Minor Eye Conditions Service v

Minor Eye Conditions Service (MECS) Pathway & Protocols

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Primary Eyecare (Stockport)
&
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Stockport MECS
Minor Eye Conditions Service

STOCKPORT
- LOCAL
- OPTICAL
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Outline Description

A Minor Eye Conditions Service (MECS) examination (often called Primary Eyecare Assessment and Referral Service assessment - PEARS) will provide a timely assessment of the needs of a patient presenting with an eye condition. This will be undertaken by an accredited optometrist within suitably equipped premises who will manage the patient appropriately and safely. Management will be maintained within the primary care setting for as many patients as possible, thus avoiding unnecessary referrals to hospital services. Where referral to secondary care is required it will be within agreed protocols to a suitable specialist with appropriate urgency.

Patients can self-refer and will be sign-posted from GPs, pharmacists, A&E, Stepping Hill Hospital Eye casualty telephone triage or optometrists.

Purpose of Service

Using the skills of primary care optometrists to triage, manage and prioritise patients presenting with an eye condition, patient care will be improved by:

- Reduction in unnecessary referrals to eye casualty clinics thus supporting SNHSFT to manage ophthalmology capacity
- More cost-effective care
- Speedier access to care
- Care closer to home in a more convenient setting
- Easier access for patients through self-referral
- Retention of patients in primary care where possible
- Reduction in antibiotic prescribing

Description

Patients can be signposted into the service by their own GP or the practice nurse (or surgery receptionist). There is a list of participating optometrists for the patient to choose from. Optometrists must, within reason, be able to offer an acute MECS examination within 48 hours of the day that the appointment has been requested by the patient, GP or pharmacist (excluding Sundays and public holidays). Where this is not possible, an appointment must be found for the patient with an accredited colleague nearby.

For acute potentially sight threatening eye conditions the optometrist should arrange to see the patient within 24hrs (e.g. recent onset flashes and floaters).

The urgency and eligibility of the assessment under this service must be determined by telephone triage. It is expected that front line ancillary staff within practices will perform this function. Where ancillary staff are unable to determine the urgency or in certain complex cases the accredited optometrist must follow up the telephone triage.
See appendix F and the separate guidance for details of the Telephone Triage.

The level of examination should be appropriate to the reason for referral. All procedures are at the discretion of the optometrist. Guidelines for the commonest eye conditions are listed below. It is recommended that practitioners utilise the College of Optometrists' Clinical Management Guidelines which can be found on their website www.college-optometrists.org/en/professional-standards/clinical_management_guidelines/index.cfm and on the Medicines Support Unit website for optometrists www.med-support.org.uk.

Follow up care must be provided where clinically necessary. It is expected the majority of patients seen by the MEC Service will not need a follow-up appointment.
Where follow-up is needed, the provider will be expected to use their clinical judgement to book the appointment within an appropriate timescale for the condition being treated. Where possible, the follow-up appointment will be booked before the patient leaves their first appointment.

If a patient cancels an appointment, within reasonable notice, the practice must arrange an alternative appointment at least once. This must be within a reasonable time frame in terms of clinical appropriateness and patient experience.

Should a patient fail to arrive for their appointment (first appointment or follow-up), the practice will be expected to contact the patient by telephone within 24 hours informing them that they have missed their appointment, giving them appropriate advice and asking them to rearrange. If this is not possible, a letter should be sent and if no response any referring clinician should be notified. A record of these instances should be kept on the IT platform for quality monitoring purposes.

All aspects of this pathway (outlined on Diag1, page 5), from telephone triage, assessment, reporting etc. must be documented on the IT platform, which will be the recording, auditing and invoicing platform.

A GOS sight test or private eye examination may also be required but it would be unusual for this to be carried out at the same time as a MECS examination. Practitioners should at all times respect the patient's loyalty to their usual optometrist and not solicit the provision of services that fall outside the scope of the service. The patient's details should NOT be added to the practice reminder system for the purpose of sending recall letters for regular eye examinations, unless the patient expressly requests it.

Children under 16 years of age should be accompanied by a responsible adult.

The criteria for inclusion of patients may include the following:

- Loss of vision including transient loss
- Ocular pain
- Differential diagnosis of red eye
- Foreign body and emergency contact lens removal (not by the fitting practitioner)
- Dry eye
- Blepharitis
- Epiphora
- Trichiasis
- Differential diagnosis of lumps and bumps in the vicinity of the eye
- Flashes/floaters
- Patient reported field defects

Exclusion criteria
The following cases will not be **treated** by the service.

- Patients identified in advance to have severe eye conditions which need hospital attention e.g. orbital cellulitis, temporal arteritis
- Eye problems related to herpes zoster
- Adult squints, long standing diplopia
- Removal of suture
- Patient's reported symptoms indicate that a sight test is more appropriate than this service
- Repeat field tests to aid diagnosis following an eye examination
- Suspected cancers of the eye
- Age related macular degeneration

Patients cannot be treated by the MEC service if their signs or symptoms indicate they are more suitable for the following locally enhanced services:

- Direct referral for cataract and post-operative cataract care
- Intra-ocular pressure service
- Diabetic retinopathy

It is recognised that as patients are self-referring it is possible that they may attend the service with a condition which is excluded for treatment but requires assessment and onward referral to an appropriate eye service. This patient assessment by the MEC Service is classed as an episode of care and payment will be made.

Outcomes

Outcomes resulting from the consultation are likely to be one of the following:

- MEC accredited clinician manages the condition, and offers advice and/or prescribes/recommends medication. A follow up consultation may be necessary
- MEC accredited clinician carries out a minor clinical procedure e.g. eyelash removal or foreign body removal. A follow up consultation may be necessary
- MEC accredited clinician diagnoses of the condition and refers the patient in line with the referral guidelines

It may be that as a result of the consultation that the MEC accredited clinician feels that the patient's overall eye health would benefit from a standard eye examination and recommends an eye test (NHS/private).

Following assessment of a patient's condition, onward referral may be required to either:

- Hospital ophthalmology services
- One of the other primary care eye conditions services
- Other health services e.g. GP

Onward referral will be made to the appropriate service with appropriate urgency.
See information provided on Stockport Local Optometry Committee website
www.stockportloc.co.uk/

Routine onward referral to ophthalmology services at SNHSFT will be made to the patient's GP by letter or secure electronic transfer. In the instance of patients with urgent symptoms, they will be advised to attend A&E or booked in to a hospital eye casualty clinic as appropriate and in accordance with agreed protocols. The proportion of patients who will need onward referral to secondary care is expected to be low.

Minor Eye Conditions Care Pathway

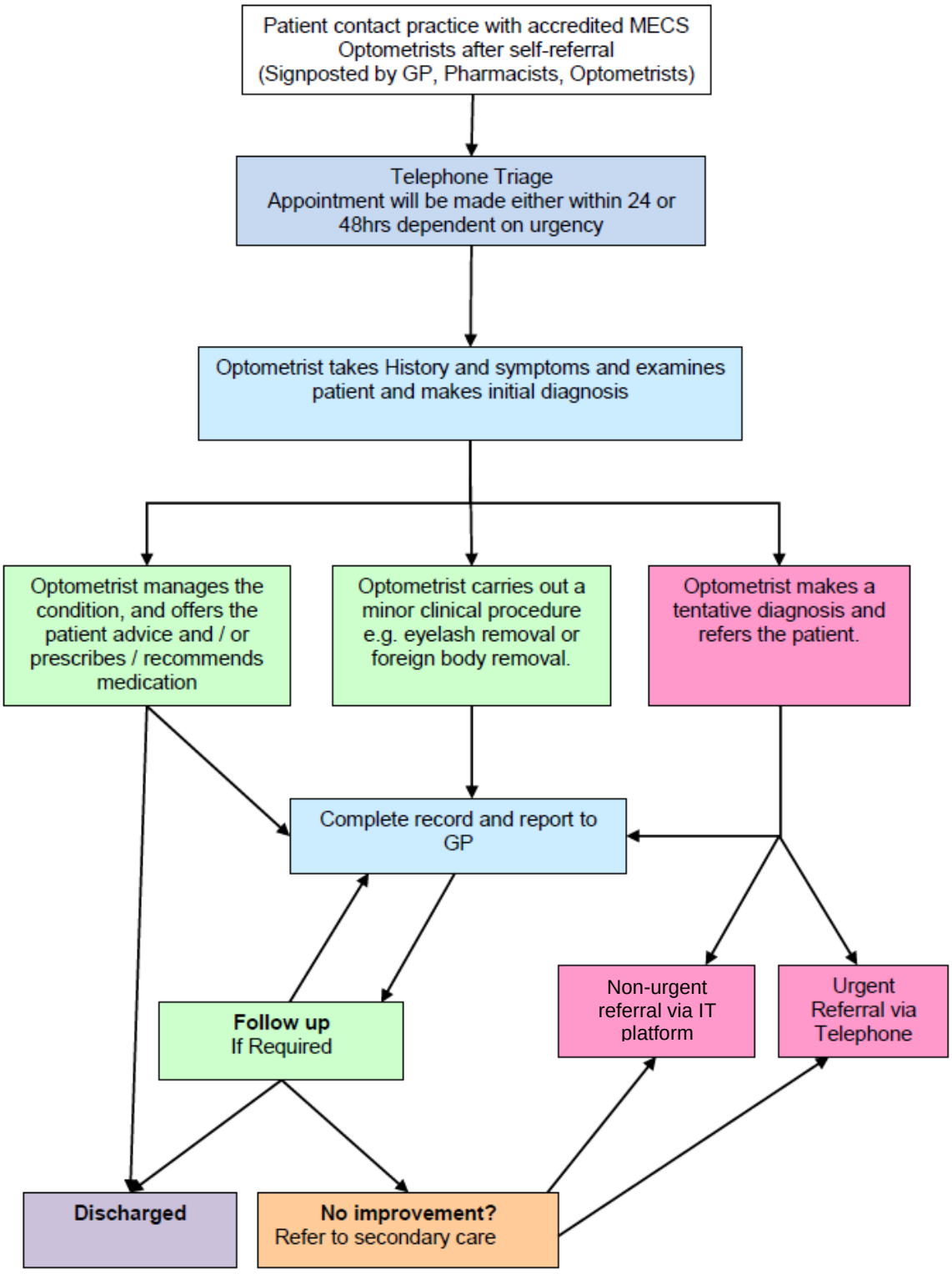


Diagram 1

Supply of Therapy

Registered Optometrists may sell or supply all pharmacy medicines (P) or general sale list medicines (GSL) in the course of their professional practice, including 0.5% Chloramphenicol antibiotic eye drops or 1% eye ointment. Optometrists may give the patient a written (signed) order for the patient to obtain the above from a registered pharmacist, as well as the following prescription only medicines (POMs).

- Chloramphenicol
- Cyclopentolate hydrochloride
- Fusidic Acid
- Tropicamide

Note that (P) Chloramphenicol is only licensed for use with bacterial conjunctivitis. For prophylactic use the POM licensed version is required and this this requires a written order to the pharmacist unless the "emergency" caveat is met.

In making a supply to the patient the optometrist must ensure:

- Sufficient medical history is obtained to ensure that the chosen therapy is not contra-indicated in the patient
- All relevant aspects, in respect of labelling of medicine outlined in the Medicine Act 1968 are fully complied with
- The patient has been fully advised on the method and frequency of administration of the product

In general, supply via a pharmacist is preferred. The College of Optometrists has produced guidelines on the use & supply of drugs as part of its 'Code of Ethics & Guidelines for Professional Conduct' section K1: www.college-optometrists.org/en/professional-standards/Ethics_Guidelines/index.cfm

If the patient is exempt from prescription charges, a written order should be provided for the patient to take to the GP surgery as a recommendation for the patient's GP to prescribe. See separate therapeutics prescribing protocol.

In the future the supply of appropriate treatments might be covered by Group Prescribing Directives and/or by Minor Ailment Services in accordance with The National Pharmacy Enhanced Service Plan already in existence.

Equality Monitoring & Patient Experience Feedback

As part of the requirement to monitor this service all providers will be required to provide patients with an Equality & Diversity and Patient Experience Feedback questionnaire and input the results into the IT platform. Note this will be part of the minimum requirement to receive payment for the service.

Equipment

All practices contracted to supply the service will be expected to employ an accredited optometrist and have the following equipment available.

- Access to the Internet
- Means of indirect ophthalmoscopy (Volk/headset indirect ophthalmoscope)
- Wide field fundus imaging lens (e.g. Volk SVF, SF or DWF)
- Slit lamp
- Applanation Tonometer
- Distance test chart (Snellen/logmar) / Near test type
- Equipment for epilation
- Threshold fields equipment to produce a printed report
- Amsler Charts
- Equipment for FB removal
- Appropriate ophthalmic drugs
    - Mydriatic / Anaesthetic / Staining agents

Competencies

All participating optometrists will have the core competencies as defined by the GOC and must meet the accreditation requirements as below.

In addition the following apply:

- Aware of own limitations.
- Does not compromise patient safety.

Training and accreditation for participating optometrists to perform within MECS will include demonstrating the ability to identify and manage a range of ocular abnormalities and proficiency in the use of certain elements of the above-mentioned equipment.

Participating optometrists must complete the Cardiff University/LOCSU MECS Distance Learning modules (Part 1) and the associated Practical Skills Demonstration (Part 2). In order to progress to the second element of the accreditation process, a candidate must have successfully passed the first.

Also all optometrists partaking in the provision of the service must also complete the DOCE Children's and Adult's Safeguarding Certificate.

An optometrist who has a relevant higher qualification and experience may be exempt from the MECS Distance Learning and/or the Practical Skills Assessment at the discretion of the Clinical Lead.

Participating optometrists will also be expected to keep their knowledge and skills up to date.

GUIDELINES FOR FLASHES & FLOATERS MANAGEMENT

Terminology

The following terms are important in this text:

Retinal break
This is a retinal hole or tear

Retinal detachment
This is any type of retinal detachment including rhegmatogenous, traction or exudative

Optometric Assessment

History and Symptoms

A full and thorough history and symptoms is essential. In addition to the normal history and symptoms, careful attention must also be given to the following:

History

- Age
- Myopia
- Family history of retinal break or detachment
- Previous ocular history of break or detachment
- Systemic disease
- History of recent ocular trauma, surgery or inflammation

Symptoms

- Loss or distortion of vision (a curtain / shadow / veil over vision)
- Floaters
- Flashes

For symptoms of **floaters** these **additional questions** should be asked:

- Are floaters of recent onset?
- What do they look like?
- How many are there?
- Which eye do you see them in?
- Any flashes present?

For symptoms of **flashes** these **additional questions** should be asked:

- Describe the flashes?
- How long do they last?
- When do you notice them?

For symptoms of a **cloud, curtain or veil** over the vision these **additional questions** should be asked:

- Where in the visual field is the disturbance?
- Is it static or mobile?
- Which eye?
- Does it appear to be getting worse?

Symptoms of less concern

- Long term stable flashes and floaters
- Symptoms >2 months
- Normal vision

Clinical Examination

All patients presenting for a MECS examination with symptoms indicative of a potential retinal detachment should have the following investigations (in addition to such other examinations that the optometrist feels are necessary):

- Tests of **pupillary light reaction** including swinging light test for Relative Afferent Pupil Defect (RAPD), **prior to pupil dilation**
- **Visual acuity** recorded and compared to previous measures if available
- **Contact tonometry**, noting IOP discrepancy between eyes
- Visual Field examination at discretion of optometrist
- **Slit lamp bio microscopy of the anterior and posterior segments, noting:**
  - Pigment cells in anterior vitreous, 'tobacco dust' (Shafer's sign)
  - Vitreous haemorrhage
  - Cells in anterior chamber (mild anterior uveitic response)
- Dilated pupil fundus examination with **slit lamp binocular indirect ophthalmoscopy using a Volk or similar fundus lens** (wide field fundus lens optimal) asking the patient to look in the 8 cardinal directions of gaze and paying particular attention to the superior temporal quadrant as about 60% of retinal breaks occur in that area. Noting:
  - Status of peripheral retina, including presence of retinal tears, holes, detachments or lattice degeneration
  - Presence of vitreous syneresis or Posterior Vitreous Detachment (PVD)

Management

If local protocols for the referral of retinal detachment are in place, then these should be followed

Symptoms requiring assessment within 24 hours

1. Sudden increase in number of floaters, patient may report as "numerous", "too many to count" or “sudden shower or cloud of floaters” Suggests blood cells, pigment cells, or pigment granules (from the retinal pigment epithelium) are present in the vitreous. Could be signs of retinal break or detachment present
2. Cloud, curtain or veil over the vision. Suggests retinal detachment or vitreous haemorrhage – signs of retinal break or detachment should be present

Signs requiring referral within 24 hours

1. Retinal detachment with good vision unless there is imminent danger that the fovea is about to detach i.e. detachment within 1 disc diameter of the fovea especially a superior bulbous detachment, when urgent surgery is required.
2. Vitreous or pre-retinal haemorrhage
3. Pigment 'tobacco dust' in anterior vitreous
4. Retinal tear/hole with symptoms

Signs requiring referral ASAP next available clinic appointment

Retinal detachment with poor vision (macula off) unless this is long standing Retinal hole/tear without symptoms
Lattice degeneration with symptoms of recent flashes and/or floaters

Require discharge with SOS advice (verbal advice and a leaflet)

1. Uncomplicated PVD without signs and symptoms listed above
2. Signs of lattice degeneration without symptoms listed above

Explain the diagnosis and educate the patient on the early warning signals of further retinal traction and possible future retinal tear or detachment:

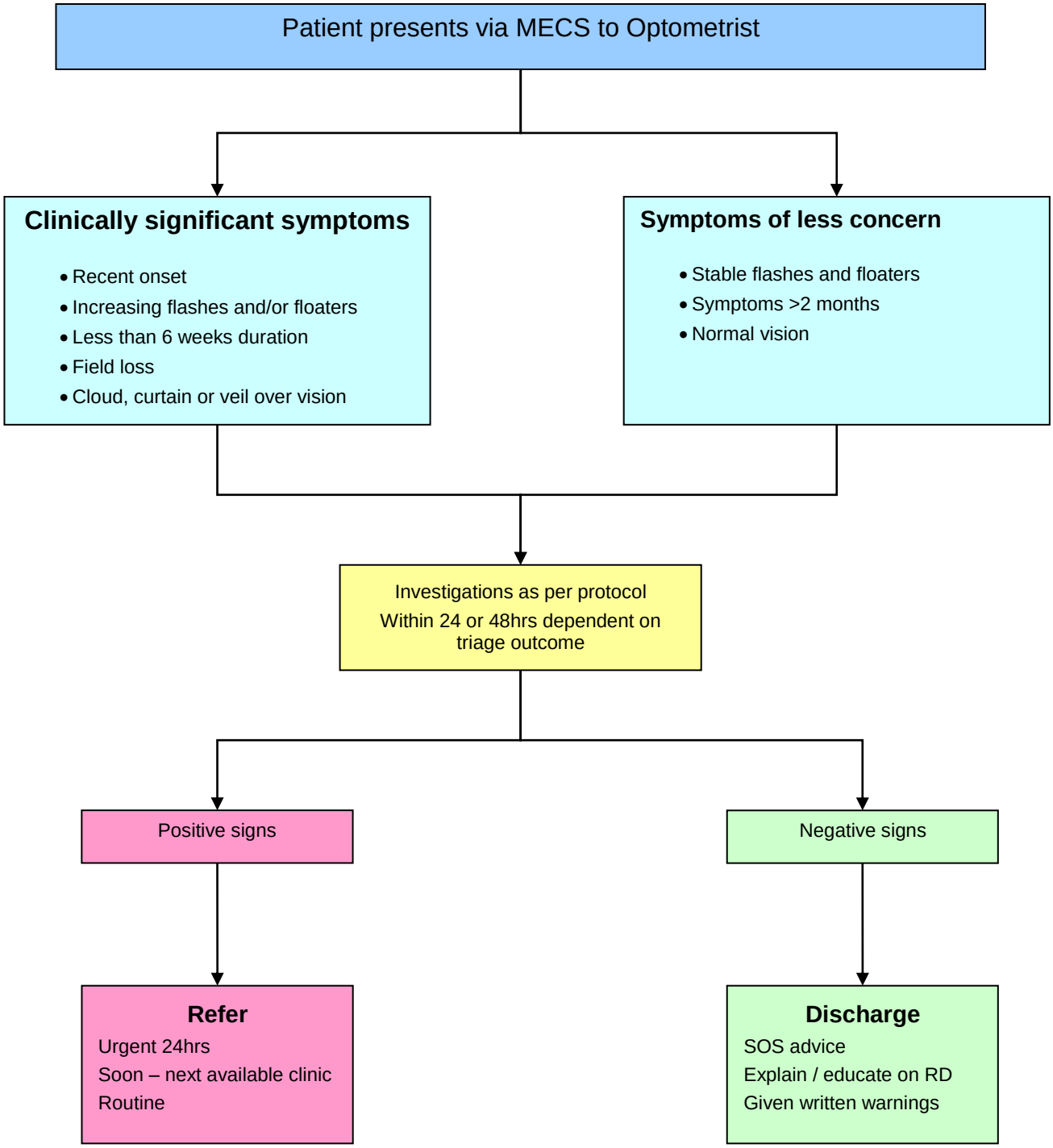
- Give the patient a **Retinal Detachment warning leaflet**
- Instruct the patient to **return immediately or go to A&E if flashes or floaters worsen**

Referral Letters

Patients requiring referral for retinal breaks or detachment must have the following noted on the referral form to the ophthalmologist. Letters should be typed via the IT platform and then faxed or sent with the patient in urgent cases.

- A clear **indication of the reason for referral**. e.g. Retinal tear in superior temporal periphery of Right eye
- A brief description of any **relevant history and symptoms**
- A **description of the location** of any retinal break / detachment / area of lattice
- In the case of retinal detachment **whether the macula is on or off**.
- The **urgency** of the referral

Flashes and Floaters Patient Pathway



Age-related Macular Degeneration Management Guidelines

Terminology

The following terms are important in this text & for differential diagnosis:

Wet (exudative) AMD

This can progress very rapidly causing loss of central vision & metamorphopsia (distortion). It is characterised by sub retinal neovascular membrane, macular haemorrhages & exudates.

Dry (atrophic) AMD

A slowly progressive disease characterized by drusen & retinal pigment epithelial changes

Optometric Assessment

History and Symptoms

A full and thorough history and symptoms is essential. In addition to the normal history and symptoms, careful attention must also be given to the following:

History

- Age
- Family history of maculopathy
- Previous ocular history
- Systemic disease eg hypertension, diabetes
- History of ocular surgery- cataract extraction, retinal detachment repair
- Myopia
- Medication e.g. chloroquine derivatives, tamoxifen
- Smoking status
- Excessive exposure to sunlight/UV

Symptoms

- Loss of central vision
- Spontaneously reported distortion of vision

These **additional questions** should be asked:

- Is loss of vision of recent onset?
- In which eye are symptoms present?
- Has the loss of vision occurred suddenly or gradually?

Clinical Examination

All patients presenting for a MECS examination with symptoms indicative of a potential macular degeneration should have the following investigations (in addition to such other examinations that the optometrist feels are necessary):

- Tests of **pupillary light reaction** including swinging light test for Relative Afferent Pupil Defect (RAPD), **prior to pupil dilation**
- **Visual acuity** recorded and compared to previous measures
- **Refraction** as a hyperopic shift can be indicative of macular oedema
- **Amsler grid or similar assessment of central vision**
- Dilated pupil fundus examination with **slit lamp binocular indirect ophthalmoscopy using a Volk or similar fundus lens** noting:
    - Status of macula, including presence of drusen(&size), haemorrhages, pigment epithelial changes i.e. hyper or hypo pigmentation, exudates,, oedema, signs of sub retinal neovascular membrane. Be suspicious of haemorrhages and/or exudates near the fovea in older people, even those with diabetes.

Management

Stockport protocols for the referral of Wet AMD are in place, these should be followed. You should note that SNHSFT ophthalmology department does not have the facilities to deal with wet age related macular degeneration. The urgent Wet AMD referrals should be referred according using the local forms and faxed with a subsequent telephone call made subsequently to confirm they have received the fax. (Further details of the fast track WET AMD referral protocol is available at Stockport LOC website). Referrals for Dry AMD and other routine referrals should be made via the IT platform which uses safe haven fax.

Symptoms requiring referral ASAP next available clinic appointment

1. Sudden deterioration in vision + VA better than 6/96 in affected eye
2. Spontaneously reported distortion in vision + VA better than 6/96

Signs requiring referral ASAP next available clinic appointment

1. Sub retinal neovascular membrane
2. Macular haemorrhage
3. Macular oedema

Requiring routine referral

1. Patient eligible and requesting certification of visual impairment
2. Patients requesting a home visit from Social Services to help them manage their visual impairment in their home.
3. Patients who require an assessment for LVA

Require routine follow up but provide an Amsler chart, verbal advice and a leaflet – see sheet appended).

- Dry AMD, drusen and / or pigment epithelial changes
- Explain the diagnosis and educate the patient on the early warning signs of wet AMD.
- Give stop smoking advice via leaflet if appropriate + advice on healthy diet + protection from blue light
- Use 4 point scale to assess risk of AMD progression (AREDS Report No. 18 2005[1]). Count one point for large drusen of 125 microns or larger (about the size of a vein at the disc margin) and one point for any pigmentary change. Score each eye separately and then add them together for a score out of 4. A full score of 4 points means a 50% chance of progressing to advanced AMD in the next 5 years. 3 points gives a 25% chance, 2 points a 12% chance and with 1 point the risk is just 3%. Zero is an 0.5% risk.
- For those at intermediate risk of AMD progression give information on AREDS findings & leaflet on anti-oxidant supplements. For those with moderate to advanced AMD the risk of progression is reduced by about 25% (AREDS Report No. 8, 2001[2]). This is essentially those with 3 and 4 points on the scale outlined above.
- Give information on local services for the visually impaired- public and third sector.
- Give appropriate information on national voluntary agencies e.g. RNIB, Macular Disease Society
- Instruct the patient to **inform the practice immediately if vision suddenly deteriorates or becomes distorted.**

Referral Letters

Patients requiring referral for macular degeneration must have the following noted on the referral form to the ophthalmologist.

- A clear **indication of the reason for referral**. e.g. macular haemorrhage
- A brief description of any **relevant history and symptoms**
- A **description of the type of macular degeneration or signs** of drusen, pigment epithelial changes, sub retinal neovascular membrane, haemorrhages, exudates, macular oedema.

[1] AREDS Report No. 18 2005. A simplified severity scale for age-related macular degeneration. *Archives of Ophthalmology*. 2005 November ; 123(11): 1570–1574.

[2] AREDS Report No. 8 2001. A randomized, placebo-controlled, clinical trial of high-dose supplementation with vitamins C and E, beta carotene, and zinc for AMD and Vision Loss. *Archives of Ophthalmology*. 2001 October ; 119(10): 1417–1436.

- The **urgency** of the referral

Differential Diagnosis

Macular hole

This is a hole at the macula caused by tangential vitreo-retinal traction at the fovea. Causes impaired central vision & typically affects elderly females

Macular epiretinal membrane

Can be divided into cellophane maculopathy & macular pucker

Central Serous Retinopathy

Typically sporadic, self-limited disease of young or middle-aged adult males. Unilateral localised detachment of sensory retina at the macula causing unilateral blurred vision.

Cystoid Macular Oedema

An accumulation of fluid at the macula most commonly due to retinal vascular disease, intra-ocular inflammatory disease or post cataract surgery,

Myopic Maculopathy

Chorio-retinal atrophy can occur with high myopia, usually > 6.00D, which can involve the macula.

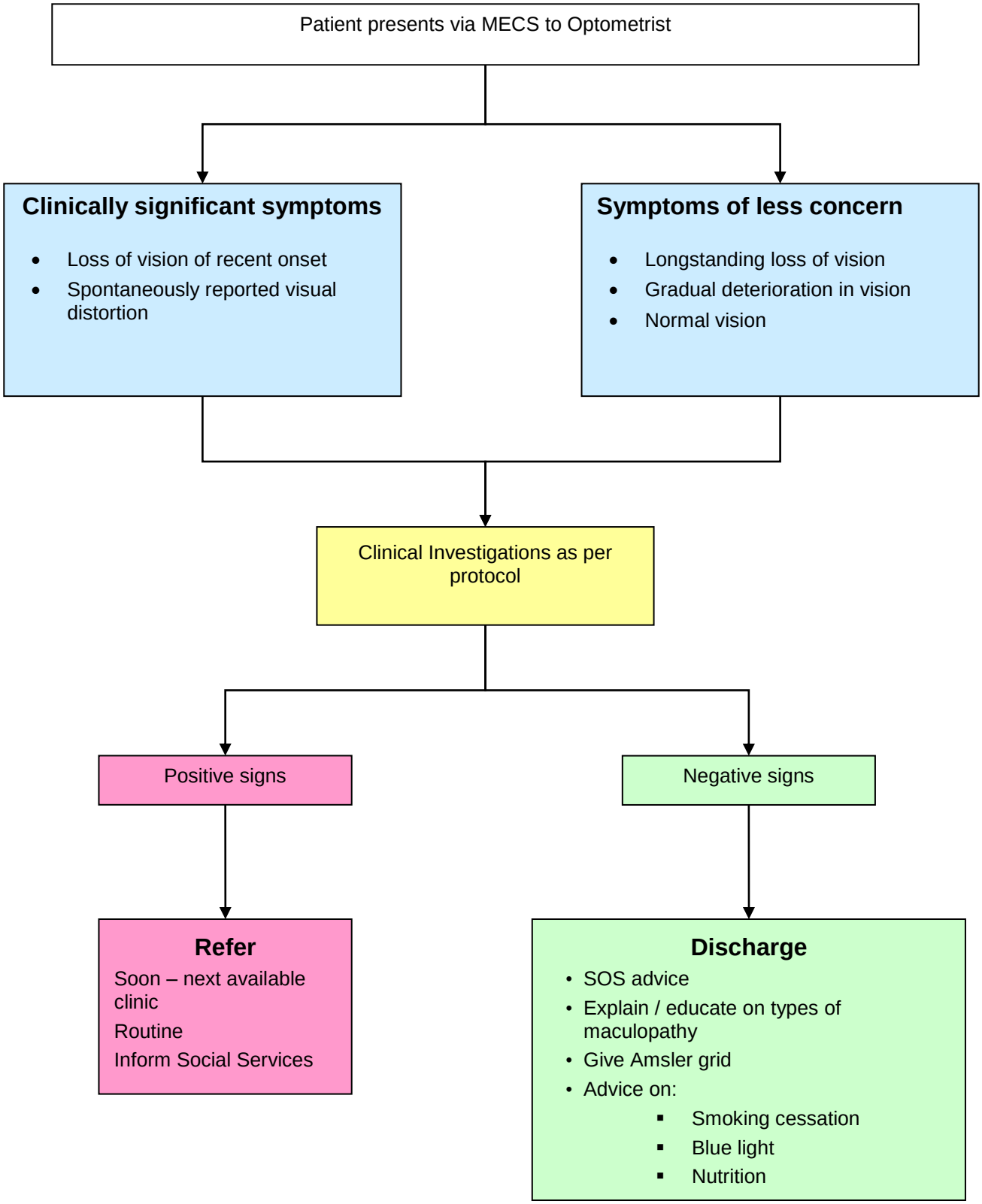
Solar Maculopathy

Due to the effects of solar radiation from looking at the sun causing circumscribed retinal pigment epithelium mottling or a lamellar hole at the macula.

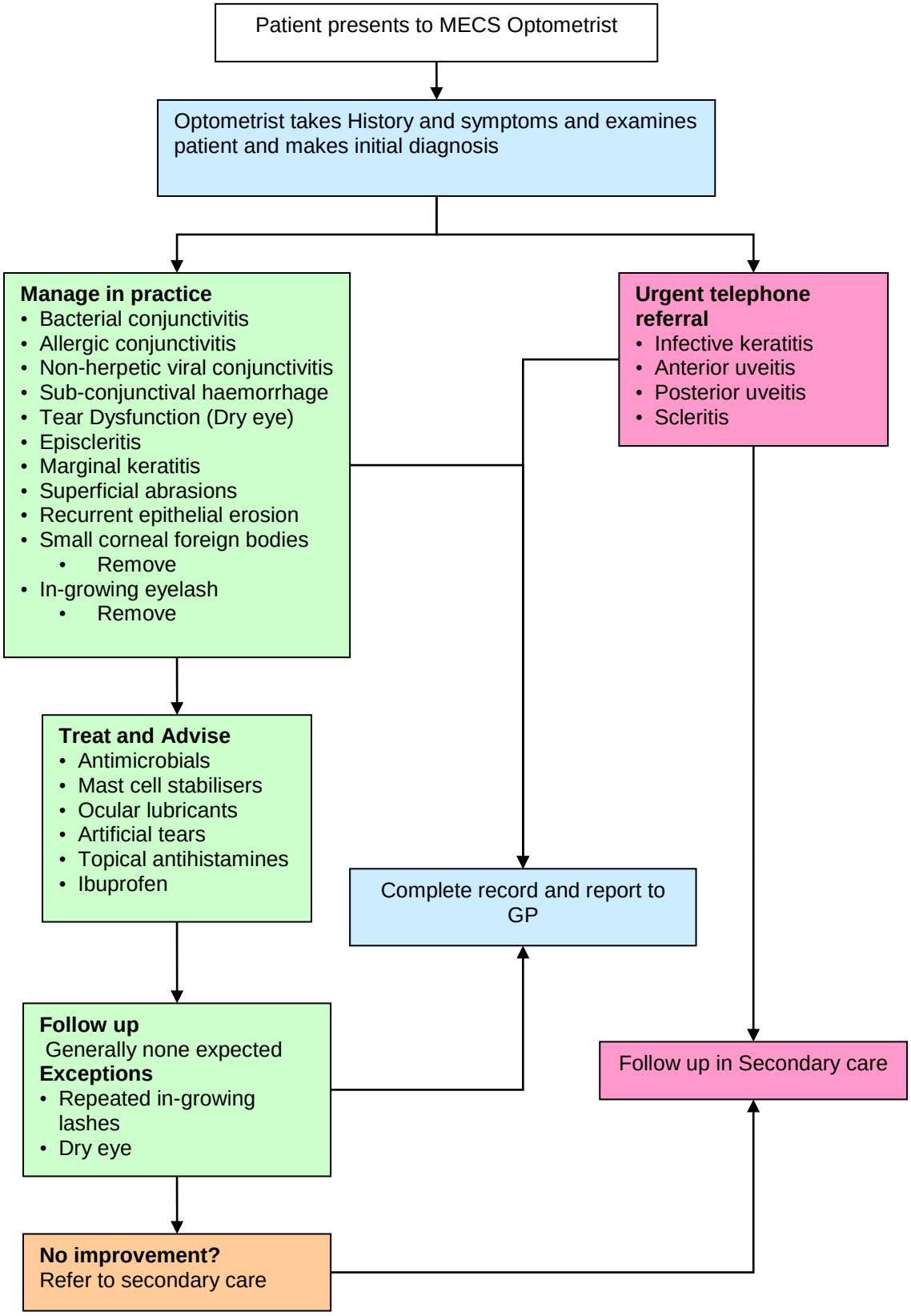
Drug Induced Maculopathies

Antimalarials e.g chloroquine, hydroxychloroquine
Phenothiazines eg thioridazine (melleril), chlorpromazine (Largactil)
Tamoxifen

Maculopathy Pathway



Red Eye Pathway



Lumps & Bumps

History

A full and thorough history and symptoms is essential. In addition to the normal history and symptoms, careful attention must also be given to the following:

- **How long been there?**
- **Discomfort / tender to touch?**
- **Discharge?**
- **Itching?**
- **Bleeding?**
- **Increased in size?**

Clinical Examination

All patients presenting for a MECS examination with symptoms and sign of lumps and bumps should have the following investigations (in addition to such other examinations that the optometrist feels are necessary):

- **Slit lamp examination to include observation of:**
  - **Appearance** (note: e.g. fluid filled cyst, grape like cluster)
  - **Lash disturbance**
  - **Presence of redness or pigmentation**
  - If available, **size measurement with graticule**
  - **Associated conditions** (note: e.g. blepharitis associated with hordeolum)
  - **Presence of corneal staining from mechanical interaction**

Suspect Foreign Body Optometric Assessment

History

A full and thorough history and symptoms is essential. In addition to the normal history and symptoms, careful attention must also be given to the following:

- **Size and nature** (i.e. gardening matter, metal) of suspect FB
- **Speed of entry** (i.e. windblown, metal from grinding)
- **Length of time in eye**
- **Any attempt made to self- or other to remove**

Clinical Examination

All patients presenting for a MECS examination with symptoms indicative of a loss of vision should have the following investigations (in addition to such other examinations that the optometrist feels are necessary):

- **Anesthetise eye** (note: will make examination easier as more comfortable for Px to open eye)
- **Visual Acuity**, before & after removal
- **Slit Lamp examination, must include:**
  - **Eversion of lids**
  - **Ask Px to look to extreme positions of gaze to check under lids**
  - **Check of globe & adnexa for signs of penetration**
  - **Check of AC for cells/flare**
  - **Fluorescein assessment**
  - **Check for Seidel's sign**
- **Pupil Reactions**
- **Dilated fundal examination**, if penetration suspected

Removal (Consider least invasive first)

- **Irrigation**
- **PVA Spears** (note: for superficial FB)
- **Needles** (note: for deeper or more long standing FB)

Aftercare

Consider:

- **Chloramphenicol**
- **Viscous ointment** (for comfort during day)
- **Lacrilube** (to prevent recurrent erosion during healing, overnight use)
- **Follow Up**

Telephone Triage Protocol

All patients that present for the MECS service whether via the telephone or in person must undergo Triage, to assess eligibility for the service and urgency of appointment required. The information gathered from this Triage must be entered on to the IT platform.

There are a set of questions to be asked to determine these two aspects. Following the guidance will enable the person carrying out the triage to either, book an appointment within 24hrs, book an appointment within 48hrs, refer to accredited optometrist for further triage or advise the patient unsuitable for this service and re direct them to a more appropriate service.

The guidance, and a form for staff to complete if this assists, are available separately as the MECS Triage Guidance and Form.