SOP- Provision of Emergency Eye Care

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Document Managed by Name:	Mr. Yahya Khedr
Document Managed by Title:	Eye Casualty Lead, Ophthalmology
Contact details for further information:	hyp-tr.policies@nhs.net
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11/05/2021	V10	Helen Cook	Updated to ARC validation process and process for seeing patients out-of-hours on Ward 35
16/01/2023	V11	Yahya Khedr	Update regarding changes in ARC clinic, ARC booking system and referral email. Update regarding changes since the closure of Ward 35 and its conversion to Ophthalmic Day Unit (ODU). Update regarding changes since easing the COVID restriction. Update regarding the current TTOs. Updated the Acute Referral Triage Form in Appendix 2.
13/07/2023	V12	Yahya Khedr	Update regarding the procedure for adding emergency patients to theatres. Added the Transient Ischaemic Attacks (TIA)/ Cerebrovascular accidents (CVA) referral pathway Added the Emergency addition to theatres list form in Appendix 3. Added the Emergency patient booking form (V1) in Appendix 4.
30/12/2023	V13	Yahya Khedr	Update regarding Paediatric Ophthalmology patients review out of hours.

Contents

1. Summary

The purpose of this Standard Operating Procedure (SOP) is to provide detailed guidance on the day-to-day operation of the Emergency Eye Care service based in the Eye Hospital and outline the roles and responsibilities of staff working in the service.

2. Purpose, Legal Requirements and Background

Hull University Teaching Hospitals NHS Trust is committed to providing patient centred care, ensuring consistency in delivery of high quality, safe care.

The Ophthalmology service operates from the Hull University Teaching Hospitals NHS Trust within the Eye Hospital which is a stand-alone facility located on the Hull Royal Infirmary site. The department provides a dedicated ophthalmic outpatient, theatre, emergency and in-patient service. An Ophthalmic Acute Referral Clinic (ARC) service also operates during office hours from Eye outpatients and out of office hours from the Ophthalmology Day Unit (ODU), providing urgent and emergency assessment and treatment as either in-patient or outpatients.

There is an emergency ophthalmic assessment and treatment service 24 hours a day, seven days a week for 365 days of the year. This service operates a booked appointment system (see below) with no facility to accept “walk-in” self-referrals. The Emergency Eye Care service comprises an appointment based Acute Referral Clinic (ARC) service, which runs within defined hours supplemented by an additional emergency care service delivered outside these hours for patients deemed to have eye conditions that require emergency assessment and treatment outside ARC clinic hours as they may be sight- or life-threatening.

The service is operated in line with the Royal College of Ophthalmologists’ (RCOphth) Ophthalmic Services Guidance for Emergency Eye Care Services and the RCOphth Way Forwards Emergency Eye Care guidance. The service is under the clinical leadership of the Clinical Lead for Emergency Eye Care. The day-to-day operational management is jointly led by the Consultant on Call for the day and the Senior Sister for Eye Outpatients/ Ophthalmology Day Unit (ODU) (depending on whether daytime or evening/ weekend).

The purpose of this Standard Operating Procedure (SOP) is to provide detailed guidance on the day-to-day operation of the Emergency Eye Care service based in the Eye Hospital and outline the roles and responsibilities of staff working in the service.

3. Responsibilities, Accountabilities and Duties

It is the responsibility of all staff (clinical and non- clinical) who are involved in delivering Emergency Eye Care to follow the guidance in this SOP.

4. Policy/Procedure/Guideline* Details

4.1. Acute Referral Clinics (ARC)

The Acute Referral Clinic (ARC) service operates from the Eye Hospital ground floor outpatient area in B Pod from 09.00-17.00 hours Monday to Friday. The service operates a booked appointment system. Patients seen in ARC clinics in standard hours will be seen by the medical or non-medical team and have a clinical assessment. Access to supplementary diagnostic tests including visual

field, orthoptic assessment, OCT scanning, fluorescein angiography, etc is usually available on an ad hoc basis.

Outside these hours, Emergency Eye Care is delivered as:

- Weekday evenings:
    - Patients needing to be seen out of hours by the on call doctor can be booked after 6pm following closure of the Eye Clinic
    - At 5:30 pm the lead nurse within Eye Casualty/ ARC will ring the ward staff on the Ophthalmology Day Unit (ODU) and let them know how many patients are still waiting to be seen and how many after 6pm ward attenders there are.
    - Any patients who have started to be seen in ARC in the Outpatient clinic should complete their treatment pathway supported by the star 6's in clinic.
    - Any patients who are still waiting after 6pm from the afternoon session/ on call will be escorted to Ward 35 and the sessional doctor will move across to see them over there.
    - ARC time-slots should not be amended and ARC sessions should not be over-booked.

- For Saturdays:
    - An Acute Referral Clinic (ARC) runs in the Ophthalmology Day Unit (ODU) in the Eye Hospital. There are fixed appointment slots between 09.30-12.30 hours on supported by two rostered Ophthalmology nurses

- For Sundays and Bank Holidays:
    - There are no formal ARC clinics on Sundays/ Bank Holidays however, patients can be seen on ODU by the Ophthalmology doctor on-call and the Ophthalmology nurse on-call.
    - On Saturday, Sunday and Bank Holidays, the first on-call Ophthalmology doctor will take the emergency calls and make a clinical decision as to whether the patient needs to be seen as an emergency "ward attendance" on ODU the same day or if the patient could be safely seen in a booked ARC appointment. The first on-call doctor will utilise the Eye Emergency Triage system which operate a Red/ Amber/ Green system to prioritise emergency referrals (see Appendix 1). If the patient needs to be seen as an ODU attender outside ARC hours the First On-Call doctor will arrange with the patient a suitable time to attend H35 and inform the Ophthalmology Nurse on-call that the patient is attending out-of-hours.

Patients seen on Ophthalmology Day Unit (ODU) will have clinical assessment undertaken by the First On-call doctor who will have access to appropriate ophthalmic diagnostic equipment and treatments in line with Royal College Emergency Eye Care guidance[1] although ancillary testing including visual fields, orthoptic assessment, OCT scanning, fluorescein angiography will not be available out-of-hours and patients may need to re-attend for additional diagnostic testing in standard office hours.

4.2 Emergency Eye Care Provision for Patients Not Medically Fit to Attend the Eye Hospital

In-patients (HRI and CHH) and main Emergency Department (ED) patients requiring urgent eye assessment who are not medically fit enough to attend the Acute Referral Clinic or to attend for emergency review on ODU in the Eye Hospital are seen by the First On-Call doctor on their in-patient ward/ Main ED via the Trust white card referral system or via doctor to doctor telephone referral for very urgent cases.

Eye assessment on a ward or in Main ED will be limited as not all the equipment required to make a full assessment will be available away from the Eye Hospital facilities, hence the First on Call doctor will need to make a clinical assessment in consultation with the responsible/ referring doctor as to whether the patient is or is not medically fit to attend the Eye Hospital for emergency assessment.

4.3 Emergency Eye Care Service Staffing

The Emergency Eye Care service is staffed by rostered Ophthalmic Speciality Trainees (FY3 and ST level), SAS Ophthalmology doctors, trained Eye Emergency Nurse Practitioners, Trust Principle Optometrists and Optometrist Consultants from 9.00-17.00 Monday to Friday and by the first on-call Ophthalmology doctor outside these hours.

Rostered Ophthalmic Doctors (FY3, ST or SAS grade) are timetabled for specific weekly sessions in the ARC Monday to Friday. If they are on leave there is a rostered 2nd and 3rd cover doctor who covers the relevant session instead of their usual timetabled session. Trust Optometrists will always have a doctor rostered alongside them in the ARC. Annual and Study leave approvals are overseen by the Ophthalmology Business Manager who confirms there is a back-fill doctor available to cover the leave. If there is no available 2nd or 3rd cover doctor due to prior leave approval the leave application would be declined.

The first on-call Ophthalmology doctor provides out of hours cover for the ARC, including evenings, weekends and Bank Holidays. The on-call cover starts at 8 am daily except at weekends where the on-call starts at 8 am Saturday until 8 am Monday. The first on-call doctor will be rostered their usual timetable during the day but is still responsible for the management of ward referrals, including seeing in-patients on their own ward if not fit enough to attend the ARC clinic in a booked daytime slot. Ophthalmology specialist trainees who have been first on-call are entitled to a rest period starting at 1 pm following their weekday on-call day/ evening/ night. Ophthalmology specialist trainees who are rostered to be on-call on Saturday/ Sunday have a rest day on the Friday before the on-call weekend plus are on a rest period starting 8 am on the following Monday. Non-training grade doctors (including Trust Grade or SAS doctors) are not currently contractually entitled to rest periods after on-calls.

The first on-call doctor from the preceding day is responsible for undertaking a formal handover to the doctor taking over the first on-call at 8 am. Ideally, this should be done in person and should include handover of outlying patients seen on other wards not fit enough to attend the ARC plus any other patients seen on an out-patient basis who require further follow-up/ immediate action on an out-patient basis. Any patients referral from overnight that was given an appointment into the ARC clinic by the first on call who might not be due to be in the hospital in the morning due to rest day or admin/study session, then the patients' details (name, DOB, NHS number, mobile number) and a brief description of the referral should be sent to

hyp-tr.eyecas.diary@nhs.net which is checked by the nurses in ARC clinic every morning, and the patients will be booked accordingly.

Non-Medical Practitioners (Nurse Practitioners and Trust Principle Optometrists/ Optometrist Consultants) assessing and treating patients in the Emergency Eye Care service have completed formal training in line with the Royal College of Ophthalmologists' Common Clinical Competency Framework for Acute and Emergency Eye Care[2] and have been competency assessed prior to independent practice in this service (see below). Non-Medical Practitioners will assess and treat patients within their training and competency and will seek advice from a doctor if required (see below).

The service is also supported by rostered out-patient Registered Nurses and Health Care Assistants from 09.00-17.00 Monday to Friday.

Patients attending the ARC between 09.00-17.00 hours, report to the Main Eye Hospital Reception desk on arrival. The Reception Desk is manned by the Administration Team staff.

The out-of-hours Acute Referral Clinic on ODU requires the support of a nurse skilled in performing visual acuity assessment, pupil dilation and appointment management. This role is routinely performed by the rostered non-registered nurse on ODU following additional training and with additional support from the ophthalmic registered nurse for any specialist procedures if required. When ODU is closed, the Ophthalmic Nurse on-call will support the on-call doctor. If a patient needs to be seen as an emergency on ODU outside of ARC clinic hours the following process should be followed:

- Doctor on call will clarify which registered nurse is covering the on-call prior to the on-call shift. This information and staff mobile phone numbers are kept at ward level. The rostered nurse on call is also written on the ward white board. Weekend on-call doctors also receive a copy of the weekend plan via email which includes details of on-call nurses and their contact numbers.
- Doctor on-call will contact the Ophthalmic Nurse on-call directly by telephone to make arrangements to meet on ODU in preparation for the patient's arrival
- Once the Doctor on-call and the Nurse on-call are present on ODU the On-call nurse will arrange transfer of any patients from the Trust ED Department.

The on-call consultant for the day provides named clinical responsibility for the Emergency Eye Care service. All patients seen are allocated to the on-call consultant as the named consultant until the point the patient is discharged or transferred to sub-speciality care as appropriate. The on-call consultant should be informed of any patients requiring senior input or admission. The on-call consultant will be contactable by phone for phone advice and will arrange to see any patients requiring senior in-put in person if required. The on-call consultant has a responsibility to formally hand-over details/ management plans of any admitted in-patients and other outstanding clinical issues which may require out-of-hours senior clinical input to the next on-call consultant at the end of their on-call period.

There is a named on-call Consultant for Vitreoretinal emergency cases, identifiable from the on-call rota who will be contactable at all times. This named on call Vitreoretinal Consultant will be the single point of contact for any urgent vitreoretinal case related clinical queries in and out of standard

working hours. The on-call vitreoretinal Consultant will provide advice for urgent Vitreoretinal emergency cases and coordinate access to theatre for any cases requiring emergency surgery.

4.4 Referrals to the Emergency Eye Care Service

The Emergency Eye Care service does not provide a walk-in service for patients. The ARC has booked appointment slots in a diary (see 3.5 below).

Telephone referrals are accepted from:

- GPs
- Community Optometrists
- Minor Injury Units
- Main Emergency Department
- Other sub-speciality doctors within HUTH
- Doctors caring for in-patients who have developed eye problems at HRI or CHH
- Existing Ophthalmology patients who hold a Recurring Ophthalmic Condition (ROC) yellow cards
- Patients who are post-operative following ophthalmic surgery including Intravitreal Injection treatment who are provided with the eye emergency telephone number to seek advice regarding new symptoms suggestive of possible post-operative complication

The telephone number for the Acute Referral Clinic is: 01482 816658 or 01482 608788, Option 2. The dedicated number for GPs and optometrists to call to refer patients is: 01482 816625.

Telephone referrals are accepted and triaged by the Emergency Eye Care Nurse Triage team between 08.30-17.00 hours Monday to Friday. The Emergency Eye Care Nurse Triage team are registered nurses who have undergone training in telephone triage and use the Hull and East Yorkshire Eye Hospital Emergency Eye Care Triage guidance (Appendix 1) to determine priority for clinical assessment. Patient demographic and clinical history details from the telephone triage event are recorded in the Telephone Triage form (Appendix 2). GPs and optometrists are also asked to fax a referral letter to the Emergency Eye Service email: Hyp-tr.arceyes.nurses@nhs.net

Following collection of the relevant demographic and clinical history details the Triage Nurse (after discussion with a member of the medical team if necessary) will make a clinical decision regarding clinical priority and triage the referral as red, amber or green as per Appendix 1. The decision, including clinical symptoms/ signs and names/ details of staff involved in the decision making process, will be recorded in the completed Telephone Triage form.

Patients triaged as:

- **RED** priority patients should be seen the same day in a booked “RED” ARC appointment slot by the registered Triage Nurse or if the call is received too late in the day to book into a RED appointment slot, the First On-Call doctor should be consulted to arrange an appropriate time for the patient to be seen as a “ward attender” on ODU that evening.

- **AMBER** priority patients should be seen within 48 hours
    - The referral should be passed on to the On-Call Consultant the same day (Monday to Friday) by the Triage Nurse team so that the On-Call Consultant can make a clinical

decision as to the most appropriate clinic to see the patient in within 48 hours. This may be in an AMBER ARC appointment slot or may be in a more appropriate sub-speciality clinic such as the urgent corneal clinic or the MACFC virtual clinic for suspected wet macular degeneration cases, etc.
    - The On-Call Consultant will liaise with the Outpatient Senior Nursing Team and Eye Administration team to identify a suitable appointment as above.

- **GREEN** priority patients require routine assessment and should be passed on to the Administration team by the Triage Nurse to be logged via Lorenzo as a routine referral and have an appointment decision form attached in line with all routine referrals to the Eye Clinic.

Weekdays in the evening and weekends/Bank Holidays urgent telephone referrals from GPs, Community Optometrists, Minor injury Units and Main ED sources are diverted via Switchboard to the First On-Call doctor. Patients contacting the department out of hours will receive a recorded message sign pointing them to the main hospital ED in the event of an emergency. The Nursing Team on ODU are responsible for ensuring the recorded message is turned on when closing ODU.

For all out of hour's referrals the First On-Call Doctor should collect the relevant patient demographic and clinical history details using the Telephone Triage form and decide on clinical priority guided by the Triage Protocol as above. The Triage form must be signed and dated by the person making the decision re priority.

Red priority referrals should be seen the same day or, if referred after midnight and deemed clinically appropriate, could be seen at the start of the morning ARC clinic. If clinically required, patients would be seen on Ophthalmology Day Unit (ODU) at any time unless the patient was medically unfit to be seen on ODU, at which point, the First On-call doctor would arrange to see the patient on their in-patient ward/ Main ED. Portable equipment required to make an initial assessment of a patient away from the Eye Hospital is taken by the First On-Call Doctor to the relevant area as required. The First On-Call Doctor is responsible for the safe return of this equipment to ODU so that the equipment is available to use when required.

The ODU House Keeper checks that all Ophthalmic equipment are present and in working order every morning Monday-Friday.

4.4.1. Intravitreal Injection/ Wet Macular Degeneration patient self-referrals:

Patients undergoing intravitreal injections are given an advice slip to contact the department if they are experiencing symptoms that may be suggestive of endophthalmitis. A telephone triage form should be completed for all intravitreal injection patients who contact the ARC in order to establish if they have symptoms suggestive of urgent conditions related to a recent injection including endophthalmitis, or due to other pathology such as giant cell arteritis, that require urgent assessment in ARC.

For patients with delayed or deferred injection treatment and those who are in the monitoring phase after completion of a treatment course, who are reporting visual symptoms, the telephone triage form should be completed to identify if there is any underlying urgent disease process causing the visual symptoms. Once this process has been completed and it is established that the visual symptoms are most likely due to the delayed/ deferred intravitreal injection or recurrent wet macular

degeneration, causing worsening of the underlying disease an urgent MACFC appointment should be requested (within 5 days).

4.4.2. Patients Reporting Worsening Symptoms via the Acute Referral Clinic Telephone Line

Existing follow-up patients or patients awaiting first assessment after initial referral who contact the ARC Emergency number to report worsening symptoms should have their call details logged on a paper triage form (Appendix 2) including relevant clinical information. The Triage form should be passed onto a relevant clinician, i.e. ARC Nurse Practitioner, Trust ARC Optometrist or member of the medical team to make a clinical decision regarding possible expedited clinical assessment. The clinical decision should be recorded on the paper Triage form and in Medisoft and the appropriate appointment should be booked as soon as possible. The patient contact should also be recorded in Medisoft as an audit trail of date of contact and nature of contact.

4.4.3 Transient Ischaemic Attacks (TIA)/ Cerebrovascular accidents (CVA) referral pathway

All TIA/stroke patients seen in ophthalmology during the hours of 0800-1900hrs (Mon-Fri) and 0800-1300hrs (Weekends/bank holidays) are to be referred to the stroke unit via a telephone call to the on-call Stroke Physician via Switchboard whilst the patient is still in the department so that they can be reviewed in person at the same hospital visit. Patients outside of those times can be referred via email (hyp-tr.referrals@nhs.net) using the TIA referral form which is present in room B2 or the Eye Casualty Diary folder.

For patients being referred via email, please ensure that you have entered a working telephone number for them on the scanned TIA referral form and they should also be informed that they will be contacted urgently and so need to have their phones with them or stay at home.

The stroke unit can thrombolyse patients with acute retinal artery occlusion. This will mean that patients with a confirmed acute retinal artery occlusion associated with visual loss with an onset within the last 4 hours should be referred **very urgently as an emergency (24/7) to the stroke team**. This information needs to be made clear at the time of referral including retinal findings.

4.5 Acute Referral Clinic Appointment Booking System

Patients are booked into the ARC paper diary by the Triage Nurse team after completion of a Telephone Triage form.

Patients should not be routinely over-booked into a session. In the event of more Red priority patients being referred in a session and there are no available appointment slots, then the On-Call Consultant should be consulted regarding diverting Amber priority patients into other appropriate clinics or amending Amber priority patient's appointments to the following day (if can still be seen within the 48 hour timescale).

Nurse Practitioner clinical sessions should be booked with patients who from clinical triage are likely to have an anterior segment of the eye condition. These cases could be Red or Amber triage cases. Level 3 non-medical practitioners including Trust Principle Optometrists/ Optometrist Consultants

can see any ARC referrals but should escalate/ seek advice from a doctor if appropriate depending on the findings of the clinical assessment (see below).

Telephone Triage forms and referral letters should be passed on to the Administration team at the end of each clinic so that they can be scanned into Lorenzo and logged as a clinical attendance. The forms and letters from the evening/ weekend “ward attender” ARC/ urgent assessment visits are placed in the folder at the front of the ARC Diary and each morning they are collected by the ARC nurses then passed on to the Eye Administration Team for cashing up/ scanning of documentation.

4.6 Responsibilities of Staff Undertaking Clinical Assessment in the Emergency Eye Care Service

Medical and Non-Medical Healthcare Practitioners working in the Emergency Eye Care service are expected to work within the limits of their competency and training and seek advice/ input from more senior medical staff if clinically indicated. This may be a more senior Speciality Trainee, the On-Call Consultant for the day or a relevant sub-specialist SAS or Consultant who is working in the Out-Patient clinic or theatre that session.

Medical and Non-Medical staff should undertake formal assessment of the patient considering the clinical history and undertake a relevant clinical examination. Relevant ancillary diagnostic tests should be undertaken as clinically indicated and depending on availability (limited range of ancillary tests available outside of Monday-Friday day time hours).

Clinical findings are recorded in the Medisoft electronic patient record system as the Eye Emergency service operates as a paper-free system. Medisoft should be used to generate a GP letter which is printed off and posted to the GP practice. Patients should be given printed information leaflets regarding their condition where appropriate.

If following clinical assessment, a medical or non-medical healthcare practitioner feels that the case needs input from a more senior member of the team/ a medical member of the team from non-medical healthcare practitioners, it is the responsibility of the doctor/ non-medical healthcare practitioner to discuss the case with an appropriate member of the ophthalmic medical team.

Staff seeing patients in the Emergency Eye Care setting work within the governance framework of the Ophthalmic department and the Trust. Incidents should be reported via the Datix incident reporting system.

4.7 Training and Competency assessment of Non-Medical Healthcare Practitioners in the Emergency Eye Care Service

The Triage Registered Nurse team are working at Level 1 in the RCOphth Common Clinical Competency Framework.

Emergency Eye Care Nurse Practitioners are working at Level 2 in the RCOphth Common Clinical Competency Framework. Emergency Eye Care Practitioners can prescribe within their competency and via Patient Group Directions (PGDs).

Trust Optometrists (Optometrist Consultant/ Principle Optometrist) are working at Level 3 in the RCOphth Common Clinical Competency Framework. Staff working within this role will have completed the Independent Prescriber qualification. Level 3 staff must work within the limitations of their independent prescriber qualification and will need doctor input to prescribe some systemic drugs. Level 2 and Level 3 non-medical staff have appropriate Lorenzo permissions/ access to order investigations including blood tests/ radiology investigations appropriate to their level of training and competency.

Non-Medical Healthcare Practitioners complete the training and competency assessment process relevant to their role (see associated training and competency assessment packages for each staff group).

Following initial assessment by Level 2 Non-Medical Healthcare Practitioners there must be escalation to a Medical Practitioner at the same visit for all cases where there are:

- Positive neurological clinical signs including acute onset visual field loss, afferent pupillary defect, reduced colour vision, swollen optic disc/s
- Symptoms/ signs suggestive of possible Giant Cell Arteritis
- Symptoms/ signs suggestive of raised intracranial pressure
- Acute onset diplopia
- Penetrating trauma
- Orbital trauma with positive signs (diplopia, reduced vision, pupillary defect etc.)
- Uveitis with posterior segment involvement, extensive fibrin or hypopyon
- Suspected post-operative/ post-injection endophthalmitis
- Positive retinal signs suggestive of vascular occlusion (arterial or venous)
- Suspected wet macular degeneration
- Suspected microbial keratitis
- Raised intraocular pressure ≥ 30 mmHg with applanation tonometry
- Symptoms/ signs suggestive of sub-acute angle closure glaucoma
- A history of flashing lights and floaters for an indented or three mirror peripheral retinal assessment to exclude retinal tears
- Retinal detachment
- Symptoms/ signs suggestive of amaurosis fugax
- Patients with corneal grafts to exclude rejection episodes
- Patients with proptosis with or without periorbital cellulitis
- Acute onset ptosis
- Acute onset anisocoria with head/ neck pain
- Patients with unexplained visual loss after initial clinical assessment
- Patients with positive systemic symptoms/ signs to exclude serious systemic disease, e.g. fever, nausea, vomiting, muscular pain, swollen joints, loss of appetite, cough, etc, etc
- Other cases at the discretion of the Level 2 practitioner where they feel appropriate to escalate the case to a doctor.

Following initial assessment by Level 3 Non-Medical Healthcare Practitioners there must be escalation to a Medical Practitioner at the same visit for all cases where there is likely to be a requirement for:

- Neurological assessment/ imaging
- Medical Retina team input due to posterior segment involving uveitis/ hypoyon/ extensive fibrin
- Admission
- Surgical intervention
- Systemic medication
- Systemic assessment, etc
- Escalation to a doctor for advice/ input at the discretion of the Level 3 practitioner.

4.8 Process for Admitting Patients Seen Via the Emergency Eye Care Service

High risk emergency cases require urgent admission and access to specialist diagnostics and treatment provided by ophthalmologists and ophthalmic nursing staff.

In hours the senior nurse in the ARC will contact the FWHG Bed placement who will escalate through the appropriate channels. Capacity permitting female ophthalmic patients will be admitted on to Cedar ward. Female ophthalmic patients that are unable to be accommodated on Cedar ward will be allocated a bed within the HRI surgical bed base. Male ophthalmic patients requiring admission will be allocated a bed within the HRI surgical bed base. Following the identification of the admitting ward the ARC nurse will hand over patient details and plan of care to the nurse in charge of the receiving ward.

Out-of-hours, the on-call Ophthalmology Nurse will contact the Site Matron team to identify a suitable bed. The Ophthalmology nurse on-call will accompany the patient to the admitting ward and provide a direct nursing handover.

Any ophthalmology patient that is admitted on to an outlying ward should be recorded on the ward attender white board on Ophthalmology Day Unit (ODU) to ensure continuity of care.

Patients who are likely to require admission include:

- Acute angle closure glaucoma
- Orbital cellulitis
- Ocular trauma
- Optic neuropathy
- Endophthalmitis
- Orbital haemorrhage
- Giant cell arteritis
- Other conditions suspected to be potentially sight-threatening and requiring emergency assessment and treatment

A written admission should be completed on Ophthalmic Trust paper for filing in the hospital notes when a patient is admitted plus a brief entry on Medisoft. A written admission/ a comprehensive Medisoft printout is required as non-Ophthalmic staff involved in multi-disciplinary care of the patient are unable to access Medisoft and there should be a record of the history, past ophthalmic and medical history, drugs, allergies, eye examination, investigations, and management plan, etc recorded for good patient management. The written record will be updated daily during the ward round and if there are any other additional updates/ changes in management, etc. All entries should be signed and dated.

A drug chart, eye drop prescription chart and a VTE form in Lorenzo should also be completed.

Patients deemed medically unstable should be admitted under the care of the Medical Team with daily review of their ophthalmic condition.

Patients who become acutely unwell whilst admitted under the care of ophthalmology on the ODU should be initially assessed by an Ophthalmic doctor if one is present on the ward. If there is no ophthalmic doctor present on the ward, the first on-call doctor should be contacted for advice.

The Ophthalmic First On-Call doctor is non-resident on call so may not be present on site in the event of a medical emergency affecting an Ophthalmic in-patient. If the patient is deemed to be seriously unwell by the Ophthalmic doctor/ Registered Nursing team, the Deteriorating Patient Outreach Team/ Hospital at Night Team and RMO covering the wards at HRI should be contacted urgently for support/ advice.

The first on-call doctor is responsible for formal handover of all in-patients including patients resident on other wards who need ophthalmic follow-up. See Section 4.3 above for details of the handover process.

In-patients admitted under the care of Ophthalmology must be appropriately reviewed in the morning and handed over as appropriate to the in-coming on-call team. The logistics of the morning review will depend on the COVID status/ COVID screening status of the individual patient; the clinical condition of the patient and the physical location of the patient and will need to be arranged with consultation with the on-call team and staff on ODU and Eye Outpatients depending on the specific scenario.

4.9 Follow-Up of Patients Seen via the Emergency Eye Care service

Patients requiring follow-up in the Eye Clinic after an ARC or an out of hour's emergency attendance should <u>not</u> be routinely booked back into the ARC for follow-up.

The doctor/ non-medical healthcare practitioner seeing the patient should make a clinical decision as to whether the patient could be discharged or if a follow-up appointment is required and the timescale for follow-up. A clinic outcome slip should be completed for each visit. The Registered Nurse or Healthcare Assistant working in the ARC is responsible for collecting all the outcome slips for each patient seen in the ARC at the end of the session and placing them in the folder for on-call consultant validation as per the process below.

All outcomes for patients seen via ARC will be validated by the on-call consultant using Medisoft for the clinical details required to make a clinical decision. The consultant on-call for the day (Monday-

Friday) will validate all outcome slips which are placed in a folder in the B Pod cubby hole marked "Awaiting Validation". The on-call consultant for Monday will also validate the outcomes for the previous Friday afternoon and the weekend. If a consultant has a split week/ mid-week single day on-call swap, the consultant of the day would be expected to pick up the validation for the preceding afternoon. Once validated, the outcome forms will be placed in the second folder in the B Pod cubby hole marked "To Action". The "To Action" folder will then be passed on to the Admin team to arrange appropriate follow-up/ discharge formally in Lorenzo as appropriate. The on-call consultant will complete the validation process twice/ day Monday-Friday, ideally lunchtime and late afternoon, although the exact timing of the validation process will vary depending on the clinical timetable of the consultant on-call for the day.

If the consultant on call agrees with the management plan they will sign the outcome slip, ideally in RED pen. If the Consultant on-call disagrees with the management plan Medisoft will be updated to reflect the amended management plan and the incorrect plan will be struck through on the outcome slip and the new plan will be added to the outcome slip. The slip will be signed (ideally in RED pen).

The Nursing Team in ARC is responsible for taking validated outcome slips to the Admin team to action.

If a patient requires follow-up within 24 hours the ARC doctor/ AHP/ Optometrist seeing the patient must contact the on-call consultant by telephone to verbally discuss the case and confirm that review within 24 hours is appropriate.

4.10 Assessment of Paediatric Emergency Patients

Paediatric patients referred to the ARC are seen by the ARC Medical/ Non-Medical Healthcare Practitioner team as per adult patients. However, wherever possible Paediatric cases are booked into ARC sessions where there is a parallel Paediatric Ophthalmology outpatient session running so that the Paediatric Ophthalmology Nursing and Medical team are on hand to provide advice/ input if required.

Paediatric patients should wait in the designated Paediatric Waiting Area in the Orthoptic Department.

Children requiring emergency assessment out-of-hours must not be assessed on ODU. They should either be assessed in the Paediatric Emergency Department (the slit lamp in ED Minors can be used for Paediatric assessments) if being referred from Paediatric ED or seen as a ward review patient using portable slit lamp/ indirect on Ward H200 (Paediatric Assessment Unit)/ Ward H20 (Woodland Ward) in tower block on the second floor if the patient is an inpatient. Any other Paediatric referrals from outside the hospital that require Ophthalmology review, will need to be seen on Acorn Ward (Women and Children's Hospital, first floor) where there is a slit lamp located in the treatment room. You would need to take the on call grab bag from B Pod in the eye clinic, with eyes drops, applanation cones, or any lenses you would need with you as there are no accessories there.

Children requiring emergency admission are admitted onto the paediatric ward in the Tower Block at HRI. All Paediatric admissions should be discussed with the Paediatric Medical team as shared care may be required. Paediatric cases requiring surgery will need to have surgery on a list with Paediatric anaesthetic cover and this will need to be arranged either in Main Theatres or in the HRI

Day Case unit if there is a suitable Ophthalmology Day Case list already arranged. Please discuss with the On-Call consultant and/ or Paediatric Ophthalmology team.

Non-medical practitioners with Independent Prescriber qualification assessing children must confirm that the dosage of any medication prescribed is correct by confirming the prescription with a doctor.

4.11 Prescribing Emergency Medication

If a patient requires commencing on medication urgently, during standard working hours the patient should be issued with a white Trust Pharmacy prescription to collect the required medication from the Trust Pharmacy. If the patient has mobility issues/ has attended on Hospital Transport a green FP10 prescription can be issued so that the patient/ patient's carer can obtain the medication from a convenient local outside Pharmacy.

The Trust Pharmacy is open:

Opening Hours at HRI Dispensary

Day	Opening	Closing
Monday - Friday	8.30am	5.45pm
Saturday	9.30am	4.45pm
Sunday	9.30am	3.45pm
Christmas Day	09.00am	3.00pm
Good Friday	8.30am	5.45pm
All other bank holidays	10.00am	3.45pm

Opening Hours - Lloyds Outpatient Pharmacy

Day	Opening	Closing
Monday - Friday	8.30 am	6.00 pm
Saturday	10.00 am	2.00 pm
Sunday	Closed	Closed
Christmas Day	Closed	Closed
All other bank holidays	10.00 am	2.00 pm

Outside these hours, if the patient does not require admission but requires to commence on emergency medication immediately, a green FP10 prescription can be issued if the patient is able to access the emergency community pharmacy in a timely manner to ensure that the medication is started promptly.

There is a supply of Take Home Emergency (TTO) medication packs for:

- Oral Acetazolamide.
- Chloramphenicol eye ointment.
- Tobradex eye drops.
- Yellox eye drops.
- Predforte 1% eye drops.
- Exocin 0.3% eye drops.
- Oral Co-amoxiclav 625mg.

- Oral prednisolone 5mg x 40 tablets (must only be prescribed after consultation with on-call consultant).

Patients issued with TTO medication from ward H35 should have a white Trust Pharmacy prescription completed and the on-call ophthalmic nurse should record the patient's details and TTO issued in the Pharmacy TTO Log-Book and place the white Trust Pharmacy prescription form in the Pharmacy TTO Log-Book for collection by the ward Pharmacy team later to ensure adequate top-up supply of TTO packs.

If it is considered medically essential that a patient should start emergency medication immediately and there is concern that the patient will not be able to access the medication promptly, the patient may need to be admitted to ensure timely commencement of the appropriate treatment to prevent patient harm.

4.12 Emergency Ophthalmic Surgery

Patients admitted as an emergency via ARC or as out-of-hours ward attenders who require emergency ophthalmic surgery must be notified to the on-call consultant. Urgent Vitreoretinal cases should also be discussed with the Vitreoretinal Team.

A dedicated ophthalmic theatre is required to perform emergency ophthalmic surgery and be equipped to allow intraocular and extraocular surgery. Theatre lists must also be supported by nursing staff with expertise in ophthalmic surgery and use of specialist equipment. The ophthalmic theatre team aim to accommodate emergency cases where feasible during the week, Monday-Friday until 18.00 This may involve cancellation of less urgent cases to facilitate. Cases should be discussed with the on-call consultant and relevant surgeon plus sister in charge of theatres as soon as possible to see if there is space to add an emergency case to a list, along with filling the ''Emergency addition to theatre list form – Ophthalmic theatres' pink slip (Appendix 3)'' which is found in the theatre sister's office as well as on the ward. There is access to ophthalmic theatres for emergencies only between 0800-1800 Saturday, and 0800-1400 Sunday and Bank Holidays. Cases requiring surgery where it is deemed urgent to operate should be added to the Main Theatres board by filling the ''Emergency patient booking form – Main theatres pink slip (Appendix 4)'' if an ODP/ Anaesthetist is required, then attending the morning emergency theatre meeting to assess priority of all the cases and secure a rough time slot. In the later situation, the ophthalmic theatre's pink slip should also be filled out at the same time in order to notify our own theatre team of the emergency patient. An ODP/ Anaesthetist will then attend the Eye Hospital to support the case once the case is at the top of the priority list in Main Theatre. Other more medically urgent cases may affect the possibility of proceeding with surgery at the weekend/ Bank Holiday.

Local anaesthetic lid repair cases where the patient is otherwise medically fit can only proceed in Eye Theatres with an ODP at the weekend/ Bank Holiday and with the support of the Ophthalmic Theatre team.

Between the hours of 1800 and 0800 Monday to Saturday and 1400 Sunday/ Bank Holidays to 0800 Monday/ next working day there is no ophthalmic surgical cover. Emergency cases requiring surgery who present from either the community or as inter-specialty referrals, during these hours should be discussed with the on-call consultant, where access to the next available list can be planned. There is no evidence that endophthalmitis rates are increased by delays of up to 24h for open globe injuries.[5] There is consensus opinion amongst the ophthalmic community that

operating with ophthalmic trained staff, together with dedicated resources during planned lists, results in superior clinical outcomes.[6]

Documented Ophthalmic emergencies which may require surgical intervention as soon as possible but do not require access to a theatre include:

- Intravitreal needle biopsy and intravitreal antibiotics in endophthalmitis
- Lateral canthotomy/cantholysis in orbital compartment syndrome

These cases should be undertaken in a clean room/ treatment room setting to minimise delay in treatment.

Multi-trauma cases with possible eye involvement which are taken to theatre due to life-threatening injury should aim to save life in the first instance and it is not expected that Ophthalmology would be required to surgically intervene in the primary emergency surgery. The on-call doctor may be required to attend to undertake an EUA during the life-saving surgery but any ophthalmic injury identified would most appropriately be managed as a secondary procedure once the patient had been medically stabilised.

Cases with extensive haemorrhage from periocular tissues where bleeding is not controlled with standard emergency compression/ elevation may require emergency out of hour's theatre input from Plastics/ Maxillofacial Surgery teams.

Cases with suspected necrotising fasciitis involving periocular tissues may require emergency out of hour's theatre input from Plastics/ Maxillofacial Surgery teams.

In working hours:

- The case should be discussed with the on-call consultant who will liaise with relevant surgical colleagues depending on the nature of the case to identify a suitable timeslot in theatre.
- This may require cancellation of less urgent cases to facilitate the surgery and if this is the case the Business Manager must also be informed.
- The Senior Sister in Theatre and on ODU must be informed re cases requiring emergency surgery. Demographic details and proposed type of surgery details should be given to the theatre team to allow the case to be added to Ormis.
- The surgeon must liaise with the Theatre Team regarding equipment required for the case and planned surgical time.
- The Anaesthetist covering the list must also be informed.

Out of working hours

- If clinically safe the case should be planned for the next working theatre list, i.e. following morning list for a case presenting in the evening during the week with an aim to operate within 24 hours for penetrating injuries.
- The First On-Call doctor should liaise with the On-Call Consultant and Senior Nurse on ODU to review which cases could potentially be cancelled on the next morning list to accommodate the emergency case, as well as, filling the Ophthalmic theatres emergency form present in the theatre sister's office.

- The relevant consultant whose list is affected should be informed regarding the changes to their list by the On-Call Consultant ideally the same evening or by 7.30 am the following morning if the case is admitted after midnight.
- The Business Manager must be informed re cancelled patients.
- The senior Sister in theatre must be notified re list changes/ new additions to the list ASAP in the morning as per process above.
- The Anaesthetic team must also be informed ASAP re list changes/ new additions to the list as above.

Pre and postoperative care should be provided by nurses experienced in the care and treatment of patients undergoing ophthalmic surgery to ensure correct post-operative care is given including correct patient posturing, instillation of topical eye treatments and early recognition of post-operative complications such as raised intraocular pressure which requires prompt medical treatment to prevent sight- loss.

4.13 Referrals to Other Specialities

- **Urgent Rheumatology referrals** should be sent with clinical details as an email request to: hyp-tr.rheum.referrals@nhs.net
- **Urgent MRI Scan reports** can be chased by calling the On call Neuroradiology Consultant.
- **Urgent TIA clinic referrals** should be sent with clinical details after filling the TIA form and logging it in the TIA book, then email to: hyp-tr.referrals@nhs.net

5. Process for Monitoring Compliance

- Policy is reviewed 6 monthly for updating.
- Compliance is regularly monitored and a local audit is conducted every 2 years.

6. References

1. Royal College of Ophthalmologists' Ophthalmic Services Guidance: Emergency Eye Care in Hospital Units and Secondary Care, August 2017. (https://www.rcophth.ac.uk/wp-content/uploads/2017/08/Emergency-eye-care-in-hospital-eye-units-and-secondary-care.pdf)
2. Royal College of Ophthalmologists' Common Clinical Competency Framework for Non-Medical Ophthalmic Healthcare Professionals in Secondary Care- Acute and Emergency Care, November 2016 (https://www.rcophth.ac.uk/wp-content/uploads/2017/01/CCCF-Acute-Emergency-Care.pdf)
3. Hull University Teaching Hospitals NHS Trust Ophthalmology Department Standard Operating Procedure for Closure of Ward H35, September 2019.
4. The Way Forward: Emergency Eye Care. The Royal College of Ophthalmologists 2017.
5. Thompson WS, Rubsamen PE, Flynn HW, Jr., Schiffman J, Cousins SW. Endophthalmitis after penetrating trauma. Risk factors and visual acuity outcomes. Ophthalmology 1995;102:1696-701
6. Kuhn F. Strategic thinking in eye trauma management. Ophthalmol Clin North Am 2002;15:171-7.

7. Equality Impact Assessments (EIA)

As part of its development this document and its impact on equality has been analysed and no detriment identified.

8. Appendices

Appendix number	Description
Appendix 1	Emergency Eye Care Triage Protocol for Hull and East Yorkshire Eye Hospital Acute Referrals
Appendix 2	Acute Referral Telephone Triage Form
Appendix 3	Emergency addition to theatres list form
Appendix 4	Emergency patient booking form (V1)

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Appendix 1 – Emergency Eye Care Triage Protocol for Hull and East Yorkshire Eye Hospital Acute Referrals

	OFFER SAME DAY APPOINTMENT	SEE WITHIN 48-72 HOURS	FOR ROUTINE REFERRAL ONLY
COMMON OPTOMETRIC REFERRALS	IOP > 40mmHg or suspected angle closure with symptoms	IOP 35-40mmHg AND no pain	IOP < 35mmHg
	Hypopyon	New flashes and floaters (offer appointment within 5 days of onset)	Unequal pupil size with normal vision AND no ptosis AND no new squint AND no pain
	Corneal ulcer in a CL wearer	Corneal staining with no ulcer	Dry eyes
	Macular on retinal detachment	Corneal ulcer in non-contact lens wearer	Macula hole/epiretinal membrane
	New floaters with tobacco dust and visual loss		Dry macular degeneration
	Optic disc swelling with reduced vision		
	Optic disc swelling with symptoms of raised ICP (headache/vomiting/pulsatile tinnitus) SEND DIRECTLY TO GENERAL A & E		
VISUAL DISTURBANCE	Sudden loss of vision with temporal headache or diagnosis of central retinal artery occlusion	Severe, acute visual loss without eye pain or headache (unless CRAO diagnosed)	
	New double vision with temporal headache	Distortion with macular haemorrhage suggestive of wet AMD (REFER TO MACFC)	
	New visual field defect with temporal headache	Isolated visual field defect noticed by patient (not on fields)	

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	OFFER SAME DAY APPOINTMENT	SEE WITHIN 48-72 HOURS	FOR ROUTINE REFERRAL ONLY
	Increased floaters with curtain like visual loss		
	Haloes and ocular pain		
	Severe visual loss < 6/36 with ocular pain		
	New sub-macular haemorrhage/ acute loss of vision with new central scotoma in known wet AMD patient		
TRAUMA	Possible penetrating eye injury	Corneal foreign body (nurse practitioner can see)	Longstanding ocular findings from previous trauma
	Chemical injury (advise to start irrigation)	Corneal abrasion not responding to treatment (nurse practitioner can see)	
	Blunt trauma with hyphaema/iris damage	Blunt trauma with no hyphaema/iris damage	
	Lid laceration	Blunt trauma and new floater	
	Trauma in a grafted eye		
EYELIDS	New unilateral ptosis and dilated pupil (SEND DIRECTLY TO A & E)	Preseptal cellulitis or acute dacryocystitis in an adult	Lid malposition (ectropion, entropion, age related ptosis) Suspected lid skin cancer- melanoma/ SCC to be seen within 2 weeks; BCC see routine
	Severe lid swelling WITH proptosis, reduced vision and/or diplopia (SEND DIRECTLY TO A &E as needs CT head to rule out orbital cellulitis or haemorrhage)	Herpes zoster with eye involvement	
	Known thyroid eye disease with acute loss of vision OR new eye pain	New diagnosis of myasthenia gravis by neurologists	
RED EYE	Red eye with associated pain, loss of vision, vomiting or malaise	Itchy or sticky eye with blurred vision and not responding to over the counter medications (nurse practitioner can see)	Itchy or sticky eyes with normal vision and symptom duration > 1 month
HEADACHE	Temporal headache with amaurosis or diplopia or severe visual loss (ie. Must rule out GCA)		
	Acute onset anisocoria (unequal pupils) with associated head/ neck pain		
PAEDIATRIC	Corneal foreign body	Abnormal pupil reflex	

	OFFER SAME DAY APPOINTMENT	SEE WITHIN 48-72 HOURS	FOR ROUTINE REFERRAL ONLY
	Lid cellulitis in a child < 4 years old	Lid cellulitis in child > 4 years old	Acute onset squint- see as URGENT in Paediatric Ophthalmology clinic
	Conjunctivitis in a baby < 1 month old	Ocular pain (reported by child)	
	Suspected swollen optic discs with systemic symptoms (headache/ nausea/ vomiting/ fever/ malaise)- Refer direct to Paediatric Medical Team to exclude neurological emergency	Suspected swollen optic discs with visual symptoms	Optometrist incidental finding of suspected swollen optic discs with no systemic/ visual symptoms
EXISTING PATIENTS	Post-op intraocular surgery/injection < 2/52 with pain, reduced vision or discharge	Post-op intraocular surgery < 2/52 without Pain or reduced vision but new complaints	Injection patients c/o gritty eyes can be reassured to use lubricants ONLY if within 24-48hrs of last injection. Otherwise need same day review
	Glaucoma surgery patients with new severe visual loss OR pain	New distortion or reduced vision in known AMD patients (book into MACFC)	
	Any corneal graft patients	Herpes simplex keratitis with new symptoms	
	Oculoplastic patients with signs suggestive of wound infection	Diabetic retinopathy with acute severe loss of vision	

Appendix 2 – Acute Referral Telephone Triage Form

Ophthalmic OPD Telephone triage sheet

Date: Time: Member of staff completing the form:

Patient Details
Name:
DOB: NHS no.:
Contact phone no.:
Contact details of referrer: (if different from above)
Source of referral (please circle): GP OPT ED/MIU SELF OTHER

Presenting Symptoms	**Past Ophthalmic History**
	PMH

Signs & Symptoms	Y	N	Duration	Nature	Signs & Symptoms	Y	N	Duration	Nature
Eye pain					Photo sensitivity				
Redness					Floaters				
Discharge					Flashing lights				
Watering					Distortion				
FB sensation					Reduction in VA				
Contact Lens wearer					Visual Field Loss				
Lid swelling					Diplopia				
Headache					Systemic symptoms				

RED (SAME DAY APPT)	**AMBER** (SEE WITHIN 48HRS)	**GREEN** (ROUTINE – CONS. FRONT SHEET)	OTHER

Triage discussed with:	Date & Time:
Date & time of appt:	Clinic:
Email requested YES/ NO	Patient informed Sign: PHONE: LETTER:

Active **COVID** symptoms (cough/fever/loss of sense of taste or smell):

REQUIRED TESTS/ DROPS:

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Appendix 3 – Emergency addition to theatres list formw

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EMERGENCY ADDITION FOR THEATRE LIST

PATIENT DETAILS

PATIENTS NAME DATE OF BIRTH HEY NUMBER SURGEON ADD A PATIENT STICKER

SURGICAL PROCEDURE				
ANAESTHETIC TYPE	SUBTENONS LOCAL GENERAL	DOES THE PATIENT HAVE A LATEX ALLERGY	YES NO	HAS THE PATIENT BEEN ADMITTED ON THE WARD/DAY CASE AREA

YES	NO
IF YES, PLEASE PROVIDE THE NAME OF THE PERSON WHO HAS CANCELLED THE PATIENT	

SIGNED.....DATE.....

COMPLETED FORM TO BE TAKEN DIRECTLY TO THE CHARGE NURSE IN THE THEATRE OFFICE

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Appendix 4 – Emergency patient booking form (V1)

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Emergency Patient Booking Form (v1)

To minimise errors, write clearly within the boxes or mark with an x where appropriate

Patient and Operation details...all details must be answered before booking can be confirmed

Date and Time	/ /	:

Patient Name/sticker	Patient unit number;	M/F
	Patient date of birth;	WARD FROM
	POST OP BED BOOKED	WARD TO
	Y N	
Infection status;		

Other relevant patient information/specific equipment requirements	Operation please be specific	PREFERRED THEATRE
		PATIENT READY FOR THEATRE Y
		TIME

SURGEON DETAILS

ADMITTING CONSULTANT;	DECISION TO OPERATE MADE BY;	NAME AND CONTACT OF PERSON MAKING THIS BOOKING;
OPERATING SURGEON;	CONTACT NUMBER;	TIME SURGEON AVAILABLE;

COVID INFORMATION TESTED Y / N DATE/TIME OF TEST .....

COVID STATUS POSITIVE / NEGATIVE DATE/TIME .....

ANAESTHETIC CLEARANCE

ANAESTHETIST CONTACTED Y N	NAME OR GRADE	SEEN BY ANAESTHETIST Y N

Only patients of the following categories can be booked on the emergency list

code	Time period (from booking)	PRIORITY INDICATION
URGENCY 1	IMMEDIATE	LIFE THREATENING URGENCY
URGENCY 4	4 HOURS	ORGAN/LIMB THREATENING URGENCY WITH POTENTIAL TO THREATEN LIFE
URGENCY 4	4 HOURS	ORGAN/LIMB THREANTING URGENCY. RISK OF DECOMPENSATION OR ORGAN DYSFUNCTION
URGENCY 12	12 HRS OR LESS	NON CRITICAL URGENT, BUT SPINAL PROBLEM MAY DETERIORATE
URGENCY 24	24 HRS OR LESS	NON CRITICAL, NON EMERGENT. NO IMMINENT DETERIORATION EXPECTED
URGENCY 48	48 HRS OR LESS	THIS PATIENT IS STABLE AND NO DETERIORTION EXPECTED FOR 48 HRS

Please record any delays or reason for cancellation in this space and on ORMIS