26 March 2020

Ophthalmology Services during COVID-19

The ROYAL COLLEGE of OPHTHALMOLOGISTS

Protecting Patients

During the COVID-19 pandemic, ophthalmology departments have a duty of care to protect patients, many of whom are at highest risk, being over 70 and with significant comorbidities. Any measures taken to protect eye patients should be consistent with action being taken elsewhere in the NHS and in the wider community.

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. In this context, The Royal College of Ophthalmologists recommends the following actions, to be implemented at NHS clinics, private practice, and independent treatment centres with immediate effect:

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

Specific exemptions:

There will clearly be patients who need to be seen and treated urgently. These may include, but are not limited to, those with the following condition which are imminently sight or life threatening with requirement to be treated urgently, especially if the patient is under 70 and this is their only/better seeing eye. These include, but are not limited to:

- 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 CVRO)
- Acute retinal detachments (macular on, macular off < 4weeks)
- Uveitis – severe active
- Ocular 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

Decisions regarding such patients must be based on their risk of significant harm if treatment is delayed.

Mitigating risk:

Ophthalmologists should review all waiting lists and outpatient clinics with a view to identifying patients that need surgery or to be seen in clinic. Patients who are deferred should be provided with appropriate advice by telephone and/or letter, and departments

26 March 2020

should organise effective telephone advice to patients concerned about their postponed appointments.

Clinics and operating lists should be organised to minimise the time patients spend in the department and the number of other patients and staff they encounter. For example, it will be necessary to reduce the number of anti-VEGF injections per list, to enforce staggered arrival times, to use longer acting anti-VEGFs and to treat with ongoing injections with no clinical review.

Protecting the Workforce

1. Full implementation of the measures to protect patients should reduce clinical activity by around 80 to 90% and is the first and most important step to protecting staff.
2. The next step is to review how many members of staff need to be physically present in the eye department.
    a. Staff should only be present if there is a clinical need for them to be there. Some ophthalmology departments are dividing their staff into two teams, taking it in turns to provide the required clinical service on a weekly or fortnightly basis. Those working from home should expect to be called in to cover for sick colleagues. This model may not be appropriate for all eye departments, and ultimately may break down if staff are redeployed to other areas of their hospital.
    b. Administrative tasks should, where possible, be undertaken from home or in individual offices away from clinical areas.
    c. Only clinicians capable of making decisions should see patients.

3. Personal Protection Equipment (PPE)
    In line with advice with recommendations from Public Health England, the College is advising the following approach to the use of PPE

    A. Patients with no respiratory symptoms and no COVID-19 risk factors:
        - Clinicians should wear standard surgical masks, when examining or treating patients at the slit lamp. Gowns and gloves are not recommended
        - Plastic breath shields attached to slit lamps provide some protection but must be disinfected between patients because studies show that the COVID-19 virus is viable for up to 72 hours on plastic surfaces
        - Avoid speaking at the slit lamp

    B. Patients with suspected or proven COVID-19 infection
        - Patients should be seen in a designated area within the eye department

- Clinicians should wear a fluid repellent mask (FFP3 mask if aerosol generating procedure), gown or apron, gloves and eye protection (face shield or goggles)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874411/When_to_use_face_mask_or_FFP3.pdf

Michael Burdon
President, The Royal College of Ophthalmologists