# Ophthalmology urgent referrals COVID transmission procedure

# Universal procedures

During telephone triage all refers or patients to be asked if any symptoms of new cough or fever of patient or anyone in their household or contact with anyone known to be positive for Covid. If this is positive **only sight threatening emergencies** to be brought to eye clinic

Slit lamps to be fitted with breath guards asap

Cleaning of slit lamp including breath-guard and clinicians hands for every patient

Chairs to be place 1 metre apart, no relatives to stay with patient unless required for communication or safeguarding

When waiting room full take patients phone number and put on clinic template, phone patient when there is space

All available clinicians to work in URC to reduce waiting time to near zero as possible

Clinicians not seeing patient face to face may be asked to help with triage phoneline which will be busier and nurses and junior doctors may be asked to work elsewhere to support Covid response.

Self-isolating but well clinicians should be available for clinical advice in their speciality. Pando app can be installed to allow sharing of clinical images.

# Treatment of proven Covid positive or suspect positive patients

Positive or suspected positive patients asked to report back door to enter area C. A nurse will need to wait for the patient in area C in protective equipment, the doctor will need to don up and join them after being contacted by phone. Treatment where possible to be carried out there if at all possible, any drugs to be supplied from our stock, do not send the patient or those with them to pharmacy. Once patient has left through back door or transferred to theatre or ward the clinical staff will doff in the examination room leaving masks in a yellow bin outside the door.

Deep clean of area after 20 minutes before any other patient can be seen.

If more than one patient needs to be seen they will need to wait in rooms in area C, these will need to be deep cleaned as well.

# Conditions or complaints to be seen despite known or suspected/ high risk of Covid positive status

Sudden (within last 48 hours) **profound** loss of vision (CF or worse) in one eye (painful or otherwise) of unknown cause

Profound (CF or worse) loss of vision in both eyes

New dark shadow in vision (suspect RD)

Severe trauma including high suspicion of penetrating trauma or severe blunt trauma

Large corneal ulcer

Corneal ulcer that remains very painful despite 72 hours of intensive hourly antibiotics

Retinal detachment

Endophthalmitis (suspected)

Angle closure glaucoma

Orbital cellulitis

Chemical injury

Corneal graft rejection

If a condition outside this list has potential to be sight threatening or suggestive of an acute neurological problem such as diplopia please take patient details and pass to consultant managing the next URC for telephone triage. Out of hours all cases should be passed to the consultant to discuss with the patient and/or referrer before bringing the patient in. If possible this should be deferred until office hours.

Where condition is less immediately urgent the patient should be given advice as to what red flags should prompt them to phone back (eg Shadow or loss of vision for flashes and floaters) A list of these patients should be made and they should be phoned back in 7 days to check if they are still symptomatic either from the viral or eye point of view and action taken accordingly. The discussion should be documented on an URC triage form and scanned to the patients CPD record.

Conditions which face to face contact can be avoided (Covid symptoms or not) – need to be told to call back if condition worsening or not resolving as expected

AAU in patients with previous AAU (script to be picked up from pharmacy by individual with no symptoms of Covid

Small CL related ulcer seen by optician (<1mm) – Give hourly levofloxacin for 2 weeks (collect prescription from Pharmacy), advise no CL wear for 4 weeks. To recontact unit if pain not better after 3 days of treatment.

Wet AMD symptoms, not to be seen in URC. Arrange colours and OCT scan either here or at opticians with VA, decision then as to bring in or not to macular clinic (to be coordinated by MR team)

Shingles if no visual loss – course of PO Aciclovir 800mg 5 times a day, arrange to phone patient in a week and bring in if decreased vision, ocular (not facial) pain or other worrying eye symptoms (discuss with consultant)

Bell’s palsy unless visual loss – advice to use frequent lubricants, ointment at night and tape at night https://youtu.be/fBwE9D6MJ\_4

Allergy to eye drops – stop drops and discuss with glaucoma consultant

# Conditions not to be accepted

Gritty sore eyes

Conjunctivitis with no visual loss

Corneal abrasion after minor trauma less than 2 days ago – only if symptomatic after that

Anything that is not symptomatic except disc swelling

Symptoms of migraine

Transient loss of vision without headache (ask to refer TIA clinic)

Aching behind the eye with no loss of vision and white eye

Everything else we need to balance risk vs benefit of coming to see us. Comorbidity and age over 70 consider if any long term consequences of not seeing for 3 months in terms of morbidity or irreversible loss of vision. On call registrar and possibly Consultant should be contacted if final decision required.