Royal College of Anaesthetists | ACSA Anaesthesia Clinical Services Accreditation

OPHTHALMIC ACCREDITATION STANDARDS 2023

Notes to Provide Clarification of ACSA Standards

Please be advised that:

- only certain parts of the cited GPAS reference text may be applicable to the ACSA standard
- the term 'appropriately trained' refers to someone who has had specific training in the knowledge and skills required to undertake their designated role
- areas that do not have any anaesthetic input will not be assessed during the onsite review visit
- the obstetric unit only refers to units led by an obstetrician: midwife-led units are not reviewed by ACSA.

Note 1	On the prioritisation of standards	Every ACSA standard has been assigned a priority. Standards are assigned priority 1 if they **must** be achieved in order for accreditation to be awarded. Priority 2 standards **should** be achievable by most departments. Priority 3 standards will be **aspirational** for most; however, they will provide targets for the highest performing departments to achieve.
		All new standards are assigned to Priority 2 in their first year but may become Priority 1 after that.
Note 2	On the use of the term 'policies'	Whilst the ACSA standards utilise the term 'policies', it should be noted that the term is used as an umbrella to refer to a form of locally agreed process that is maintained, kept up to date , can be used as a reference and is used during staff induction. This could be in the form of a policy document, practice document or even a piece of software that fulfils the function of the standard. The important criteria are that everyone knows the reference point exists and where to find it, and that the reference point is kept up to date in accordance with the trust/board policies. Policy documents should be standardised in format, have clear review dates and have been ratified in accordance with trust/board policies.
Note 3	For hospitals that do not provide services for patients under 18 years of age (or, in Scotland, under 16 years of age).	If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.
		If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.

Note 4	On anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates (collectively referred to as 'supervisee').	The diverse nature of these posts means that the standards of education, training and experience that can be expected from post holders can vary quite widely. To ensure the safety of patients, anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates must be subject to an appropriate level of supervision of all their clinical practice and follow the 2021 RCoA guidance on 'Supervision arrangements for anaesthetists'.
Note 5	On terminology	Please use the following definitions and explanation to facilitate your understanding of the ACSA standards: **Immediate** Without any appreciable delay, within a matter of seconds or minutes. Unless otherwise specified, this should be no more than five minutes. **Remote sites** A remote site is any location where general or regional anaesthesia or sedation is administered away from the main theatre suite and/or anaesthetic department. This may be within or away from the base hospital. Common examples include MR or CT scanners, maternity units or dental sedation suites. **Supervision** The "Guidance on the supervision of anaesthetists 2021" comprehensively outlines arrangements for supervision and the different levels of supervision. Audit data based on the Cappuccini Test should be used to provide evidence for supervision arrangements. **Sedation** Unless otherwise specified, sedation refers to sedation delivered by an anaesthetist. **Lead** There should be anaesthetic clinical leads with clear and agreed responsibilities for different areas or specialties. The number of leads will depend on the size of the anaesthetic department, their areas of specialisation, workload and any ongoing areas of special focus. Where appropriate a named 'lead' can be a non-anaesthetist. **Multidisciplinary** This will have different meaning in respect of which healthcare professionals are referred to according to context and clinical situation. It is referred to as an integral part of perioperative care; 'the practice of patient-centred, multidisciplinary and integrated clinical care for patients from contemplation of surgery until full recovery.'

		Autonomously practicing anaesthetists are SAS Doctors who can function autonomously to a level of defined competencies, as agreed within local clinical governance Frameworks. **SAS Doctors*** are Speciality Doctors, SAS Specialists, Associate Specialists, Staff Grades and other closed SAS Grades. **Locally-employed Doctors (LEDs)***are doctors on local, employer-based contracts, commonly based on a current or historical version of the trainee contract. Examples of these roles include Trust Doctors, Trust Grades, Clinical Fellows, and Medical Training Initiative doctors. Some doctors are in this position short-term, between stages of training, or before becoming SAS doctors or consultants. Others are now in this position longer-term. *These definitions are taken from the Association of Anaesthetists style guide: https://anaesthetists.org/Portals/0/PDFs/Wellbeing/Association%20style%20guide%20for%20describing%20types%20of%20anaesthetist%20and%20staff%20groups.pdf?ver=2022-12-21-122110-427

STANDARD

5.2.1.1 There is a named lead clinician responsible for ophthalmic anaesthesia.

EVIDENCE REQUIRED

Documented evidence provided e.g. Job plan or rota.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Management and leadership

HIS Domains

Workforce management and support

GPAS REFERENCES

13.1.3 Each department or facility that provides ophthalmic anaesthesia services should have a clinical lead with nominated responsibility for ophthalmic anaesthesia.

STANDARD

5.2.1.2 All patients undergoing ophthalmic anaesthesia or sedation are assessed preoperatively by appropriately trained staff underpinned by guidelines on patient selection and perioperative management.

EVIDENCE REQUIRED

Copy of policy provided. Staff should be able to give verbal confirmation that this assessment takes place.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

13.1.5 Many ophthalmic patients have significant comorbidities that may require optimisation and co-ordination prior to surgery. There should be a lead anaesthetist (with an appropriate number of programmed activities in their job plan and appropriate secretarial support) for preoperative assessment, who works closely with an appropriately trained preoperative assessment team.

13.2.5 Patients having ophthalmic surgery should undergo preoperative preparation, where there is the opportunity to assess medical fitness and impart information about the procedure.

13.2.6 Patients who require general anaesthesia or intravenous sedation should undergo preoperative anaesthetic assessment.

13.2.7 As part of preoperative preparation, the plan for the perioperative management of any existing medications, such as anticoagulant drugs and diabetic treatment, should be agreed, taking into account the relative risks of stopping any medication in the light of the patient's medical condition and the anaesthetic technique required. Advice should be sought from the multiprofessional team (e.g. medical colleagues, clinical pharmacists, specialist nurses) as required, in particular for complex patients.

13.2.8 The majority of ophthalmic surgery is performed as a day case procedure under local anaesthesia. Preoperative assessment should identify those patients who are not suitable for this approach and who might require general anaesthesia or intravenous sedation.

STANDARD

5.2.1.3 The WHO checklist should be adhered to including a robust procedure for checking the laterality of the eye to be operated on and that it is marked clearly with indelible ink, prior to local anaesthetic block or general anaesthesia. Where bilateral surgery is planned, there is a policy in place to ensure that each eye receives the correct operation.

EVIDENCE REQUIRED

Documented evidence that this occurs. Copy of policy provided. Verbal confirmation from staff. Audit of evidence.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

13.5.6 National safety standards for invasive procedures should be adapted for local use as local safety standards for invasive procedures. The WHO process. The WHO preoperative team brief and checklist system, for example, could be adapted to incorporate intraocular lens selection to help prevent 'wrong lens' errors.

13.5.7 There should be a procedure for checking the laterality of the eye to be operated on prior to local anaesthetic block or general anaesthesia. This should include the eye being marked with an indelible mark by the responsible surgical team prior to admission to the operating theatre. 'Stop before you block' protocols should be adhered to. Inadequately performed 'sign-in' is the primary cause of incorrect eye blocks.

STANDARD

5.2.1.4 The 'PREP STOP BLOCK' protocol is adhered to.

EVIDENCE REQUIRED

Documented evidence that this occurs. Copy of policy provided. Verbal confirmation from staff. Audit of evidence.

PRIORITY

1

CQC KLoEs

Safe, Effective

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

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STANDARD

5.2.1.5 There is a policy on patient selection for ophthalmic day case procedures.

EVIDENCE REQUIRED

Copy of policy provided. Verbal confirmation from staff that policy is followed.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

13.2.8 The majority of ophthalmic surgery is performed as a day case procedure under local anaesthesia. Preoperative assessment should identify those patients who are not suitable for this approach and who might require general anaesthesia or intravenous sedation.

13.5.4 Patients assessed to be at high risk of serious perioperative complications, such as a cardiorespiratory event, should be carefully stratified for surgical and anaesthetic requirements, and may be unsuitable for surgery in isolated units without immediate access to anaesthetic/medical cover.

STANDARD

5.2.1.6 There is a policy on patient selection for ophthalmic procedures under local anaesthetic.

EVIDENCE REQUIRED

Copy of policy provided. Verbal confirmation from staff that policy is followed.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

13.2.8 The majority of ophthalmic surgery is performed as a day case procedure under local anaesthesia. Preoperative assessment should identify those patients who are not suitable for this approach and who might require general anaesthesia or intravenous sedation.

13.5.4 Patients assessed to be at high risk of serious perioperative complications, such as a cardiorespiratory event, should be carefully stratified for surgical and anaesthetic requirements, and may be unsuitable for surgery in isolated units without immediate access to anaesthetic/medical cover.

13.5.8 The following local guideline should be held and easily accessible:

- practice guideline for the choice of general anaesthesia or local anaesthesia or local anaesthesia with sedation for ophthalmic procedures.
- management of patients requiring intravenous sedation
- management of patients requiring urgent ophthalmic surgery
- escalation to higher levels of care and the safe transfer of patients
- management of patients on anticoagulants and antithrombotic agents
- assessment of postoperative cognitive dysfunction risks and the prevention and management of postoperative delirium.

STANDARD

5.2.1.7 There is a formal system in place for assessing and recording the cognitive status of patients during preoperative assessment.

EVIDENCE REQUIRED

Documented evidence, e.g. Preoperative assessment records such as Mini Mental State Evaluation or Abbreviated Mental Test.

PRIORITY

1

CQC KLoEs

Safe, Caring, Responsive

HIW Domains

Safe and effective care; Quality of patient experience

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance; Impact on patients, service users, carers and families

GPAS REFERENCES

13.3.5 Older patients should be assessed for risk of postoperative cognitive dysfunction and preoperative interventions undertaken to reduce the incidence, severity and duration. Hospitals should ensure guidelines are available for the prevention and management of postoperative delirium and circulated preoperatively to the relevant admitting teams.

13.3.6 Postoperative cognitive dysfunction is a particular concern and can disrupt otherwise stable home circumstances. The risk should be reduced as far as possible by minimising interventions and using local anaesthesia alone when feasible.

13.5.8 The following local guideline should be held and easily accessible:

- practice guideline for the choice of general anaesthesia or local anaesthesia or local anaesthesia with sedation for ophthalmic procedures.
- management of patients requiring intravenous sedation
- management of patients requiring urgent ophthalmic surgery
- escalation to higher levels of care and the safe transfer of patients
- management of patients on anticoagulants and antithrombotic agents
- assessment of postoperative cognitive dysfunction risks and the prevention and management of postoperative delirium.

STANDARD

5.2.1.8 There is a policy for sedation of patients for ophthalmic procedures, including specifications of the facilities provided.

EVIDENCE REQUIRED

Copy of policy provided.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

13.2.10 In units where ophthalmic surgery is performed, including locations that may be isolated from main theatre services, facilities provided should allow for the safe conduct of anaesthesia and sedation. This would include monitoring equipment, oxygen, availability of opioid and benzodiazepine antagonist drugs, a recovery area, and drugs and equipment to deal with emergencies such as cardiac arrest, anaphylaxis and local anaesthesia toxicity.

13.3.17 Patients exhibit extremely wide variation in response to drugs used for sedation. It is difficult to and undesirable to have to manipulate the airway of an unpredictably over-sedated patient during surgery, and so administration of intravenous sedation during ophthalmic surgery should only be undertaken by an anaesthetist whose sole responsibility for the duration of the surgery is to that patient.

13.3.18 Patients do not need to be starved when sedative drugs are used in low doses to produce simple anxiolysis. Patients should follow fasting guidelines as for general anaesthesia when deeper planes of sedation are anticipated or sedative infusions employed.

13.5.8 The following local guideline should be held and easily accessible:

- practice guidelines for the choice of general anaesthesia or local anaesthesia or local anaesthesia with sedation for ophthalmic procedures
- management of patients requiring intravenous sedation
- management of patients requiring urgent ophthalmic surgery
- escalation to higher levels of care and the safe transfer of patients
- management of patients on anticoagulants and antithrombotic agents
- assessment of postoperative cognitive dysfunction risks and the prevention and management of postoperative delirium.

STANDARD

5.2.1.9 There is a policy for scheduling of urgent procedures in and out-of-hours with particular regard to the condition of the eye, the proposed operation, the ASA grade and age of the patients.

EVIDENCE REQUIRED

Copy of policy provided. Audit data available.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

13.5.3 Many procedures do not have to be performed out of hours. Anaesthetists and surgeons together should devise departmental protocols for the handling of patients requiring urgent procedures, to allow prioritisation from both surgical and anaesthetic perspectives.

13.5.8 The following local guideline should be held and easily accessible:

- practice guidelines for the choice of general anaesthesia or local anaesthesia or local anaesthesia with sedation for ophthalmic procedures
- management of patients requiring intravenous sedation
- management of patients requiring urgent ophthalmic surgery
- escalation to higher levels of care and the safe transfer of patients
- management of patients on anticoagulants and antithrombotic agents
- assessment of postoperative cognitive dysfunction risks and the prevention and management of postoperative delirium.

STANDARD

5.2.1.10 There is a policy for the transfer of patients who become sick unexpectedly to an appropriate higher level of care.

EVIDENCE REQUIRED

Copy of policy provided. Audit data available.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

13.3.12 Protocols should be in place for the transfer of patients from isolated units who become ill unexpectedly. They should be moved safely and rapidly to a facility which provides an appropriate higher level of care.

13.5.4 Patients assessed to be at high risk of serious perioperative complications, such as a cardiorespiratory event, should be carefully stratified for surgical and anaesthetic requirements, and may be unsuitable for surgery in isolated units without immediate access to anaesthetic/medical cover.

13.5.8 The following local guideline should be held and easily accessible:

- practice guidelines for the choice of general anaesthesia or local anaesthesia or local anaesthesia with sedation for ophthalmic procedures
- management of patients requiring intravenous sedation
- management of patients requiring urgent ophthalmic surgery
- escalation to higher levels of care and the safe transfer of patients
- management of patients on anticoagulants and antithrombotic agents
- assessment of postoperative cognitive dysfunction risks and the prevention and management of postoperative delirium.

STANDARD

5.2.1.11 Guidelines are in place for the prevention and management of postoperative cognitive dysfunction and postoperative delirium.

EVIDENCE REQUIRED

Copy of guidelines provided. Verbal confirmation from staff that guidelines are followed.

PRIORITY

1

CQC KLoEs

Safe, Effective, Responsive, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

13.3.5 Older patients should be assessed for risk of postoperative cognitive dysfunction and preoperative interventions undertaken to reduce the incidence, severity and duration. Hospitals should ensure guidelines are available for the prevention and management of postoperative delirium and circulated preoperatively to the relevant admitting teams.

13.3.6 Postoperative cognitive dysfunction is a particular concern and can disrupt otherwise stable home circumstances. The risk should be reduced as far as possible by minimising interventions and using local anaesthesia alone when feasible.

13.5.8 The following local guideline should be held and easily accessible:

- practice guidelines for the choice of general anaesthesia or local anaesthesia or local anaesthesia with sedation for ophthalmic procedures
- management of patients requiring intravenous sedation
- management of patients requiring urgent ophthalmic surgery
- escalation to higher levels of care and the safe transfer of patients
- management of patients on anticoagulants and antithrombotic agents
- assessment of postoperative cognitive dysfunction risks and the prevention and management of postoperative delirium.

STANDARD

5.2.1.12 Guidelines are in place for the perioperative management of patients on anticoagulants and antiplatelet agents scheduled for ophthalmic surgery.

EVIDENCE REQUIRED

Copy of guidelines provided. Verbal confirmation from staff that guidelines are followed.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

13.5.8 The following local guideline should be held and easily accessible:

- practice guidelines for the choice of general anaesthesia or local anaesthesia or local anaesthesia with sedation for ophthalmic procedures
- management of patients requiring intravenous sedation
- management of patients requiring urgent ophthalmic surgery
- escalation to higher levels of care and the safe transfer of patients
- management of patients on anticoagulants and antithrombotic agents
- assessment of postoperative cognitive dysfunction risks and the prevention and management of postoperative delirium.

STANDARD

5.2.2.1 Appropriate staffing levels and skill mix is provided in all units delivering ophthalmic anaesthesia (multidisciplinary general hospitals, isolated units and large single specialty centres).

EVIDENCE REQUIRED

Documented evidence provided e.g. Rota. Verbal confirmation from staff.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care; Management and leadership

HIS Domains

Safe, effective and person-centred care delivery; Workforce management and support

GPAS REFERENCES

13.1.1 Appropriate staffing levels and skill mix should be provided in all units, multispecialty general hospitals, isolated units and large single specialty centres, delivering ophthalmic anaesthesia. For most operating sessions, this should include surgeon, anaesthetist, two theatre trained scrub practitioners, one trained nurse or operating department practitioner to assist with local anaesthesia/patient monitoring, and one theatre-support worker/runner.

13.1.2 Dedicated, skilled assistance for the anaesthetist should be available in every situation where anaesthesia or sedation is employed.

13.1.2 All ophthalmic surgery should be carried out in a facility that is appropriately staffed and equipped for resuscitation.

13.1.8 In isolated units, where no anaesthetist or medical emergency team is immediately available, there should be at least one person with advanced life-support training or equivalent. A clear and agreed pathway should be in place for isolated units to enable the patient to receive appropriate advanced medical care, including intensive care, in the event of it being required. Patients should be assessed preoperatively to ensure that they can be expected to be suitable for surgery in such an isolated unit.

13.1.13 All members of clinical staff working within the recovery area should be certified immediate life support providers and mandatory training should be provided.

STANDARD

5.2.2.2 An anaesthetist is present in the operating theatre at all times when intravenous sedation is administered for ophthalmic procedures.

EVIDENCE REQUIRED

Policy on provision of sedation. Verbal confirmation from staff.

PRIORITY

1

CQC KLoEs

Safe, Responsive, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

13.3.17 Patients exhibit extremely wide variation in response to drugs used for sedation. It is difficult to and undesirable to have to manipulate the airway of an unpredictably over-sedated patient during surgery and so administration of intravenous sedation during ophthalmic surgery should only be undertaken by an anaesthetist whose sole responsibility for the duration of the surgery is to that patient.

STANDARD

5.2.2.3 Needle blocks are administered only by trained surgeons or anaesthetists, or under the direct supervision of an experienced surgeon/anaesthetist.

EVIDENCE REQUIRED

Copy of policy provided. Verbal confirmation from staff.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

13.3.15 Sharp needle based blocks (e.g. peribulbar or retrobulbar block) should only be administered by medically qualified personnel, because of the increased risks of life-threatening complications. Intravenous access should be established prior to performing sharp needle blocks and for any patient deemed to be high risk due to severe comorbidity.

STANDARD

5.2.2.5 There is an identified group of senior anaesthetists who manage and deliver a comprehensive ophthalmic anaesthesia service, including the use of orbital regional anaesthetic techniques.

EVIDENCE REQUIRED

Documented evidence provided, e.g. job plan or rota.

PRIORITY

1

CQC KLoEs

Safe, Responsive, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Workforce management and support

GPAS REFERENCES

13.1.4 There should be an identified group of senior anaesthetists who manage and deliver a comprehensive ophthalmic anaesthesia service, including the use of orbital regional anaesthetic techniques.

STANDARD

5.2.2.6 When lasers are in use for ophthalmic surgery, the correct safeguards are in place.

EVIDENCE REQUIRED

Copy of policy provided. Verbal confirmation from staff that policy is followed.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

13.2.4 Where lasers are in use for ophthalmic surgery, the correct safeguards must be in place.

STANDARD

5.2.3.1 Appropriate equipment is available to adjust patient position to ensure maximum comfort and optimum surgical access.

EVIDENCE REQUIRED

Verbal confirmation from staff. Equipment should be seen.

PRIORITY

1

CQC KLoEs

Safe, Caring, Responsive

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

13.2.13 Optimal patient positioning is critical to the safe conduct of ophthalmic surgery and for patient comfort. Adjustable trolleys/operating tables that permit correct positioning should be available.

13.2.14 Some patients, for example those with restricted mobility, may require specific equipment such as hoists to position them. Preoperative planning should ensure that such equipment is available, and allow for the extra time and staff needed to position these patients safely.

STANDARD

5.2.3.2 Staff are trained to safely help patients on and off operating tables with care and dignity.

EVIDENCE REQUIRED

Verbal confirmation from staff. Documented evidence provided, e.g. policy or staff training records.

PRIORITY

1

CQC KLoEs

Safe, Caring, Responsive

HIW Domains

Safe and effective care; Quality of patient experience

HIS Domains

Safe, effective and person-centred care delivery; Impact on patients, service users, carers and families

GPAS REFERENCES

13.2.14 Some patients, for example those with restricted mobility, may require specific equipment such as hoists to position them. Preoperative planning should ensure that such equipment is available and allow for the extra time and staff needed to position these patients safely.

STANDARD

5.2.3.3 Specific patient information regarding procedures for the day of admission and explanation of local or general anaesthetic techniques is available prior to admission.

EVIDENCE REQUIRED

Patient information should be provided in a wide range of formats and styles relevant to the patient population, e.g. large print, Braille, easy-reading, QR codes, videos or other media.

PRIORITY

1

CQC KLoEs

Caring, Responsive

HIW Domains

Safe and effective care; Quality of patient experience

HIS Domains

Safe, effective and person-centred care delivery; Impact on patients, service users, carers and families

GPAS REFERENCES

13.9.3 Information should be made available to patients that gives details of the surgery and local and general anaesthesia for ophthalmic procedures, as well as advice on what to expect on the day of admission. The Royal College of Anaesthetists and the Royal College of Ophthalmologists have a range of booklets available on their websites to help to inform patients.

13.9.5 Written information for patients should be easy to read. It should be available in an appropriate language and format for those patients who are visually impaired. It may be necessary to provide translations of patient information booklets into languages suitable for the local population.

STANDARD

5.2.4.1 All ophthalmic theatre nurses, anaesthetic nurses and operating department practitioners must have up-to-date appropriate life support training and ophthalmic nurses are trained in cardiopulmonary resuscitation.

EVIDENCE REQUIRED

Documented evidence of training provided. Verbal confirmation from staff.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

13.1.7 Staff should be trained in basic life support and there should be immediate access to a medical team with advanced life-support capabilities.

13.1.8 In isolated units, where no anaesthetist or medical emergency team is immediately available, there should be at least one person with advanced life-support training or equivalent. A clear and agreed pathway should be in place for isolated units to enable the patient to receive appropriate advanced medical care, including intensive care, in the event of it being required. Patients should be assessed preoperatively to ensure that they can be expected to be suitable for surgery in such an isolated unit.

13.1.9 If no anaesthetist is present in theatre, an appropriately trained anaesthetic nurse, ophthalmic theatre nurse or operating department practitioner should be present to monitor the patient during establishment of local anaesthesia and throughout the operative procedure. This should be their sole responsibility.

13.4.6 All staff should have access to adequate time, funding and facilities to undertake and update training that is relevant to their clinical practice, including resuscitation training.

STANDARD

5.2.4.2 Ophthalmic anaesthesia is included in departmental audit programmes, including on-going audit of patient satisfaction, elective and emergency anaesthesia activities, complications and adverse events.

EVIDENCE REQUIRED

Written and verbal evidence should be provided.

PRIORITY

1

CQC KLoEs

Safe, Responsive, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery; Quality improvement focussed leadership

GPAS REFERENCES

13.7.2 Ophthalmic anaesthesia should be included in departmental audit programmes, which may include patient satisfaction, complications and adverse events.

STANDARD

5.2.4.3 Structured training in regional orbital blocks is provided to all inexperienced doctors who wish to learn any of these techniques. This includes the applied knowledge of anatomy, and recognising and minimising the risks of complications.

EVIDENCE REQUIRED

Documented evidence of training provided e.g. objective assessment of competence in performance of blocks, clinical governance meeting minutes and verbal confirmation from staff.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

13.4.3 Structured training in regional orbital blocks should be provided to all inexperienced practitioners who wish to learn any of these techniques. This should include an understanding of the relevant ophthalmic anatomy, physiology and pharmacology, and the prevention and management of complications. Where possible, trainees should be encouraged to undertake 'wetlab' training or use simulators to improve practical skills.

13.4.5 All anaesthetists working in ophthalmic services should have access to continuing educational and professional development facilities for advancing their knowledge and practical skills associated with ophthalmic anaesthesia.

13.4.6 All staff should have access to adequate time, funding and facilities to undertake and update training that is relevant to their clinical practice, including resuscitation training.

STANDARD

5.2.4.4 Doctors learning orbital regional anaesthesia are directly supervised by an expert until assessed to be competent.

EVIDENCE REQUIRED

Documented evidence of training provided. Verbal confirmation from staff.

PRIORITY

1

CQC KLoEs

Safe, Effective, Well-led

HIW Domains

Safe and effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

13.4.3 Structured training in regional orbital blocks should be provided to all inexperienced practitioners who wish to learn any of these techniques. This should include an understanding of the relevant ophthalmic anatomy, physiology and pharmacology, and the prevention and management of complications. Where possible, trainees should be encouraged to undertake 'wetlab' training or use simulators to improve practical skills.

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13.4.6 All staff should have access to adequate time, funding and facilities to undertake and update training that is relevant to their clinical practice, including resuscitation training.

Royal College of Anaesthetists

Royal College of Anaesthetists, Churchill House, 35 Red Lion Square, London WC1R 4SG 020 7092 1500 | www.rcoa.ac.uk/acsa | acsa@rcoa.ac.uk