When requesting FFA/ICG's there are packs made up, consisting of three sections which must be completed:

1. The cover is an info sheet for the patient to take away with them, at the time of the request, for their info regarding the procedure.
2. The second is the drug release form which does require a signature from the requesting Consultant/ Doctor for the procedure to be carried out.
3. The third is the consent form.

We have had several instances where:-

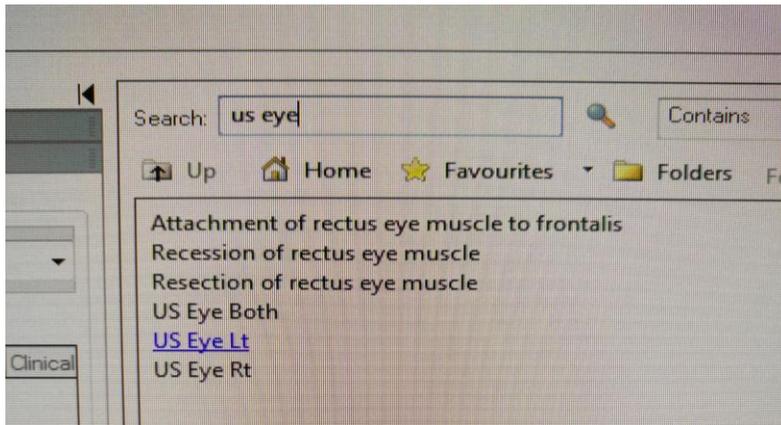
- patients have come to have the procedure unaware what they were there for, or
- the drug release form has not been signed, or
- consent form not signed

Having to ask someone else to sign a drug release form for a patient they have not seen is embarrassing and possibly compromises that person. It also slows the process down trying to find someone in a busy clinic to sign the form.

**Please do not request FFA or start a new patient on treatment if not discussed and authorised by a Consultant.**

## Ocular Ultrasound

The ultrasound is performed within the main radiology department by Mr Herbert. He has a weekly list on a Tuesday. These can be ordered through powerchart. Under radiology procedures search 'us eye'. If you require a more urgent ultrasound at any other time please discuss with Mr Herbert. You are not able to access the ultrasound scanner out of hours unless you have had training by the radiology department and signed off for its use. If you feel an urgent ultrasound is necessary it is better to discuss with Mr Herbert, making the appropriate VR referral, the next working day.



## 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 the plan for their management is.
- Ask for help from your Clinical Supervisor or other senior colleague in clinic if you are having any difficulty with a diagnosis or management plan.

## Letters

A letter has to be sent for each visit, for every patient. Ensure that all your letters are dictated 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 you 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:

Date of birth AND MRN

State letter recipient (GP/patient) and if there is anyone else it should be copied to. NB all paediatric patient letters are copied to the parents automatically.

The dictation should then follow the format below:

### 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

### [Letters on Medical Retina patients](#)

#### **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

Miss Nenova asks that for AMD patients to please fill in the outcome form and the listing form **as shown in Appendix 4.**

### [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 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 (Please use generic names of all drops)
4. The interval to the next appointment.

## Pre-assessment, Operating Lists

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 particularly an autorefractometer if the patient is attending for second eye surgery. You should also ensure that the patient is suitable for the chosen anaesthetic.

**PLEASE SEE APPENDIX 5: 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 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 a week before the date of surgery and submit to Pharmacy that day to ensure the drug is available in good time for the list.

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.

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.

Medisight should be used to record the surgical notes and produce a discharge summary.

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, or nevenac/acular for diabetic patients.

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

After the list check that all instructions are clear to the ward staff.

**Please do not finalise discharge summaries or complete 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 (see Eye Casualty Rules, appendix 6)

MONDAY- FRIDAY 9:00AM – 5:00PM

There is a Casualty Clinic each weekday morning and afternoon. The morning clinic is staffed by two doctors and the afternoon by one senior doctor. The Friday afternoon clinic is run by the doctor on call that day. All new referrals from that day are graded by the casualty team assigned to Casualty that day. The on-call doctor will attend at 5pm to take over from the afternoon casualty doctor if there are any patients remaining to be seen.

Morning Huddle – this happens at the beginning of the morning eye casualty session to ascertain who is on call, how many available appointments there are for that day, and establishes who are the doctors in casualty are and who will be holding the bleep and grading the referrals (see appendix 7).

There are Eye Casualty Guidelines to help you with the treatment and management of conditions frequently seen in Eye casualty. You will be sent an e-copy and there is a copy for you to access in the eye casualty for your reference.

GP referrals:

- If a GP asks you to see a patient **please do not refuse, unless suitable telephone advice can be given and the GP is happy with this.**
- All GP referrals should be made via email on [eye.clinic@nhs.net](mailto:eye.clinic@nhs.net). This email is regularly checked throughout the day and we contact the patient directly with their appointment. GPs receive an automated response so that they know the referral has been received. There is a referral letter template which GPs should use (see appendix 8).
- To make same day referrals, or if there is a patient that a GP simply needs to discuss, to obtain advice, they are advised to bleep 296 between 9a.m.-5p.m. or switchboard will direct to the mobile of the Doctor on call after 5p.m. If the registrar on call accepts the patient to be seen that day, GPs must be advised that they still need to email the referral to the email address above in order for the patient to be booked and registered. The GP must state on the referral who they discussed the patient with and that they accepted the same day referral, so please give them your name as the accepting doctor.
- For patients referred with an ongoing problem for which they are already under our care, bring the patient back to that Consultant's clinic, unless there is a new, acute issue. Pass the referral and patient notes to the relevant consultant with a covering form attached (see Appendix 9) so they can grade the urgency of appointment.

## Casualty Follow Ups

We do not encourage multiple reviews in Casualty:

- **Suitable cases for Casualty follow-up should ONLY be those requiring review within 1-2 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 a Consultant clinic. Arrange follow-up by passing the Eye Casualty notes to the relevant sub-specialty consultant with the covering form attached (Appendix 9) so they can grade the appointment appropriately. **Do not give an outcome form to the patient to book a clinic appointment.**
- Any patient that is not appropriate for a sub-specialty clinic should be followed up in a general clinic. In this case, notes should be directed to whichever Consultant is on call that day, to grade accordingly. **Do not give an outcome form to the patient to book a clinic appointment.**
- **Do not give patients a follow up time frame.** Please advise patients that this will be decided by the Consultant grading the referral. This avoids conflict between your assessment of urgency and that of the Consultant.

## Paediatric patients

Paediatric patients should not be followed up in eye casualty. Any paediatric patients that require review, or who have had further investigations ordered, must be referred to Miss Weston for clinic follow up. This can be done by passing the clinic notes to her Secretary, Karen Pearce, in the portacabin opposite Brickfield House, along with the referral form (appendix 8) or by emailing Miss Weston directly if urgent.

**All paediatric patients require a visual acuity to be taken.** The orthoptists will assist if the child is too young to be assessed confidently in casualty.

Babies less than 8 weeks old referred with ?absent red reflex should not be seen in casualty but alerted to Miss Weston immediately by email, who will arrange for the baby to be seen in the next paediatric clinic. Please ensure you have the patients details and contact number for the parents.

We are receiving a large number of referrals from opticians for children with 'indistinct/blurry disc margins'. If there is a high level of suspicion of papilloedema, or the child has presented with headache, they must be seen the same day. However if this is an incidental finding at a routine opticians review and the child is fit and well, please redirect the referral to Miss Weston or Mr Wilson who will book the child to a paediatric clinic within 6 weeks.

## On Calls

The on-call is from 9am to 9am. The on-call rota is managed by one of the trainees. It is accessible online as a Google calendar. You will have a rest day the Monday immediately following your on call weekend.

There is a baton bleep used for urgent referrals between 9am until 5pm.

In the morning the bleep will be held in Eye casualty, but must be collected at **midday** by the on call person. If you are off site in the afternoon or in theatre you must arrange between yourselves who will cover the bleep for you. Please do not give the bleep to nursing/secretarial staff to answer for you. At 5pm please notify switchboard if you are moving over to your mobile or when leaving the hospital.

When on call it is important that any inpatients on the ward are sorted out prior to your leaving the hospital. 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 before you leave. Once you are at home you must be available for telephone advice.

If it is necessary to admit a patient, inform the on-call Consultant. If admitting a patient after midnight and you do not need advice, or the patient does not require immediate surgery, you may inform the Consultant first thing next morning. However, if you need advice do not hesitate to ask for it.

You must immediately inform the consultant on call if you diagnose/suspect post-operative or post-injection endophthalmitis. The protocol for managing these cases has been updated in 2018 and is to be found in Appendix 10 of this document.

Any patients admitted on your on-call remain your responsibility to review daily/as necessary until they are discharged. Please involve a subspecialty team if appropriate for their input, and update the consultant on call each day, to discuss the management plan. Similarly, if you are asked to see a ward patient during your on-call who will need a subsequent review, they also remain your responsibility to see.

Ophthalmology inpatients or ward review patients should be seen in the mornings between 8am and 9am, either on the ward or in eye casualty before the eye casualty clinic starts. If you are off site in the morning and it is appropriate to do so, you may see the patient at lunchtime. If you are off site all day, or the patient cannot wait until lunchtime for review, then please arrange for your colleague in Eye casualty

to review the patient if mobile, or the on-call doctor to review on the ward if not.

If you bring back casualty patients for review after a weekend on call, either see them yourself between 8am and 9am, or add their names to the casualty appointments book (which is kept in the eye clinic by the nursing station). 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.

If you see a patient during your on-call who will need a clinic follow up in a sub-specialty clinic, please give the casualty notes and covering referral letter (Appendix 8) to the appropriate consultants' secretary.

### Handover

It is your responsibility to hand over to your colleague taking over the on call each morning when you finish your period of duty, and this is done via email and must be copied to the on-call consultant. This must be done, even if to say 'nil to hand over'. Ensure there is handover on Friday evening to the weekend on call doctor about any inpatients that need to be reviewed.

### On call swaps

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.

### Out of Hours

After 5:00pm all casualties will be dealt with by the doctor on call. They must attend the eye casualty at 5pm to take over from the afternoon casualty doctor. The eye casualty will remain running with nursing staff support, for the on call doctor to see any urgent cases from ED, or patients referred during the afternoon. The location for seeing out-of-hours patients once the eye casualty is closed is a dedicated Emergency Eye Room in the Emergency Department on the ground floor. Swipe access is needed to enter the ED Department. **Please therefore contact Jackie Sandford in the Estates Department ASAP after induction to arrange this.**

Clinical notes and discharge summaries should be recorded electronically on Cerner for every out-of-hours patient seen. If the patient cannot be registered or Cerner during out of hours or Cerner is temporarily down, the on call doctor should use the emergency paper proformas provided in the drawer to record entries.

The filing of all patient documentation with discharges/follow-ups/consultant referrals should be placed in the appropriate sections of the out of hours lower drawer

**Please see the Patient Flow Pathway and Powerchart Guide for Out of Hours Ophthalmology at the end of this handbook. This will be explained in more detail during induction.**

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**).

Emergency out of hours theatre access must be discussed with the on call consultant, and arranged via theatre co-ordinator (Blp 944) for the CPOD list +/- the anaesthetist (Blp 930)

Equipment for inpatient reviews: portable slit lamp and indirect ophthalmoscope can be picked up from the main outpatients department. The equipment must be returned to its original place after use.

## Weekends

The weekend arrangements are that the doctor on call for Saturday and Sunday must be available for telephone advice from 9:00am. At the moment the expected number of hours you will be in the hospital on Saturday are 5 hours between 7am and 9pm. On Sunday the rota allows for 3 hours of work in the hospital (between 7am and 9pm). At all other times you may be at home but must be 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 scheduled 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.**

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. **If the plan of management for the weekend is unclear, please ask.**

**The doctor on Sunday should review all the A&E referrals left on in the drawer by MIU/ED staff on the weekend and grade them appropriately using the emergency guidelines template.**

## Out of hours lasers

Lasers are preferably carried out during the time the eye casualty is running and nursing staff are present. Retinal laser should not be performed after 8pm. Urgent PIs however must be performed at any time. If a laser needs to be performed out of eye casualty hours or on the weekend, then please ask ED or outpatients for a chaperone.

## Retinal Detachments

Please contact Mr Herbert **BY TEXT** on 07956 226276 before referring these out of the hospital in case he has the capacity to manage the patient internally. If he is not available discuss with the on-call Consultant.

## Complex Lid or Orbital Trauma

Please inform the on-call consultant and then discuss with the Oculoplastics Fellow at Queen Victoria Hospital, East Grinstead.

## Corneal Scrapes, Intravitreal/AC Taps (see appendix 10)

The VIT TAP Packs for suspected Endophthalmitis cases are stored in the bottom drawer of the large drug cupboard on Limpsfield room AA25, in the room next door to the manager's office. There is a yellow notice attached to the door of the cupboard. Please be sure to familiarise yourselves if you are not sure of the location. Ceftazidime and vancomycin are in the cupboard.

Taps must be sent to the Microbiology on-call technician based at Crawley. Phone them in advance via Switchboard to arrange safe receipt and processing. Vitreous or aqueous taps do not need to be plated out but sent in the syringe by courier to the microbiology lab in Crawley.

For corneal scrapes, the agar plates are kept in the fridge in the path lab. It would also be useful to familiarise yourself with this location.

## 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 tab 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. You are required to present your audits at these meetings (see below).

### M&M meeting

These occur once every 2 months and will be presented at the audit meeting by one of the registrars. A diary to record surgical complications is kept in each of the ophthalmology theatres (Limpsfield, main theatre at ESH, Crawley).

### Audit

You are required to perform one audit per year. You are expected to be on site at ESH during your timetabled research/audit sessions. Please discuss your audit topic with your Educational or Clinical Supervisor and the Clinical Audit Lead.

Once the topic is agreed and the lead consultant has discussed the aims with you, you must register the audit topic with Lisa Norton in the Audit Department. When the audit is complete you must present the findings to the Audit meeting and then forward the presentation and a separate action plan document to the Audit Lead Mr Georgopoulos and to Lisa Norton. The dates for monthly governance meetings can be obtained from Catherine Thomas.

## Annual/Study leave

**8 weeks' notice** is required for any period of leave.

You are entitled to 27 days (ST1-2) or 32 days (ST3+) annual leave per year. You can have one additional day in leu for each bank holiday worked or rest day that coincides with a bank holiday. You should not repeatedly take leave on the same individual day of the week but spread leave equally across all days of the week so that you are not repeatedly missing one particular clinical activity.

Therefore, **please take annual leave in blocks of one week.**

Annual leave must be **spaced throughout the year** – everyone needs to please take the first half of their leave by 31<sup>st</sup> Jan and the second half by 31st July. You cannot carry leave over.

A **maximum of 2 weeks** consecutive leave is permitted (of either study leave, annual leave, or combination). The Trust M&D Leave policy states:

“Requests for extended periods of annual leave (usually 3 or more weeks' duration) should be exceptional and will be granted at the discretion of the Clinical Lead because of the potential impact on colleagues' ability to take leave and for significant service disruption”

With the exception of reginal study days, only one ST1/ST2 may be away at any one time, and only one senior trainee (ST3-7) may be away at the same time so please check amongst yourselves before submitting leave. It is at the discretion of the leave co-ordinator for any two trainees to be on leave at one time.

**Only under exceptional circumstances (e.g. wedding or other significant event) can the above be reviewed – please discuss with College Tutor.**

You have 30 days study leave per year, of which 15 days are for external courses.

- There is a list of mandatory and optional courses accessible to you and held by the Head of School who will be assessing your study leave application. If you wish to undertake a course or event that is not included on the Mandated and Optional Lists, you should discuss with your Educational Supervisor and Training Programme Director to ensure that the course or event is relevant to your professional development. The Head of Speciality School will have final sign off for such events which are considered 'aspirational'.

Additional private study leave, to a maximum of 5 days, which includes any days taken to sit exams, is at the discretion of the department.

All leave forms must be signed by the College Tutor (and Educational supervisor for study leave). Once your leave has been agreed and your form signed, you will be asked to submit a clinic cancellation request, which must state all those clinics that will need to be cancelled during your period of leave. **Do not submit clinic cancellation forms or book any holiday/flights until leave has been approved and signed off.**

Please do not include clinics where you are supernumerary on the clinic cancellation form as this may result in another doctors list being cancelled in error.

**Please ensure leave is requested for all days that you will be away from work – this MUST include any days where your timetable does not have booked clinical activity e.g. admin/audit/research/study session. You are being paid by the Trust to be available for work during these times and therefore must be included in your leave.**

## TEACHING PROGRAMME

### Regional Study days

These are organised by the deanery and occur throughout the year. You will be notified by the TPD. Please submit study leave for these days so that your clinic activity can be cancelled.

### Friday afternoon teaching in Brighton

Each week there is a Regional Teaching half day on Friday afternoons at the Sussex Eye Hospital, Brighton. There are no clinical commitments for trainees on Friday afternoons in order for you to attend. Attendance is compulsory and trainees should be released from their morning clinical activity by 12.30pm. When you are on call however, you will need to cover the eye casualty on a Friday afternoon.

Claiming expenses:

The head of school has confirmed that you can claim for your travel to weekly teaching. You will need to action this through our normal study leave EOL portal.

- If you are claiming mileage, you need to ensure you have business insurance, otherwise the Trust will not process the claim.
- If you are claiming for public transport or for any parking you must upload a receipt.
- Your claims will be cross checked with teaching registers, so please ensure you have attended dates before putting claims through.
- Please feel free to add multiple lines to one claim rather than creating lots of new claims.
- You will also need to submit an application form for study, but again just list all the teaching dates on one form to make it easier.

## Skills Training

We provide ST1 trainees with ½ day training opportunities each month 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. You should also make arrangements to attend the RCOphth to use the surgical simulator.

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

## 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.

## E-portfolio

You are required to complete your e-portfolio on a regular basis. All WBAs for the year of training and supervisor reports must be uploaded onto your e-portfolio. Please follow the RCOphth instructions on this accurately – it is your responsibility to inform yourself of these requirements.

## WBA/OSATs

- These should be done in 'real time' i.e. during clinic or theatre sessions and ideally completed with dual sign off. If you are submitting assessments after the event, please ensure this is done within a day or two of performing the assessment or it may be rejected.
- Please inform your clinical supervisor at the start of the clinical session that you would like to do a particular WBA so that they are prepared.
- It is good practice to print the assessment form and give to your assessor so that this is available to them as reference when observing you.
- Spread the assessments throughout the year, rather than clustering near the time of your ARCP.
- Remember that it is *expected* that you will not 'meet expectations' on all of your assessments, and that this is a way of showing evidence of progression in your training.
- Aim to get the MSF completed before your mid-point meeting with your educational supervisor.
- The most senior trainee will 'buddy' the ST1 to assist them with the e-portfolio in the first year.

## Educational/Clinical Supervision

Your Educational Supervisors are responsible for overseeing your training and ensuring that you make the necessary clinical and educational progress. Arrange to have your first educational supervisor meeting within the first 2 weeks of starting in post 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.

Your mid-point review should be held by the end of January, and the final review in May, ideally no later than 2 weeks prior to the e-portfolio deadline for the ARCP in June.

If you have any concerns during your time here, please do speak to your educational supervisor promptly so these can be addressed – they are here to help you in all aspects of your training. They should be your first point of contact for advice and support.

Clinical Supervisors are responsible for your day-to-day supervision in clinic or theatre. Please meet your clinical supervisors at the start of each new rotation so that your CS can tell you their expectations for the clinic or theatre you will be with them.

### ARCP

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 8 weeks' notice. 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 Group

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 Local Faculty's work is quality controlled by the HEKSS Standards for the Local Faculty GEAR.

Local Faculty Group (LFG) meetings are held three times per year, after the Audit meeting. These are attended by the Consultants, Education and Training Department staff, a member of library staff, and one or more trainees. Depending on the agenda items, other members of staff may be invited to attend to address specific items for discussion (e.g. HR). It is your opportunity to give feedback on your training in the department.

Amongst you, one trainee will need to be appointed as the LFG representative to be the spokesperson for you all, however you are all invited to attend as a group to provide feedback and bring to the attention of the LFG any issues arising during your training at ESH promptly. Please meet up prior to the LFG to decide on anything you would like discussed.

### 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 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)

## APPENDIX 1(a)

### CRITERIA FOR LISTING PATIENTS FOR CATARACT SURGERY

#### Listing criteria:-

1. **Meets the criteria set by local CCGs for surgery - see appendix 1(b)**
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:-

- First or second eye surgery with no additional pathology or factors of additional complexity (see appendix 2)

AND

- Vision of 6/12 or worse

AND

- Meets the above criteria

#### Cases which must be discussed with the Consultant:-

- For patients with any factor that is not straightforward, the decision to list for surgery and who performs the operation **must** be discussed with the Consultant in charge of the clinic. Examples of patients who must be discussed with the consultant are listed on appendix 2. The named consultant who has agreed to list the patient must be clearly noted on the waiting list form and identified as the 'specific consultant to do'.
- Vision better than 6/12

## APPENDIX 1(b)

### CATARACT SURGERY GUIDELINES IN WEST SUSSEX

#### **“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

#### **“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.

**Departmental Policy for Listing Patients for Cataract Surgery  
Ophthalmology Department – East Surrey Hospital  
For the attention of all ophthalmology medical staff, trainees and locums.**

We would like to draw your attention to the departmental policy on listing patients for cataract surgery. It has been agreed by all the Consultants that you may only list patients for cataract surgery without first discussing with the Consultant if the cataract is straightforward and there are no other complicating factors.

In any patient with any factor that is not straightforward, the decision to list for surgery and who performs the operation must be discussed with the Consultant in charge of the clinic. Examples of patients who must be discussed with the consultant are the following, but this is not an exhaustive list:

1. Children or young adults or patients > 90 years
2. Patients who had any previous eye surgery of any type
3. Very dense cataracts
4. Patients with axial length > 26 mm or < 22 mm OR hypermetropia > 5D or myopia > 5D
5. Patients with previous trauma
6. Patients with complex cataract surgery in the fellow eye
7. Only eye
8. Any patient who may have issues with giving consent
9. Any patient listed for cataract surgery under general anaesthetic or with sedation
10. Any patient who may have problems co-operating with Local anaesthetic e.g. communication /language barrier, inability to lie flat, severe anxiety, severe deafness
11. Patients with other coexisting retinal conditions, e.g. previous retinal detachment surgery or vitrectomy, patients under treatment or with advanced macular degeneration, retinal vein occlusions or significant diabetic retinopathy.
12. Patients with prior refractive surgery, radial keratotomy, LASIK, corneal guttata, corneal graft or other significant corneal pathology
13. Patients with advanced glaucoma, uncontrolled eye pressures, pseudoexfoliation, previous trabeculectomy or narrow angle glaucoma.

Essentially, if there is any doubt in your mind about whether the case is straightforward or not, it is best to discuss it with the supervising Consultant. Please ensure you have the clinical notes with you at that discussion.

From January 2019, it is no longer permissible to write on the listing form 'Senior Surgeon to do' or 'Consultant to do'. Any case that is complex should be discussed with the supervising consultant and the surgery performed by the Consultant who has agreed to that patient being listed. Therefore he/she must be mentioned by name on the listing form, the patient is then added to their waiting list. There will be a common waiting list for straightforward cataracts only.

We will be grateful if you could adhere to the above protocol at all times.

Appendix 3 Outcome form (blank) – to be completed after every consultation in clinic

PLEASE GIVE THIS FORM TO RECEPTION BEFORE LEAVING TODAY

Date:	
Check in time:	Please fix patient label

**TODAY'S INVESTIGATIONS AND PROCEDURES**

RETINA	Code	LASER	Code	LID AND ADNEXAL	Code
OCT	C873	YAG capsulotomy	C733	Lash epilation	C226
Fundus Photography	C871	YAG iridotomy	C623	Syringe/Probe tear duct	C273
FFA	C865	SLT/ALT/ Argon laser iridoplasty	C611	Removal of lid sutures	C205
ICG	C872	Retinal Laser	C826	Drainage of abscess	C191
Intravit Lucentis/Aflibercept	C794/X93.1	Retinal Laser for tear: retinopathy	C812	Tarsorrhaphy	C164
Intravit Ozurdex	C798/X93.2			Cyst incision and curettage	C124
Intravit Other e.x. AVASTIN	C794			Lid lesion excision	C121
<b>GLAUCOMA</b>		<b>ANTERIOR SEGMENT</b>		<b>NEURO, PAEDS, STRABISMUS</b>	
HFT/ Goldmann/ Phasing	C868	Refraction (autorefr/retinoscopy)	C878	Hess Chart	
Pachymetry	C518	Biometry		Orthoptic assessment	
Releasable suture removal	C654	Removal of corneal suture	C473	Botox injection	
5-FU injection to bleb	C652	Punctal occlusion	C293	Visual Fields	
Needling	C651	Corneal Scrape	C511	Corneal Topography	C518
Injection of substance into AC	C693	Conjunctival swab			

**TREATMENT STATUS: PLEASE CIRCLE ONE OPTION**

Follow up status	Code:	Discharge status	Code
Treatment to be arranged at future OPA	20	Treatment completed today	30
Treatment given in a previous appointment	90	Treatment completed previously	90
Treatment done today or medicines prescribed	30	No treatment required	34
Admit from clinic for treatment	30	Patient declined treatment	35
Start active monitoring (patient's decision)	31	<b>Did not attend (DNA) status</b>	
Start active monitoring (hospital's decision)	32	DNA and discharge	35
Continue active monitoring	91	DNA 1st and re-appoint (mark time scale below)	33
Refer to another SASH colleague	20	DNA f/u and re-appoint (mark time scale below)	20
Refer to another Trust	21	<b>Add to waiting list status</b>	
		Add to waiting list	20
		Add to Waitlist after Active Monitoring/treatment	11

**FOLLOW UP ARRANGEMENTS**

<b>Next appointment:</b>		
Days	Weeks	Months

<b>Follow up clinic:</b>  Consultant      Any		<b>Other services:</b>					
		FFA (Monday am only ESH)	Minor ops		LVA		
		Fundus Photographs (alternate Wed Am ESH)			Laser		
		Orthoptist assessment		Visual fields		Contact Lens	
		OCT (Thur am HR, alternate Wed am ESH)				Primary Care	
<b>Glaucoma</b>	<b>GL1</b> <small>stable</small>	<b>GL2</b> <small>Uncontrolled</small>		<b>OH1</b> <small>stable</small>		<b>OH2</b> <small>uncontrolled</small>	
<b>VEGF</b>	<b>RETINA</b>	<b>R0</b>	<b>R1</b>	<b>R2</b>	<b>R3A</b>	<b>R3S</b>	

**Appendix 4 Miss Nenova's instructions re consent, listing and outcome forms for Retinal patients having treatment. 2018 (6 pages)**



Patient identifier/label

**Consent Form 3**

**Patient/parental agreement to investigation or treatment**

(procedures where consciousness not impaired)

**Name of procedure**

(include brief explanation if medical term not clear)

LEFT course of Eylea intravitreal injection for AMD

**Statement of health professional** (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient/parent. In particular, I have explained:

The intended benefits ..... improve or stabilize the vision .....

Serious or frequently occurring risks: infection, retinal tear, retinal detachment, loss of vision 1:1000, raised intraocular pressure, cataract, floaters, external bleed .....

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved.

The following leaflet/tape has been provided.....

Signed: [Signature] Date: 9/07/18

Name (PRINT): NENOVA Job Title: Consultant

**Statement of interpreter** (where appropriate)

I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he they can understand

Signed ..... Date ..... Name (PRINT) .....

**Statement of patient/person with parental responsibility for patient**

I agree to the procedure described above.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that the procedure will/will not involve local anaesthesia.

Signature: ..... Date .....

Name (PRINT) ..... Relationship to patient .....

**Confirmation of consent** (to be completed by a health professional when the patient is admitted for the procedure, if the patient/parent has signed the form in advance)

I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

Signature: ..... Date .....

Name (PRINT) ..... Job Title .....

**Copy accepted by patient/parent: yes / no** (please ring)

**YELLOW COPY: CASE NOTES WHITE COPY: PATIENT/PARENT**

## INJECTION LISTING

LISTED BY: <u>DR NAME</u>  CONSULTANT: <u>DR NAME</u>  DATE: <u>01 / 01 / 18</u>	Collate patient label here:	
<b>Within: <u>4</u> / 52</b>	TREATMENT NUMBER: <span style="border: 1px solid black; padding: 2px 5px;">1</span>  To be administered at:    ESH    HR <input checked="" type="checkbox"/> <input type="checkbox"/>	
<i>Please encircle correct option:</i>  <div style="display: flex; flex-direction: column; gap: 10px;"> <span style="border: 1px solid black; border-radius: 50%; padding: 2px 10px;">LUCENTIS</span> <span>EYLEA</span> <span>OZURDEX</span> <span>AVASTIN</span> <span>KENALOG</span> </div>	<i>Please encircle correct diagnosis:</i>  <div style="display: flex; flex-direction: column; gap: 10px;"> <div style="display: flex; justify-content: space-between;"> <span style="border: 1px solid black; border-radius: 50%; padding: 2px 10px;">AMD</span> <span>CRVO</span> </div> <span>BRVO</span> <span>Uveitis</span>   <span>DIABETIC</span>   <span>MYOPIC CNV</span> </div>	
<span style="border: 1px solid black; border-radius: 50%; padding: 2px 10px;">LEFT</span>	BILATERAL	RIGHT
FUNDING APPLIED ON <u>01/01/18</u>	HOSPITAL TRANSPORT?  <div style="display: flex; justify-content: space-around;"> <span style="border: 1px solid black; border-radius: 50%; padding: 2px 10px;">YES</span> <span style="border: 1px solid black; padding: 2px 10px;">NO</span> </div>	NURSE INJECTIONIST?  <div style="display: flex; justify-content: space-around;"> <span style="border: 1px solid black; border-radius: 50%; padding: 2px 10px;">YES</span> <span style="border: 1px solid black; padding: 2px 10px;">NO</span> </div>
FUNDING EXPIRES ON ___ / ___ / ___		

Version 1 from 09/11/17

PLEASE GIVE THIS FORM TO RECEPTION BEFORE LEAVING TODAY

Date: \_\_\_\_\_

Check in time: \_\_\_\_\_

Please fix patient label

TODAY'S INVESTIGATIONS AND PROCEDURES

RETINA	Code	LASER	Code	LID AND ADNEXAL	Code
OCT	C873	YAG capsulotomy	C733	Lash epilation	C226
Fundus Photography	C871	YAG iridotomy	C623	Syringe/Probe tear duct	C273
FA	C865	SLT/ALT/ Argon laser iridoplasty	C611	Removal of lid sutures	C205
CG	C872	Retinal Laser	C826	Drainage of abscess	C191
travit Lucentis/Aflibercept	C794/X93.1	Retinal Laser for tear: retinopexy	C812	Tarsorrhaphy	C164
travit Ozurdex	C798/X93.2			Cyst incision and curettage	C124
travit Other e.x. AVASTIN	C794			Lid lesion excision	C121
<b>GLAUCOMA</b>		<b>ANTERIOR SEGMENT</b>		<b>NEURO, PAEDS, STRABISMUS</b>	
HFT/ Goldmann/ Phasing	C868	Refraction (autorefr/retinoscopy)	C878	Hess Chart	
achymetry	C518	Biometry		Orthoptic assessment	
Releasable suture removal	C654	Removal of corneal suture	C473	Botox injection	
i-FU injection to bleb	C652	Punctal occlusion	C293	Visual Fields	
eedling	C651	Corneal Scrape	C511	Corneal Topography	C518
njection of substance into AC	C693	Conjunctival swab			

TREATMENT STATUS: PLEASE CIRCLE ONE OPTION

<b>Follow up status</b>	<b>Code:</b>	<b>Discharge status</b>	<b>Code</b>
treatment to be arranged at future OPA	20	Treatment completed today	30
treatment given in a previous appointment	90	Treatment completed previously	90
treatment done today or medicines prescribed	30	No treatment required	34
omit from clinic for treatment	30	Patient declined treatment	35
start active monitoring (patient's decision)	31	<b>Did not attend (DNA) status</b>	<b>Code</b>
start active monitoring (hospital's decision)	32	DNA and discharge	35
continue active monitoring	91	DNA 1st and re-appoint (mark time scale below)	33
refer to another SASH colleague	20	DNA f/u and re-appoint (mark time scale below)	20
refer to another Trust	21	<b>Add to waiting list status</b>	<b>Code</b>
		Add to waiting list	20
		Add to Waitlist after Active Monitoring/treatment	11

FOLLOW UP ARRANGEMENTS

Next appointment:

Days	4 Weeks	Months
------	---------	--------

LISTING RD HOC INJECTION AND FOLLOW UP CLINIC

Follow up clinic: <b>MR</b>  Consultant <b>Any</b> <b>NENOVA OR ↑</b>	<b>Other services:</b> FFA (Monday am only ESH) <b>Minor ops</b> <b>LVA</b> Fundus Photographs (alternate Wed Am ESH) <b>Laser</b> Orthoptist assessment <b>Visual fields</b> <b>Contact Lens</b> OCT (Thur am HR, alternate Wed am ESH) <b>Primary Care</b>					
	<b>Glaucoma</b> VEGF	<b>GL1</b> stable	<b>GL2</b> Uncontrolled	<b>OH1</b> stable	<b>OH2</b> uncontrolled	
	<b>RETINA</b>	<b>R0</b>	<b>R1</b>	<b>R2</b>	<b>R3A</b>	<b>R3S</b>

PLEASE GIVE THIS FORM TO RECEPTION BEFORE LEAVING TODAY

Date: \_\_\_\_\_

Check in time: \_\_\_\_\_

Please fix patient label

**TODAY'S INVESTIGATIONS AND PROCEDURES**

RETINA	Code	LASER	Code	LID AND ADNEXAL	Code
OCT	C873	YAG capsulotomy	C733	Lash epilation	C226
Fundus Photography	C871	YAG iridotomy	C623	Syringe/Probe tear duct	C273
FA	C865	SLT/ALT/ Argon laser iridoplasty	C611	Removal of lid sutures	C205
CG	C872	Retinal Laser	C826	Drainage of abscess	C191
intravit Lucentis/Aflibercept	C794/X93.1	Retinal Laser for tear: retinopexy	C812	Tarsorrhaphy	C164
intravit Ozurdex	C798/X93.2			Cyst incision and curettage	C124
intravit Other e.x. AVASTIN	C794			Lid lesion excision	C121
<b>GLAUCOMA</b>		<b>ANTERIOR SEGMENT</b>		<b>NEURO, PAEDS, STRABISMUS</b>	
HFT/ Goldmann/ Phasing	C868	Refraction (autorefr/retinoscopy)	C878	Hess Chart	
Perimetry	C518	Biometry		Orthoptic assessment	
Releasable suture removal	C654	Removal of corneal suture	C473	Botox injection	
Anti-FU injection to bleb	C652	Punctal occlusion	C293	Visual Fields	
Needling	C651	Corneal Scrape	C511	Corneal Topography	C518
Injection of substance into AC	C693	Conjunctival swab			

**TREATMENT STATUS: PLEASE CIRCLE ONE OPTION**

<b>Follow up status</b>	<b>Code:</b>	<b>Discharge status</b>	<b>Code</b>
Treatment to be arranged at future OPA	20	Treatment completed today	30
Treatment given in a previous appointment	90	Treatment completed previously	90
Treatment done today or medicines prescribed	30	No treatment required	34
Admit from clinic for treatment	30	Patient declined treatment	35
Start active monitoring (patient's decision)	31	<b>Did not attend (DNA) status</b>	<b>Code</b>
Start active monitoring (hospital's decision)	32	DNA and discharge	35
Continue active monitoring	91	DNA 1st and re-appoint (mark time scale below)	33
Refer to another SASH colleague	20	DNA f/u and re-appoint (mark time scale below)	20
Refer to another Trust	21	<b>Add to waiting list status</b>	<b>Code</b>
		Add to waiting list	20
		Add to Waitlist after Active Monitoring/treatment	11

**FOLLOW UP ARRANGEMENTS**

Next appointment:

Days	Weeks	Months
------	-------	--------

LISTING INJECTION / SURGERY

Follow up clinic:	Other services:						
Consultant	FFA (Monday am only ESH)	Minor ops	LVA				
Any	Fundus Photographs (alternate Wed Am ESH)	Visual fields	Laser				
	Orthoptist assessment	Contact Lens					
	OCT (Thur am HR, alternate Wed am ESH)	Primary Care					
	<b>Glaucoma</b>	<b>GL1</b> stable	<b>GL2</b> Uncontrolled	<b>OH1</b> stable	<b>OH2</b> uncontrolled		
	VEGF	RETINA	R0	R1	R2	R3A	R3S

**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.

## EYE CASUALTY RULES!

- Respect the rules and all members of staff. Remember the emergency service is a team effort and not only the on-call Drs responsibility.
- When booking, respect the template and be mindful of your colleagues.
- Arrange follow ups in CAS with the Triage/CAS nurse; allow max number of 2 follow ups with a max interval of 2 weeks; otherwise refer to specialist clinic or discharge.
- To arrange an appointment in a specialist clinic, fill in the referral form to the relevant consultant and pass to their secretary with the notes for him/her to review.
- To book an appointment in General clinic fill in the referral form to the relevant consultant on call that week and leave with the notes for him/her to review.
- Take ownership of your patients and follow them up in your clinic unless they require specialist input (see above)
- Keep the bleep on you and answer it at all times when you are the bleep holder.
- If you are the bleep holder but are not able to keep it for good reason, ensure a colleague can take it for you; do not ask the nurses to answer it.
- Do not accept referrals on the bleep; ask an e-referral to be sent. The bleep is for advice or for immediate emergencies only, please feed this back to referral source when misused.
- Follow the guidelines template to triage the letters.
- Allow time in clinic to prioritise triaging the urgent letters if requested by the nurses. This to help your colleagues on call to see the patients as early and efficiently as possible.
- Letters triaged by a Consultant cannot be re-graded.
- If the referral letter doesn't contain all the important information to secure proper triaging, ask the nurse to reject it via email.
- Never accept referrals on the bleep for out of hours unless it is yourself on call; potentially urgent cases for out of hours should be discussed with the on-call Dr before being booked. Inform the nurse, to register the patient on the system.
- Sight-threatening cases must always be prioritised and seen before 5 p.m. If seen in clinic rather than eye casualty, they should be added to the clinic list as an extra.

- Good communication between eye casualty team, nursing staff and on-call doctor enables the smooth running of the service.
- Accept the possibility that not all cases will be true emergencies!
- Do not hesitate to propose new ideas, everyone's opinion is valued.

Ophthalmology Emergency Service Morning Huddle

**Date:** \_\_\_\_\_ **Team initials:** \_\_\_\_\_

On call Junior:

On call Consultant:

---

**Morning Session**

Casualty Doctors am:

Bleep holder am:

Grader(s) am:

---

**Afternoon Session**

Casualty Doctor pm:

Clinic Doctors pm:

Bleep holder/Grader pm:

---

**Capacity**

Number of Drs in CAS:

Number of eye casualty slots this morning:

Number of eye casualty slots this afternoon:

Number of clinic slots this afternoon:

---

**Updates regarding performance on the previous day:**

Please email this form to all named people in the form and to the management team

## EAST SURREY HOSPITAL EYE CASUALTY REFERRAL LETTER

Referral source: (e.g. GP surgery/Optician)	
Referral date:	
Patients name*:	
Patients DOB*:	
Patients contact tel* : (mobile and home)	
Patients NHS number:	
Site of symptoms*:	<input type="checkbox"/> Right eye <input type="checkbox"/> Left eye
Visual acuity*: (please state if with or without glasses/contact lenses)	Right: _____                      Left: _____
Duration of symptoms*:	<input type="checkbox"/> 1-2-3 days <input type="checkbox"/> 1 week <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> >1month
Presenting symptoms*:	<input type="checkbox"/> pain <input type="checkbox"/> redness <input type="checkbox"/> discharge <input type="checkbox"/> photophobia <input type="checkbox"/> headache <input type="checkbox"/> double vision <input type="checkbox"/> flashes <input type="checkbox"/> floaters <input type="checkbox"/> visual field defect <input type="checkbox"/> change in vision/distortion <input type="checkbox"/> epiphora (watery eye)
Past ocular history*:	<input type="checkbox"/> Eye surgery/injection (less than 4/52) <input type="checkbox"/> Contact lens wearer <input type="checkbox"/> Trauma <input type="checkbox"/> Previous shingles <input type="checkbox"/> Previous herpes simplex <input type="checkbox"/> Uveitis/iritis <input type="checkbox"/> Glaucoma <input type="checkbox"/> Wet AMD <input type="checkbox"/> Diabetic retinopathy
Examination findings*: (e.g. lid swelling, pupils/RAPD, ocular movements, visual fields)	
Treatment: (details of any therapy tried so far)	
Any relevant past medical history:	
Allergies:	
Any additional information:	
<b>This section is for the use of Eye Casualty staff only</b>	
Outcome	<input type="checkbox"/> Same day review in-hours/out of hours <input type="checkbox"/> Routine eye cas review within 1 week <input type="checkbox"/> Routine eye cas review within 2 weeks <input type="checkbox"/> Not for eye cas – refer to specialist clinic

All sections marked with (\*) are compulsory and your referral will be rejected if it does not meet the requirements.

### **Appendix 9. Form for referring casualty patient to a consultant**

**DATE**

Patient ID

\_\_\_\_\_

**Please forward patient notes to:**

**Miss Nadarajah**

**Miss O'Sullivan**

**Mr Sheik**

**Mr Georgopoulos**

**Miss Nenova**

**Mr Wilson**

**Mr Herbert**

**Miss Weston**

**For advice regarding follow-up in their clinic as appropriate.**

**Message:**

**Secretary:**

# SASH Endophthalmitis Protocol

## Perform Vitreous Tap +- AC tap as soon as possible after diagnosis of Endophthalmitis

- If post anterior segment procedures do an AC tap as well
- If post intravitreal injection just vitreous tap

### Vitreous tap: (Step wise instructions)

- Proxymetacaine anaesthesia
- Povidone iodine prep
- Lidocaine 1% sub conjunctival
- Use 2ml dry syringe with blue 23g needle. Insert into mid vitreous cavity 3-4 mm posterior to limbus.
- Extract fluid slowly (if you can see fluid you have enough – only 0.2ml required).
- Withdraw needle, use separate prepared intravitreal injections in insulin syringe with mounted needle. Inject through the same area.
- Plate sample - one drop into each of two sets of agar, a slide and aerobic then anaerobic blood culture bottles; OR SEND SAMPLE IN SYRINGE TO AVOID DELAY IF IMMEDIATE ACCESS TO PLATES NOT POSSIBLE.
- Antibiotic choice:  
Ceftazidime 0.2mg **AND**  
vancomycin 1mg  
If allergic to ceftazidime use:  
Amikacin 0.4mg  
(All are given in 0.1ml volume)

Bring Specimens to Pathology Lab reception, Dr has to inform Crawley Hospital that specimens are on route.

### List of Items needed to assist if requested:

- TAP pack- available in the drug cupboard on Limpsfield ward
- Trolley
- 2 packs (3 AGAR PLATES), kept in Limpsfield ward fridge.
- Povidone iodine 10%, Vancomycin 500mg/1000mg ampoule AND Ceftazidime 250 mg/500mg/1g/2g ampoule- available in the drug cupboard on Limpsfield ward
- Pencil to write on the slide
- Enough patient labels
- 2 secure plastic bags for specimens
- Endophthalmitis register – in the drug cupboard on Limpsfield ward

### NB:

1. Please check Expiry dates for Agar plates and culture bottles, if out of date contact path lab which receive these from microbiology department Crawley
2. Please enter the procedure in the register and complete DATIX report.

### Dilution methods for Intra-vitreous Antibiotics:

#### Vancomycin 1mg/0.1ml:

**From 500mg Vancomycin Ampoules:** Dissolve 500mg vancomycin in 10ml 0.9% sodium chloride (=50mg/ml), then make volume up to 50ml in a 50ml syringe with 0.9% sodium chloride (=10mg/ml), inject 0.1ml (=1mg) into mid vitreous.

**From 1gm Vancomycin Ampoules:** Dissolve 1000mg vancomycin in 10ml 0.9% sodium chloride taken from a 100ml small saline infusion bag (=100mg/ml), reinject into same 100ml bag (=10mg/ml), inject 0.1ml (=1mg) into mid vitreous.

#### Ceftazidime 1mg/0.1ml:

**From Ceftazidime 250mg injection:** Use a 20ml syringe to draw up 10ml of 0.9% sodium chloride. Dissolve 250mg of Ceftazidime in saline, withdraw into syringe then make up to 12.5ml with 0.9% sodium chloride(=20mg/ml). Inject 0.1ml (0.2mg) into mid vitreous.

**From Ceftazidime 500mg injection:** Use a 50ml syringe to draw up 10ml of 0.9% sodium chloride. Dissolve 500mg of Ceftazidime in saline, withdraw into syringe then make up to 25ml with 0.9% sodium chloride(=20mg/ml). Inject 0.1ml (0.2mg) into mid vitreous.

**From Ceftazidime 1g injection:** Use 10ml syringe to draw up 10ml 0.9% sodium chloride from a 100ml bag of saline. Dissolve 1000mg Ceftazidime in the saline, withdraw into syringe then inject into 100ml saline bag (=20mg/ml). Inject 0.1ml (0.2mg) into mid vitreous.

**From Ceftazidime 2g injection:** (Only use 2g Ceftazidime if you have no choice) Use 10ml syringe to draw up to 5ml of 0.9% sodium chloride from a 100ml bag of saline. Take an additional 5ml of saline from an ampoule into same syringe. Dissolve 1000mg Ceftazidime in the saline, withdraw into syringe and discard 5ml of this solution, inject the rest 5ml into the 100ml saline bag (=20mg/ml). Inject 0.1ml (0.2mg) into mid vitreous.

**Amikacin 0.4mg/0.1ml: From 500mg injection:** Withdraw entire vial into a 25ml syringe, make up to 25ml with normal saline. Inject this 25ml into a 100ml normal saline bag and mix. The resultant solution is 0.4mg in 0.1ml



**THERE IS A CODE TO ENTER THE ROOM FOR ACCESS TO THE KEY CUPBOARD, SPEAK TO YOUR CLINICAL SUPERVISOR, ONE OF THE CONSULTANT TEAM OR MEDICAL SECRETARY FOR MORE DETAILS.**



**KEY FOR THE TREATMENT ROOM CUPBOARD**

**ITEMS NECESSARY FOR ENDOPHTHALMITIS**

**CASES IN HERE.**

**VIT TAP KIT IN BOTTOM DRAWER**

**AGAR PLATES IN FRIDGE IN PATH LAB**

**IV MEDICATION**

**PLEASE KEEP CEFTAZIDINE 500MG AND  
VANCOMYCIN 500MG IN THIS CUPBOARD TO  
ENSURE ACCESS FOR THE ON CALL DOCTORS**

**THANK YOU**

**PLEASE NOTE; NO CONTROLLED DRUGS KEPT  
IN THIS CUPBOARD**

**NOTICE ON TREATMENT ROOM CUPBOARD**

## Out of Hours Ophthalmology – Powerchart system

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

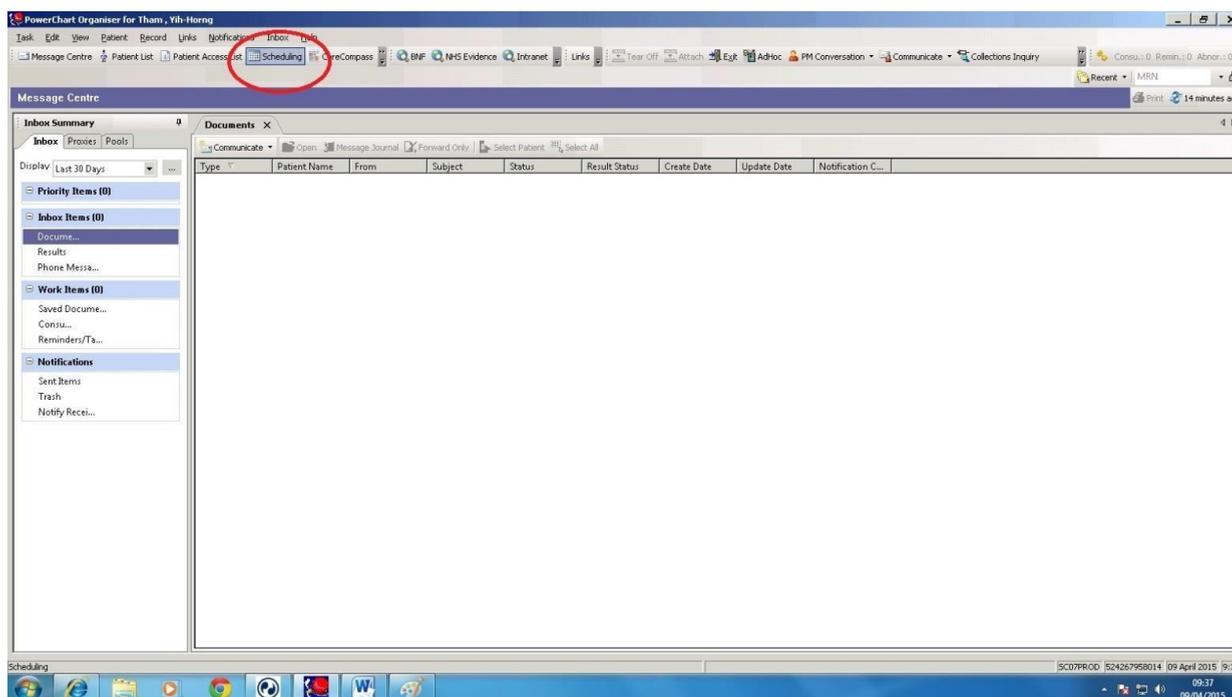
1. Finding a patient on your Powerchart Out of Hours list.
2. Adding a new clinical note.
3. Adding a discharge letter (GP letter)
4. Printing your notes the discharge letter through power chart
5. Checking the patient out of powerchart.

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.

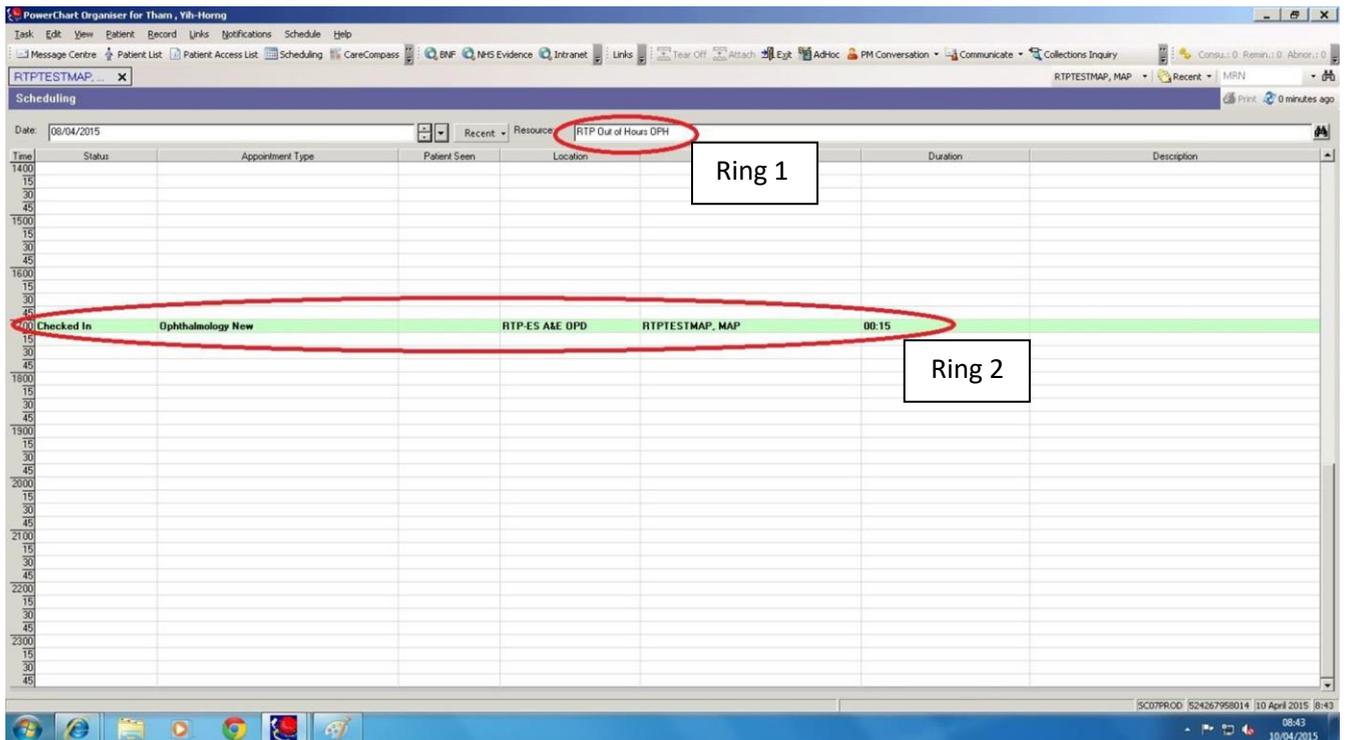
### Step 1 Finding a patient on your Powerchart Out of Hours List

#### a) Open Powerchart



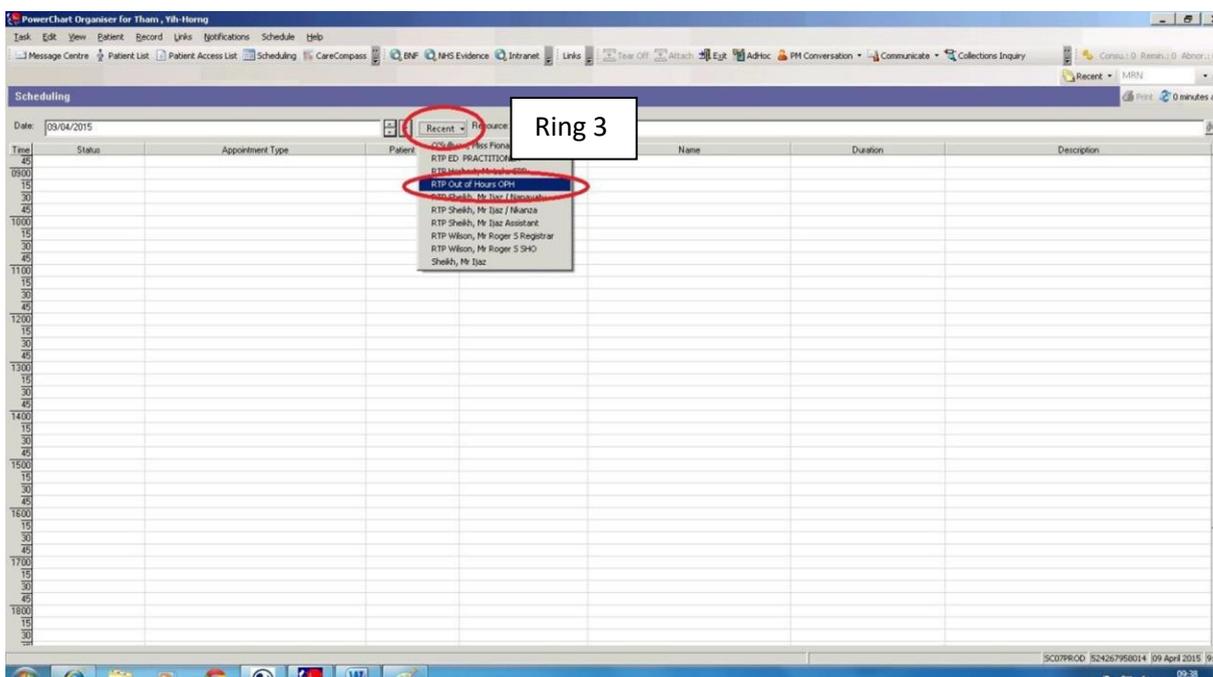
As per the picture above

#### b) Click on the scheduling button (red ring).

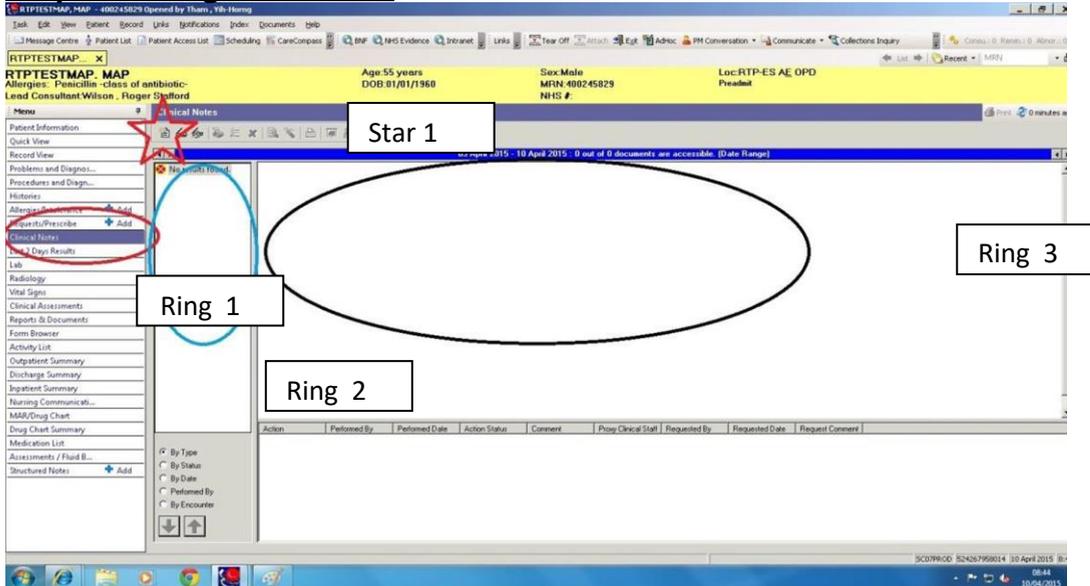


As per the picture above

- 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).

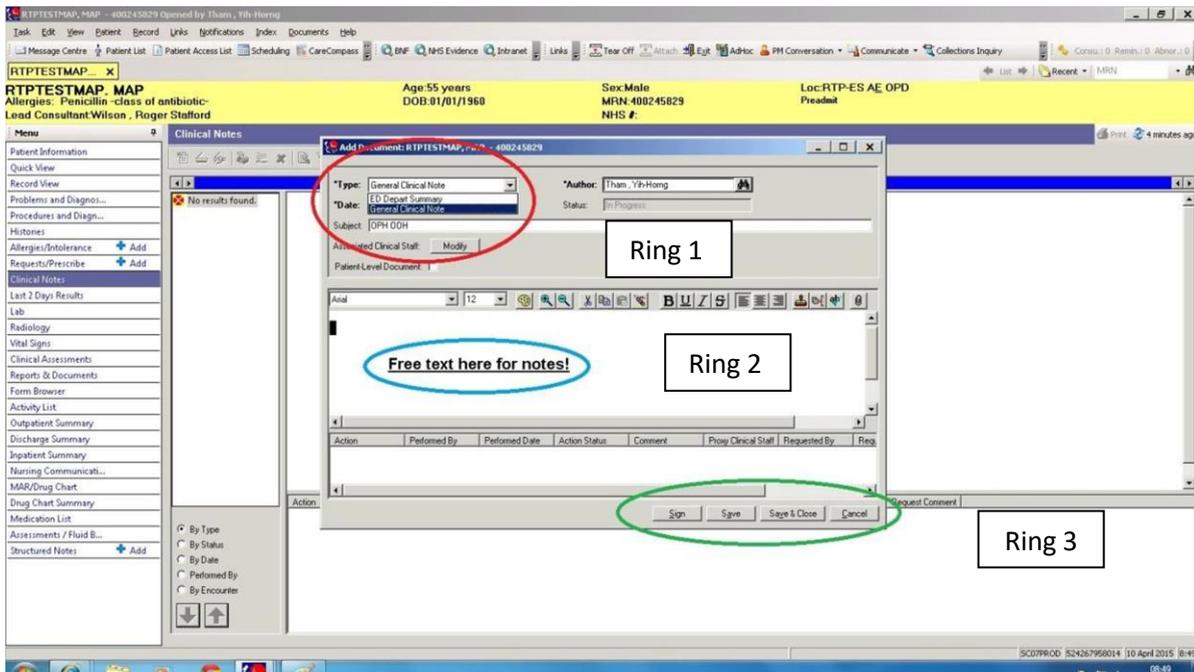


## Step 2 Adding New Notes



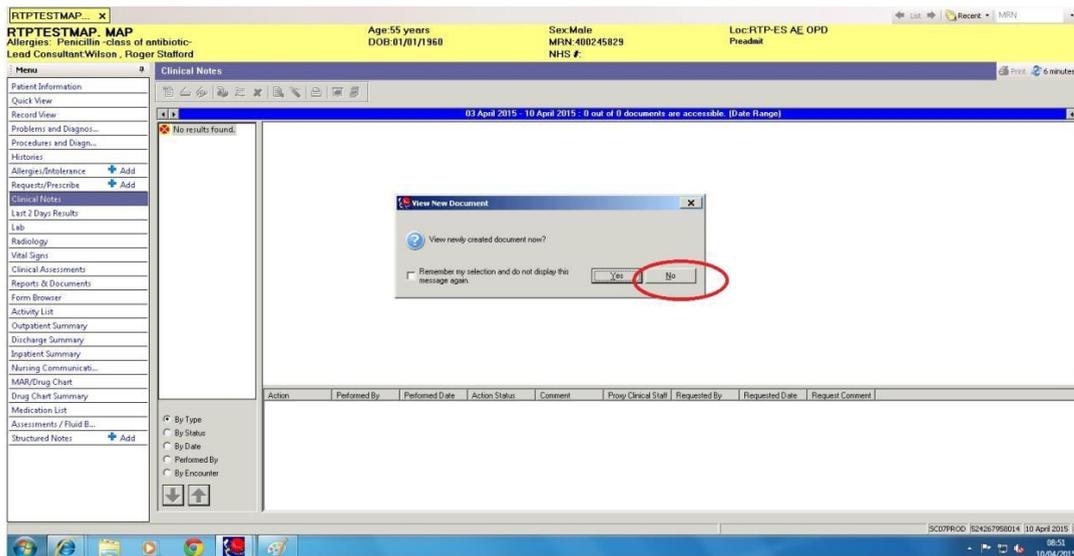
As per the picture above

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

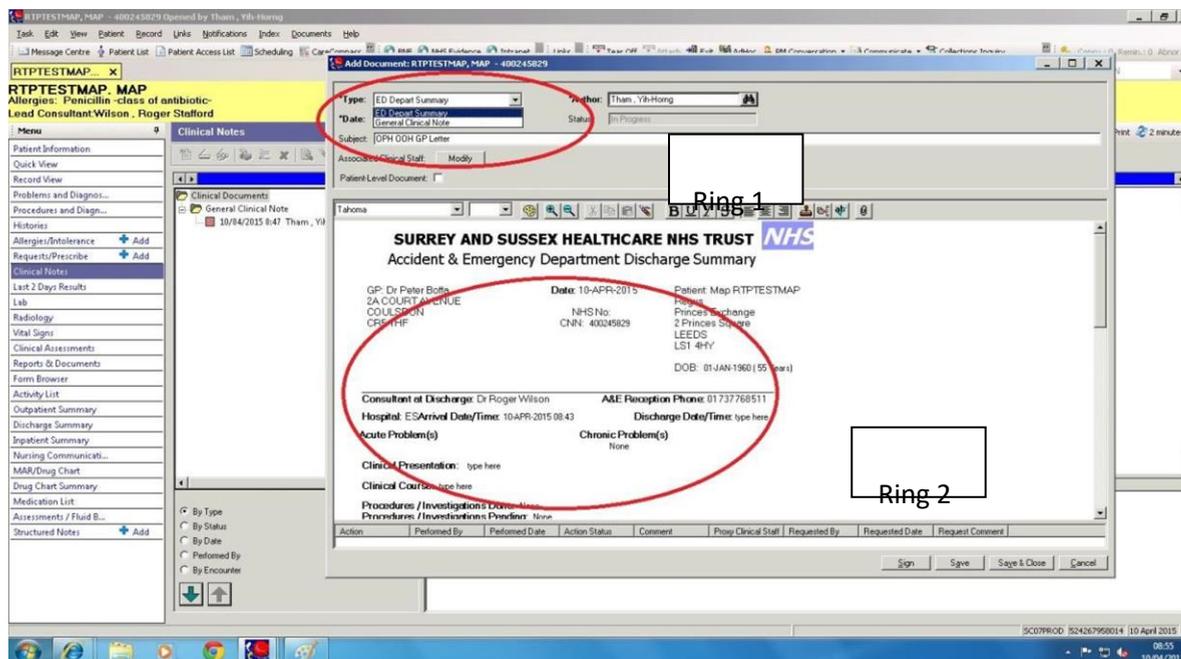
3. A new window pops up.
4. In Ring 1, there are two options. Please select General clinical note and fill the subject as “OPH OOH” for the correct coding. (NB we will use the “ ED Depart Summary” selection for the next task – Discharge letter)
5. Write your notes (Ring 2)
6. Click “sign” (Ring 3)



As per the picture above

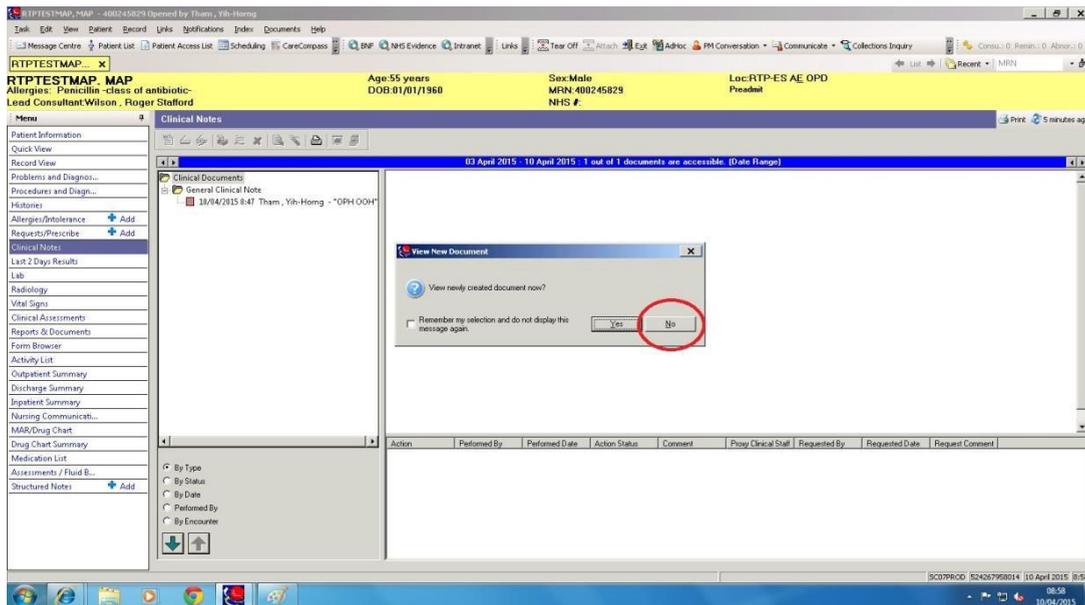
7. Another window pops up asking if you want to view the document, Click “No”.
8. Congratulations, you’re done with your notes for now. Next step, the discharge letter

### Step 3. Discharge letter



As per the picture above

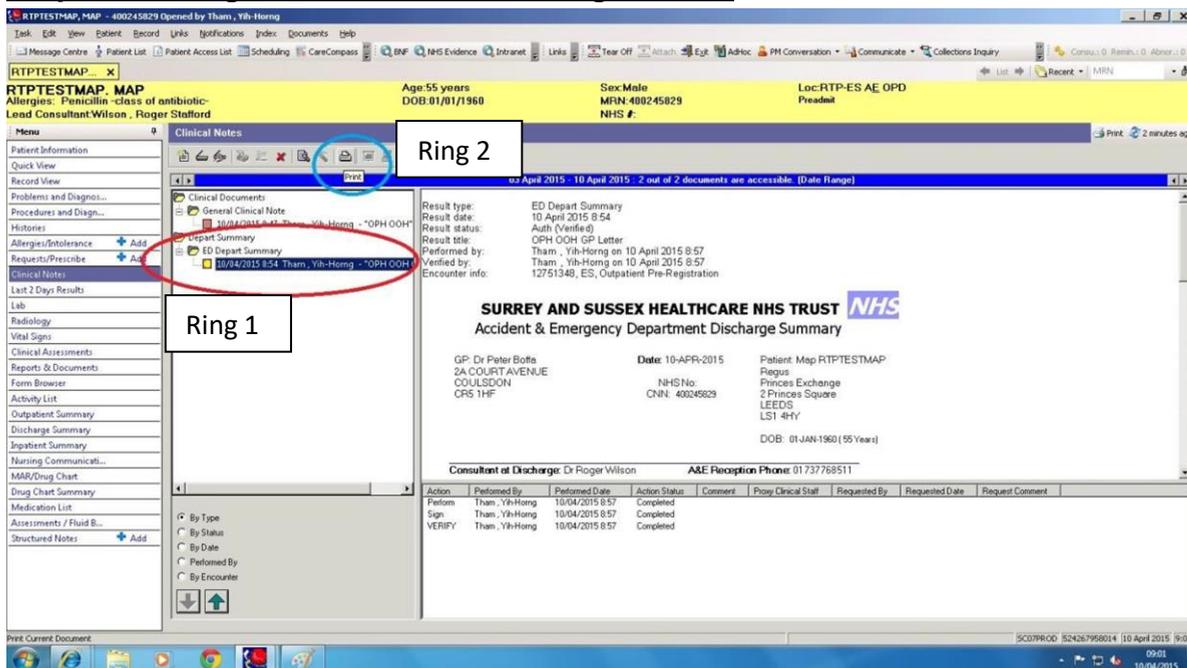
1. In the same manner, add a new note, but this time select “ ED Depart Summary” (Ring 1). This will produce a pre-written template which you can fill.
2. You must fill the subject as “OPH OOH GP Letter” for easy coding (Ring 1).
3. Edit the letter as you see fit (Ring 2).
5. Click “Sign”



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.

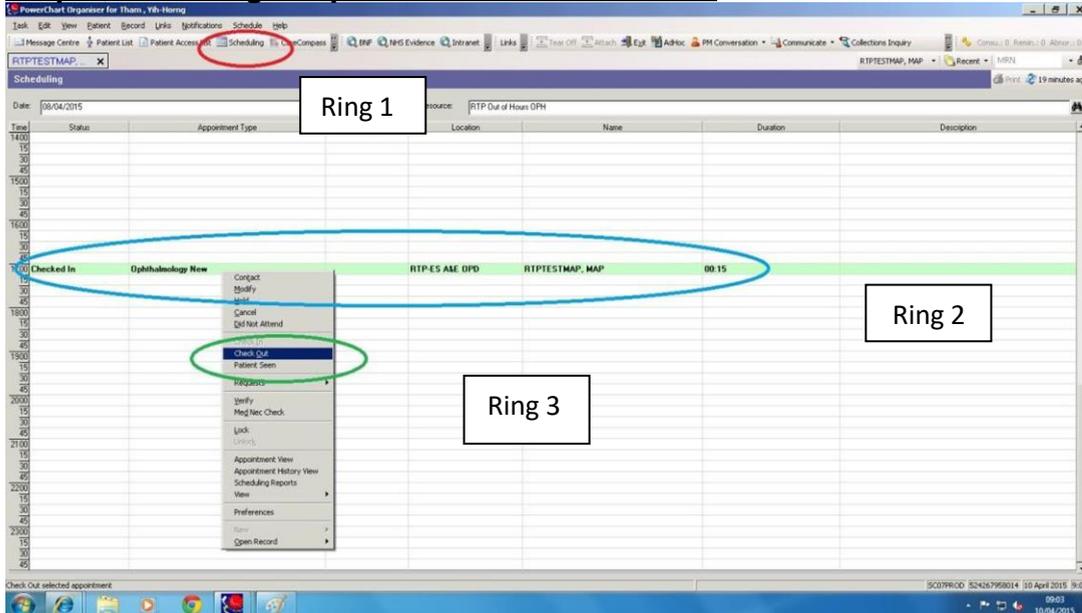
#### Step 4. Printing Notes and the Discharge Letter.



As per the picture above

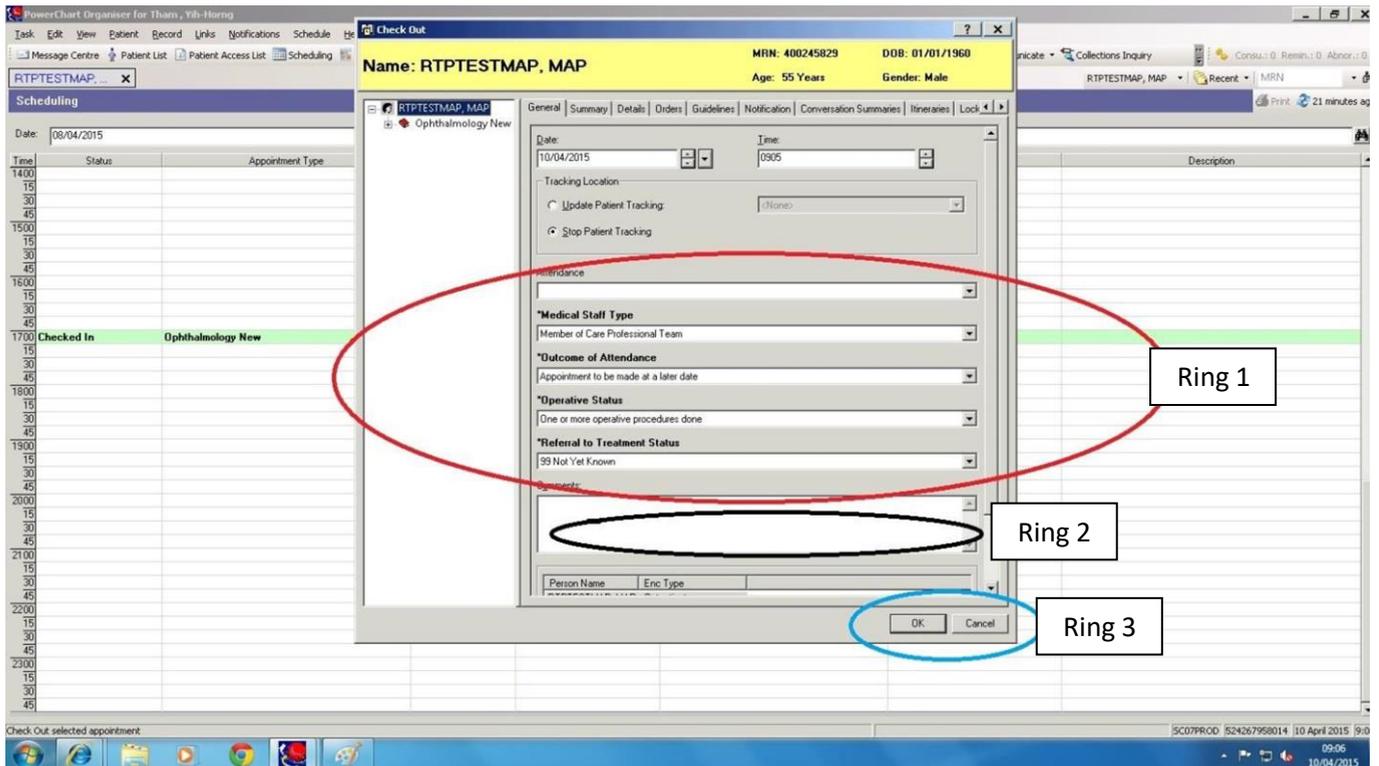
1. As shown in ring 1, find and double-click on your completed note from the cascade folders.
2. Click the print button (ring 2).
3. Repeat the same process to find and print the discharge letter.
4. Print 3 copies of the discharge letter, 1 copy for the patient, 1 copy for the GP, 1 copy for the notes.
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)

