

## RCOphth: Management of Ophthalmology Services during the Covid pandemic

\*Please note the coronavirus situation changes rapidly. This is the most up to date advice we have at this time, please check the Gov.UK website:

<https://www.gov.uk/government/collections/coronavirus-covid-19-list-of-guidance>

and the RCOphth website for updated information

<https://rcophth.ac.uk/2020/03/covid-19-update-and-resources-for-ophthalmologists/>

### Guiding principles

The risk of patients acquiring COVID-19 infection during an ophthalmology appointment must be weighed against their risk of coming to harm through failure to treat serious eye disease. The RCOphth recommends the following be implemented at NHS clinics, private practice, and independent treatment centres with immediate effect:

All routine ophthalmic surgery should be postponed

1. All face-to-face outpatient activity should be postponed unless patients are at high risk of rapid, significant harm if their appointment is delayed
2. Ophthalmology Accident and Emergency services should stay open with consultant level support for both triage and seeing patients
3. Routine diabetic retinopathy screening should be postponed, with provision made for high risk situations eg pregnancy

### Prioritising and Managing Patients – Put plans in place

Hospitals and eye units need to have plans to prioritise care for patients who have sight or life threatening conditions, to deliver non face-to-face care and to defer appointments for non-urgent elective surgery, outpatients and low risk patients.

All non-urgent elective operations, low risk or non-urgent outpatient care should be suspended immediately with plans to review and rebook as required. You should discharge all in-patients who are fit to leave. For unplanned attendances, low risk patients with minor eye conditions (eg conjunctivitis) should be diverted with appropriate advice on self-management, the likelihood of spontaneous resolution and red flag symptoms. A senior ophthalmologist or consultant should supervise urgent and A&E clinics.

Urgent and emergency eye services must not cease for patients with sight or life threatening conditions who require urgent treatment. When undertaking urgent surgery, restrict general anaesthesia to cases where there is no other option but to use a general anaesthetic.

Communication systems should be put in place to manage and advise patients on their condition and care. There should always be a nominated senior ophthalmologist available to support communications with patients and provide advice to community optometrists and GPs. Eye patients should be given accurate and reassuring advice regarding risks of coronavirus infection and protecting against avoidable loss of vision, patients need to be

reassured that those who need to come will be protected as much as possible from covid infection risks and those who are asked not to come will be protected as much as possible from harm to eye condition and sight

For patients who still need some care but are not high enough risk to warrant hospital attendance, use other forms of consultation, such as telephone review or virtual clinics. See RCOphth guide to telemedicine systems which are compliant with healthcare requirements. The College has an escalation plan detailing low, medium and high risk cases for each subspecialty (that can be further adapted as required for local use) and shared resources from Moorfields Eye Hospital and other units.

Draw up plans for future service maintenance for emergency-only patients should the situation seriously deteriorate. Ensure that senior trust leaders understand that some ophthalmology services for conditions which are imminently sight, eye integrity or life threatening with requirement to be treated urgently MUST CONTINUE, especially if the patient is under 70 and the only/better seeing eye is affected. These include:

- Glaucoma
  - acute glaucoma
  - uncontrolled very high IOP >40mmHg or rapidly progressive glaucoma
- Wet active age-related macular degeneration
- Sight threatening treatable retinovascular disease (proliferative diabetic retinopathy and ischaemic CVRO)
- Acute retinal detachments (macular on, macular off < 4weeks)
- Uveitis – severe active
- Ocular and adnexal oncology - active, aggressive, uncontrolled or untreated lesions
- Retinopathy of prematurity (screening and treatment)
- Endophthalmitis
- Sight threatening trauma
- Sight threatening orbital disease eg orbital cellulitis, severe thyroid eye disease
- Giant cell arteritis affecting vision

Patients within likely medical conditions which require urgent treatment eg acute third nerve palsy, Horner's syndrome, retinal artery occlusions, stroke, giant cell arteritis and papilloedema may be better served seen by the medical or general A&E team.

## Managing face-to-face appointments

### Before arrival in clinic

Work with your clinical lead for ophthalmology and your hospital infection control team to ensure messages reach patients that, if they are at risk or symptomatic, they should check before attending and can assess their symptoms online through the NHS 111 online symptom checker.

Communicate effectively through trust website pages, letters and text alerts, recorded messages on the hospital phone line, posters in clinic. Ensure admin staff at the front of the hospital or in reception know about eye patient protocols. Proactively call patients with scheduled appointments.

### **Detect at-risk patients**

Ask patients whether they have symptoms of coronavirus infection, particularly a fever including acute onset persistent/continuous cough but also hoarseness, shortness of breath, sore throat, wheezing, muscle pains.

You should also establish if the patient has or has had contact with a known or likely coronavirus infected person or if they have travelled to any at risk area.

Follow the detailed guidance on case definition and risk and categorise as detailed by Public Health England. Ideally the patients are temperature checked. For unplanned attendances, establish if they have an immediate sight threatening issue but do not let that delay any required isolation or sending the patient home.

Ensure that you have a suitable isolation room agreed with IC and you know where it is, or use the nearest room and shut the door if necessary. Ensure you have a supply of PPE and understand how to use this including removal after use.

### **PPE and infection control**

Ophthalmologists and other ophthalmic clinical professionals performing similar clinical assessments are in prolonged close contact with patients and may be at higher risk than some other specialties. Follow the advice in our PPE table and other PHE latest guidance.

We recommend use of a breathguard. There are various possibilities for sourcing these including commercial slit lamp breathguards eg from Zeiss, Haag Streit, Daybreak Medical and Star Optical. All such guards will require regular cleaning with alcohol after every consultation. See RCOphth COVID-19 page.

### **Reducing exposure for those who must attend**

- Minimise onsite waiting time / patient journey time
- Implement social distancing in waiting areas
- Limit the number of accompanying adults with the patient in waiting rooms and avoid accompanying relatives in examination rooms unless absolutely necessary
- Reduce workforce-patient contact time
- Keep more than two meters away from patients except where clinical examination requires it
- Establish as much of the medical and ophthalmic history, or investigation results, as possible before calling the patient into the room including potentially via phone or video
- When testing visual acuity, start from the lowest achievable line to speed things up
- Keep the examination brief and pertinent to the decision making required
- Avoid re-examination of patients who have already been assessed
- Avoid investigations (visual field, OCT, ultrasound) unless critical to decision making
- Do not use airpuff tonometry; use I care tonometry or similar and confine Goldmann slit lamp tonometry to those in whom its critical for care
- Minimise lengthy procedures at the slit lamp

- Use other investigations if they can provide the required clinical information and reduce the time of close contact eg at slit lamp or gonioscopy eg. van herick, ret cam, optos, OCT, anterior segment cameras, ultrasound
- Use treatment changes that can reduce the frequency of required attendances for the next few months eg changes in intravitreal treatment regime or longer-acting drug or procedure
- Provide injection only clinics for wet AMD and other conditions where possible – it is acceptable to treat without visual acuity and OCT testing if necessary to protect patients and maintain service
- Where appropriate use an indirect ophthalmoscopy in preference to slit lamp examination for laser delivery

### **For immunosuppressed and vulnerable patients**

Immunosuppressed patients needing to attend uveitis or inflammatory disease clinics are at high risk medically and review by telephone or video triage should be used in place of face-to-face attendance where clinically appropriate. Where this triage identifies vision loss or other very high risk situations, they should be invited to attend face-to-face with efforts to isolate them from other patients via a dedicated clinic area or time period.

Try to arrange local blood test taking and remote monitoring for therapy, and make arrangements to continue supply of their medicines by registered post or local pharmacy. Follow the Academy of Medical Royal Colleges guidance on identifying and writing to such patients.

It is also important to formulate an action plan now to protect other vulnerable patients (pregnant, old and frail, serious systemic co-morbidities) in terms of deferring treatment or seeing away from other patients in crowded areas.

### **Workforce**

Plan to support, utilise and deploy staff to maintain services and to cover gaps. Some staff will be deployed to general medical care services and refresher training will be provided. Make rotations and contingency plans with 1st, 2nd, 3rd tier teams to cover as staff go off, including for on-call. Think how non-clinical staff can be trained and used to support outpatient clinical care.

Consider segregating staff into teams with those dealing with covid + patients and those dealing with covid -ve patient (“hot” and “cold” teams), to minimise risks to patients and staff.

Colleagues who are at an increased risk, as defined by NHSE guidance, should speak with their line manager in order to make adjustments to their working conditions, but with the aim of being able to continue to work where possible, eg working remotely or moving to a lower risk area.

Visit the PHE and NHSE websites for more information, links are on RCOphth COVID-19 web page.

It is important that clinical leads support staff at this time and look after their own well-being.