Sandwell and West Birmingham Hospitals NHS
NHS Trust

# Standing Operating Process (SOP)
# Adult Ophthalmic Emergency Theatre Patients

| Theme | Details | Whom |
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| **Purpose of the SOP:** | Clear guidance of surgical treatment pathway for ophthalmic emergency patients at the Birmingham & Midland Eye Centre - to be used in conjunction with the SOP for Vitreo-Retinal Emergency Patients and Temporal artery biopsies. | |
| **Inclusions/ Exclusions** | **Inclusions;** All patients requiring ophthalmic surgery within 48 hours of presentation to resolve / support diagnosis of sight threatening conditions.<br><br>**Exclusions**; All Children including Children under the age of 1 as per SWB Anaesthetic Policy, patients scheduled for elective surgery, VR emergency patients and TAB's.<br><br>  <br>Guidelines-for-the-ca<br>re-of-children-and-yo | |
| **Ophthalmic Emergency Booking Process** | It is the responsibility of the referring clinician to obtain authorisation from the consultant on call to progress with an emergency theatre booking and discuss and agree management which then needs to be communicated to all parties including;<br><br>- Theatres<br>- Ward<br>- Anaesthetist on call<br>- Ophthalmic General Management<br>- Sub-specialty consultant colleague if required<br><br>Please see embedded emergency booking form document that needs to be completed;<br><br>xxxxx<br><br>All necessary clinical details including any past ophthalmic history need to be recorded for assessment. All sections on the form are mandatory and will be audited. The form is completed by the referring ED or OPD clinician at BMEC, including an appropriate consent form. Once completed this is taken to BMEC Theatres | Referring clinician<br><br>Referring clinician<br><br>Practitioner in Charge |

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| | and handed over to the Practitioner in Charge who will add to the emergency board.<br><br>As part of the decision making process the following needs to be considered;<br><br>- Review current in hours lists to see if there are any unutilised time/cancellations.<br>- Is the patient appropriate for an out of hours theatre session<br>- Does the 4th on call have the skillset required to complete the case<br>- If access to the in hours emergency theatre is required, discussion is held with the surgeon of the allocated emergency theatre (unless sub-speciality is required) who would identify elective patients that are clinically appropriate to be postponed as the emergency patient takes clinical priority.<br>- A verbal communication from the consultant on call to the emergency allocated consultant is to take place to deem the level of urgency compared to the booked day case patients for the day in that allocated theatre, to decide the slot allocation for the operating surgeon.<br>- Patients that need to be postponed are notified at the earliest possible opportunity once a decision has been made regarding the update of the scheduled emergency allocated theatre for the day.<br>- All decisions must be communicated to the theatre practitioner in charge during the theatre huddle.<br>- If the general emergency patient is not an inpatient on the ophthalmic ward, the patient is to be informed to starve and once agreement has been made the ward clerk is to be informed to contact the patient to arrive to the ward and inform them that there surgery is now booked for the day.<br>- Communication to service managers is then provided from the theatre manager regarding the update scheduling for the theatre to ensure management of sitreps and long waiters can be scheduled to an alternative day. | Referring clinician |
| **Clinical priority guidelines** | **Intraocular injuries:**<br><br>-Penetrating Eye Injuries – globe rupture and corneal perforation (most likely to be an inpatient)<br><br>-Anterior chamber wash out e.g. Hyphaema | |

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| | - Vitrectomy/Vitreous TAP/Intravitreal antibiotics for Endophthalmitis<br><br>- Intraocular foreign bodies (most likely to be an inpatient)<br><br>- Corneal Melt/perforations – (possible inpatient)<br><br>**Extraocular injuries:**<br><br>Lid lacerations involving the canaliculus (Will need Oculoplastic discussion)<br><br>Lid lacerations<br><br>Extraocular foreign body removal<br><br>EUA – especially in children and vulnerable adults. | |
| **General Ophthalmology Theatre Capacity** | Currently there is one theatre session (AM & PM) allocated on the Theatre Rota as the nominated 'emergency list' (Monday to Friday), to ensure a fair distribution of emergency cases and reduce potential disruption to booked cases over the month.<br><br>Emergency theatre lists will always be allocated to general anaesthesia on the theatre rota.<br><br>Currently, elective lists are booked to full utilisation as not all sessions will require emergency activity to take place.<br><br>BMEC theatre staff are rostered for 1 theatre on Monday to Friday from 17.00 – 20.00 for the purpose of undertaking emergency work, this would normally be led by the evening 4th on call Doctor, depending on the type of case. Patient needs to be in recovery by 19.15. There is an on call anaesthetist also available on evenings until 20.30.<br><br>At the weekend, one theatre is covered by an on call from 08.00-20.00. The staff require an hour's notice and can be contacted from 08.00. This would normally be led by the 4th on call (for general emergencies) or VR fellow (for VR emergency patients only). The on call anaesthetist is then contacted via switch by the 4th on call. | |

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| **Clinical prioritisation** | Any emergency theatre that requires a sub-speciality consultant input should have a consultant to consultant handover.<br><br>Should more than one emergency be listed, the on call consultant will have the final decision as to which case takes clinical priority, having discussed with the appropriate sub-specialty representatives. | |

## Emergency Theatre Pathway Flow chart