



OPHTHALMIC ACCREDITATION STANDARDS 2019

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	<p>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.</p> <p>All new standards are assigned to Priority 2 in their first year but may become Priority 1 after that.</p>
Note 2	On the use of the term 'policies'	<p>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 (reviewed at least every three years), 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.</p>
Note 3	For hospitals that do not provide services for patients under 18 years of age	<p>If your department does not treat patients under 18 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 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.</p> <p>If you have an emergency department but do not routinely treat patients under 18 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.</p>

<p>Note 4</p>	<p>On Staff Grade, Associate Specialist and Specialty (SAS) Doctors</p>	<p>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. The degree of supervision a SAS doctor requires should be agreed via a robust, local governance process and follow the RCoA guidance on 'Supervision of SAS and other non-consultant anaesthetists'.</p> <p>Where the standard refers to a consultant anaesthetist, it is acceptable for SAS doctors whom this process has agreed can practice without consultant supervision, to fulfil this role.</p>
<p>Note 5</p>	<p>On terminology</p>	<p>Please use the following definitions and explanation to facilitate your understanding of the ACSA standards:</p> <p>Immediate Without any appreciable delay, within a matter of seconds or minutes. Unless otherwise specified, this should be no more than five minutes.</p> <p>Remote sites A remote site is any location where general or regional anaesthesia 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.</p> <p>Supervision Direct supervision: This means that the individual is working directly with a supervisor who is actually with the supervisee or can be present within seconds.</p> <p>Indirect supervision: Indirect supervision falls into three categories: local, distant and remote sites. For local supervision the supervisor is usually within the theatre suite e.g. 'the starred consultant' system, is immediately available for advice and is able to be with the supervisee within minutes of being called. For distant supervision, the supervisor is rapidly available for advice but is off the hospital site or separated from the supervisee by over 10 minutes. Remote sites are as defined above. Supervisees should only be permitted to work in remote sites under distant supervision if they meet certain criteria.</p> <p>These definitions for levels of clinical supervision are as outlined in the curriculum. Please refer here for more detail.</p>

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 consultant 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.
- 13.2.8** Patients having ophthalmic surgery should undergo preoperative preparation, where there is the opportunity to assess medical fitness and impart information about the procedure.
- 13.2.9** 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.
- 13.2.10** The majority of ophthalmic surgery is done as day case procedures 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.
- 13.2.11** Patients who require anaesthesia or intravenous sedation should undergo pre-operative anaesthetic assessment.

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 (NatSSIPs) should be adapted for local use as local safety standards for invasive procedures. The WHO process, for example, could be adapted to incorporate intraocular lens selection to help prevent 'wrong lens' errors.
- 13.5.7** There should be a robust 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. The RCoA/NPSA 'Stop before you block' protocols should be adhered to.

STANDARD

5.2.1.4 The RCoA 'STOP before you 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

13.5.7 There should be a robust 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. The RCoA/NPSA 'Stop before you block' protocols should be adhered to.

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

13.2.10 The majority of ophthalmic surgery is done as day case procedures 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

5.2.1.6 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

13.2.10 The majority of ophthalmic surgery is done as day case procedures 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

5.2.1.7 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.

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

- 13.2.13** 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.
- 13.3.16** Patients exhibit extremely wide variation in response to drugs used for sedation. Coupled with this uncertain pharmacodynamic response, patient access during ophthalmic surgery is often very limited and airway manipulation may be difficult should a state of deep sedation occur. In view of these safety concerns, 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.
- 13.3.17** Patients do not need to be starved when sedative drugs are used in low doses to produce simple anxiolysis. Patients should be starved when deeper planes of sedation are anticipated or sedative infusions employed.

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.

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

13.3.11 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.

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.

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.

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

13.3.16 Patients exhibit extremely wide variation in response to drugs used for sedation. Coupled with this uncertain pharmacodynamic response, patient access during ophthalmic surgery is often very limited and airway manipulation may be difficult should a state of deep sedation occur. In view of these safety concerns, 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

13.3.14 Owing to the risk of life threatening complications, sharp needle-based blocks (e.g. peribulbar or retrobulbar block) should not be administered by non-medically qualified personnel. 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

5.2.2.4 Where general anaesthesia is administered, monitoring and anaesthetic equipment, and appropriate lighting is provided to enable safe delivery of the full range of anaesthesia.

EVIDENCE REQUIRED

Verbal confirmation from staff especially if they feel that any equipment is lacking based on the procedures undertaken.

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

13.2.5 All necessary anaesthetic equipment should be available. Devices and equipment should be suitable for the task for which they are used, and should conform to verified standards. Equipment should be maintained and serviced regularly.

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

2

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

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

STANDARD

5.2.3.1 There is comfortable access to the theatre suite and 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

- 13.2.16** Optimal patient positioning is critical to the safe conduct of ophthalmic surgery and for patient comfort. Adjustable trolleys/operating tables which permit correct positioning should be available.
- 13.2.17** 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

13.2.17 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

Copies of written information should be provided.

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, which 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.

STANDARD

5.2.4.1 All ophthalmic theatre nurses, anaesthetic nurses and ODPs 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.

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. clinical governance meeting minutes. 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.

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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