



OPHTHALMIC OUTPATIENT DEPARTMENT

1. Introduction and context

The Ophthalmic Outpatient Department (OPD) handles a significant proportion of all Ophthalmology workload and activity. An increasing amount of Ophthalmology treatments such as laser photocoagulation, chalazion treatment, botulinum treatment and intra-vitreous injections are now undertaken in OPD. As diseases of the ageing eye (cataract, glaucoma, AMD) are the most prevalent diseases in developed societies the majority of adult patients attending ophthalmic OPDs are over 65 years of age. Similarly the majority of people with sight problems are aged over 60. These large numbers of older people attending ophthalmology OPDs are added to by large numbers of diabetic individuals with or at risk of eye disease. Importantly Ophthalmology OPDs also deal with significant numbers of children. Furthermore OPD activity in ophthalmology is proportionately greater than in other surgical specialties. It is recognised from NHS Hospital Episode Statistics returns that Ophthalmology clinics account for 10% of all hospital outpatient visits. At present a significant proportion of both ophthalmic primary care and management of long term care for ophthalmic chronic conditions takes place in the Hospital Eye Service in OPD. All of these factors make the Ophthalmic OPD a hub of activity and underpin the importance of quality OPD architecture, layout and patient flows. Some of these factors may change due to staff working practices; such as the development of the extended role of optometrists in the community and the GP with a Specialist Interest (GPwSI) in ophthalmology. Novel Integrated Clinical Assessment and Treatment services (ICATs) may change the traditional 'divide' that separates primary and secondary care and are being developed in ophthalmology. In some areas NHS Commissioners are aiming to move aspects of ophthalmic care into the community.

The standards for appropriate OPD care and facilities are the same regardless of whether care is delivered in the Hospital Eye Service, in independent sector treatment centres or in the community. This document seeks to refresh the College's commitment to the maintenance of proper professional standards in the ophthalmology OPD and to see the quality of care improve. The Care Quality Commission (CQC) provides generic or core standards with which all providers of healthcare in England must comply, and which are regularly inspected. For up to date information, and to examine reports of inspections and 'health checks' of ophthalmology providers visit the [CQC website](#). The College has provided a discussion paper on Ophthalmic Primary Care.



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2. Eye Clinic Design

The Department of Health (DoH) announced at the Institute of Healthcare Engineering and Estates Conference on 5 October 2010, that it will no longer produce guidance on the built environment for providers of health services. In future, the DoH stated it will be up to an autonomous NHS, its professional advisers and industry to work together to co-produce the design and technical guidance that has previously been relied upon. The DoH stated in a letter to the College in December 2010 that the NHS will need to ensure that the Health Technical Memorandum (HTM) and Health Building Note (HBN) documents focus on essential standards for the built environment that will support regulators in ensuring premises are both safe and suitable. Resultantly this document's focus is on providing the College's view on ophthalmic facilities (See further resources at end of document).

The Ophthalmic OPD requires a comprehensive range of optical/ophthalmological equipment which is mostly fixed or non-portable and is usually expensive. Accordingly such clinic rooms are generally not suitable for other medical specialties. Easy access to supportive diagnostic technology such as optical coherence tomography and ocular imaging in OPD ensures smooth running of clinics while providing a quality service to patients.

Many departments have open plan eye clinic areas with multiple workspaces. This allows an ideal environment for both teaching and clinical supervision whilst maintaining a reasonable degree of privacy. With the evolving requirement to reduce healthcare associated infections and the Department of Health's aim to ensure MRSA screening for all admitted patients, facilities for undressing for ophthalmology patients for swabs may be needed in the ophthalmology OPD if 'swabbing centres' are not provided centrally at hospitals. Raised expectations of confidentiality and some 'noisy' paediatric refractions would favour some separate examination rooms.

It should be possible to vary the lighting level in the clinic room, preferably via a dimmer switch near the slit lamp or by remote control. Window blinds are needed to ensure darkened examination rooms and air conditioning should thus be present throughout the department. All rooms should include an illuminated Snellen visual acuity test chart although there should be provision in the eye clinic for logMAR charts and contrast sensitivity testing. For adult clinics the 6 metre distance between patient and chart can be reduced to 3 metres by using a mirror. Scaled down vision charts for 3 metres direct are also available. Increasingly logMAR charts are used for low vision use and in age-related macular degeneration patients as well as in children. Each clinic room or workstation must be equipped with a slit lamp, tonometer, indirect ophthalmoscope as well as a reclining chair or examination couch. A portable slit lamp and tonometer should be available for occasional use.

There must be adequate hand washing facilities and alcohol gel dispensers to allow



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clinical staff to decontaminate their hands between each patient contact. Guidance on instrument decontamination from the College relevant to ophthalmology should be followed.ⁱⁱ

Ease of access to the Eye OPD for visually impaired and wheelchair patients is critical. Often Eye Clinics are best located on ground floor levels. Directions to OPD should be very well signposted bearing in mind the need of low vision users. Navigational aids, sometimes tactile, embedded into walls or floors are in use for low vision users in some hospitals. If ground floor provision is not possible adequate elevator access is vital. It is helpful to have 'drop off' parking areas close to the ophthalmic OPD and day care facility where patients can be dropped off by relatives or ambulances. Rooms must be large enough to allow visually impaired and wheelchair patients to be transferred –use safe manual handling techniques- to the slit lamp or examination couch. Cantilever mounted slit lamps can be used to examine patients in wheelchairs as an alternative. However such cantilever mounts need to be adaptable to a range of patient and wheelchair sizes to be effective.

Many eye units use a modular system incorporating the slit lamp along with other diagnostic equipment combined with an electrically adjustable chair, suitable for most patients. The clinician's chair must also be adjustable and provide good lumbar support.

Equipment for obtaining microbiology and virology specimens from the ocular surface should be available. Equipment needed for undertaking examination of lacrimal drainage apparatus should be readily available as should any surgical equipment as needed if minor eyelid procedures, such as treatment of chalazion are undertaken in the OPD. Specific guidance on disease specific equipment requirements for assessment or treatment of specific eye conditions or interventions undertaken on an outpatient or daycare basis will be found in the relevant College publications, such as Cataract Surgery Guidelines, AMD or Diabetic Retinopathy Guidelines. These are available on the College website and regularly updated. Additionally guidance on Emergency Eye Services, and or Intravitreal Injections, and which are often undertaken in the Ophthalmology OPD should be read in conjunction with this document.^{iii iv}

Many ophthalmology OPDs may undertake some teaching of medical and or optometric students who often 'sit in' during clinic sessions. Where such teaching is undertaken video screen display of slit lamp images is helpful.

It is important to have easily available high speed access to internet resources such as: NICE guidelines, Royal College websites as well as clinical information sources, NHS Trust guidance and databases. All clinic rooms should thus have access to the hospital's network and internet access. Such computers must have adequate quality monitors for diagnosis of patient images captured from retinal angiograms or diabetic retinal screening and OCT and for viewing of other digital examinations,



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including radiology images. College guidance on ophthalmic imaging equipment requirements and on informatics has been provided but must be considered in the context of continuing rapid developments of such technology.^{v vi} Access to the hospital's radiology imaging network is desirable in all cases and is mandatory if digital imaging is only performed, as is increasingly the case in modern radiology departments.

Visual field testing should be undertaken in a room with appropriate lighting conditions and laser rooms should conform to regulations governing the safe use of class 4 lasers. There must be emergency resuscitation equipment available if fluorescein angiography is carried out.

In the orthoptic department, clinic rooms can be 4 m providing there is access to 6m lane for examination of distance exotropias. Clinic rooms should be appropriately equipped for the examination and assessment of children. There should be a separate waiting area for children and parents/ guardians.^{vii} Where possible children should be seen and treated in dedicated paediatric clinics. The College has provided advice on services for children.^{viii}

Optometric examination rooms should have appropriate facilities for visual acuity testing and refraction and there should be a slit lamp and keratometer available for contact lens fitting.

Clinic waiting areas should be well lit and ventilated, preferably with air conditioning and be clearly signposted, bearing in mind that there will be many patients and carers present, some of whom may themselves be visually impaired. Separate 'sub-waiting' areas are usually provided for patients who have had their visual acuities measured and are waiting to see the clinician or who are waiting for drops to dilate their pupils. Provision should be made for patients in wheelchairs. Ideally there should be a separate waiting area for young children and families. Toilets (including facilities for the disabled) and facilities for refreshments should be available and clearly signposted. Public telephones and direct taxi lines should be available.

3. Eye Clinic Location

Ophthalmologists should seek to be involved at the earliest stages of any planning and design of buildings used for clinical activities. There are examples of excellent layouts of dedicated facilities that can be drawn upon by those planning such projects. Ideally, the layout of both the ophthalmology OPD, ophthalmology day unit or ward area and ophthalmology theatre should lend itself to high volume day case surgery and to high volume OPD throughput. For instance, the day unit should be in close proximity to theatres to enable patients to walk to and from theatre for cataract surgery as suggested in '*Action on Cataract*^{ix}' and refreshed in '*Focus on Cataract*^x'. Similarly if the OPD area is close to the theatre or treatment area



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patients can be progressed directly to treatment where this is appropriate, such as might be the case for intravitreal injections for AMD patients. Self contained Ophthalmology units which are discrete within a hospital's design often demonstrate better patient flow. This has been the principle underlying the architecture of treatment centres, either NHS or independent sector.

4. Workload and staffing

While NHS care is becoming increasingly consultant led and based, ophthalmology however remains heavily reliant upon Staff and Associate (SAS) grade doctors and especially so in OPD. Allied clinical professionals (nurses, nurse specialists, optometrists, orthoptists, photographers and medical technicians) play an increasing role in OPD settings in areas such as cataract assessment management and glaucoma monitoring. The College has been active in outlining the skills required for allied healthcare practitioners in such settings.

There are many new challenges, in addition to the challenges of the ageing of the population, to face in ophthalmic OPDs including waiting times targets, 'Choose and Book' and the advent of the electronic patient record. In a general ophthalmic clinic with full nursing support, 15 to 20 minutes should be allocated for each patient and adequate space must be left on the clinic template for emergency/ urgent referrals. Specialist clinics with multiple steps in the OPD pathway require longer times per patient. The clinic session should last 3-3.5 hours depending upon local circumstances and there should be adequate time to allow for dictation of clinic letters and phone calls to GPs and to other specialists.

The number of patients that can be accommodated in an OPD clinic session is dependent upon the team of doctors and health professionals working in the clinic. The consultant in charge must have sufficient time to review patients seen by SAS grade doctors, trainee ophthalmologists and increasingly non-medical staff. Junior trainees require close supervision and doctors in the early years of specialty training are now unlikely to have any previous ophthalmology experience and clinic template must reflect this. Methods available to increase clinic numbers and productivity are; longer clinics, more staffing, better use of technology, service redesign and or role redesign. Specialist eye nurse practitioners/ ophthalmology technicians and optometrists are playing an increasingly important role in ophthalmology clinics particularly in areas of chronic disease management e.g. glaucoma and in the initial assessment of new patients. Better quality patient care and enhanced productivity will be achieved by completing as many examinations and investigations as is needed at one clinic visit rather than having patients re-attend to complete investigations at subsequent dates. *'Do it once and do it well'* is a concept to remember. More time per patient thus often needs to be allocated to one stop clinics. Similarly in special or treatment clinics it will be necessary to allocate more time for each appointment so that proportionately fewer patients will be seen.



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Many ophthalmology departments have an Eye Clinic Liaison Officer who provides an effective link with Social Services and or local charities for the visually impaired and low visual aid provision in the hospital and or community setting. The College recommends such provision.

5. OPD Patient pathway

It is helpful to use service improvement techniques to identify and reduce any bottlenecks in the patient flow in OPD. On arrival patients should be directed to a clearly signposted reception desk and then advised where to wait until they are called into the clinic rooms. The clinic nurse should be aware of any patients with special needs. Clinics work more efficiently if thought is given in advance to patient flows. For new patients a patient letter vetting process can usefully include a series of initial instructions when the patient arrives in the clinic (in addition to visual acuity testing) such as -

1. Examination for afferent pupillary defect
2. Field of vision examination
3. Orthoptic assessment
4. Refraction examination undertaken on arrival
5. Instillation of mydriatic eye drops.

However it is recognised that the arrival of both 'Choose and Book' and the 18 Weeks referral to treatment time target place additional strain on the administration and smooth flows and logistics of such quality and efficient OPD care. An experienced ophthalmic sister in charge and or clinic proformas for retinal or glaucoma clinics may make a significant contribution to the smooth running of clinics to take into account such matters.

For follow-up patients instructions placed in notes at the end of the previous consultation can help improve the quality and efficiency of later subsequent contact.

6. Information for patients

Letters advising patients of appointment detail times and location should be printed on a high quality printer with a font size of at least 14 points. The patient should be advised to bring their spectacles and a list a current medications and the letter should explain what they may expect to happen during the appointment. It should be clearly stated that as patients may require dilating eye drops this might temporarily impair their ability to drive.



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Patient information leaflets (of appropriate size and quality print) explaining common ophthalmic conditions and surgical procedures should be readily available as should information leaflets on patient support groups and access to social services. This information should also be available on audio cassettes or CDs for patients with severe visual impairment and where possible should also be available in languages other than English. Most NHS hospital trusts have a translation or link worker service available. The College also recommends that posters and leaflets highlighting the ocular hazards of lifestyle, such as smoking, as well as details highlighting access to NHS smoking cessation services be displayed in Ophthalmic OPD.

7. Clinical Governance

Staff should wear identification badges so that patients are aware of the name and professional status of individuals involved in their care. The nurse in charge of the clinic must keep patients aware of the general progress of the clinic and the likely waiting time. Displays with such information have been found helpful while taking into account the needs of low vision users.

Patient safety incidents in the ophthalmology OPD, may be administrative such as missing patient records, patient mis-identification etc. or clinical such as missed diagnosis. The College recommends that such events should be recorded on local clinical risk incident reporting forms and discussed at departmental clinical governance meetings with a view to improving quality by learning from such events.^{xi}

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