Immediate sequential bilateral cataract surgery

Standard operating procedure for immediate sequential bilateral cataract surgery

IT IS THE RESPONSIBILITY OF ALL USERS OF THIS SOP TO ENSURE THAT THE CORRECT VERSION IS BEING USED

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SOP Summary

Theatre standard operating protocol for immediate sequential bilateral cataract surgery (ISCBS).

Version: Version 1.01

Status: FINAL

Approved: 15 June 2020

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Version History

Version	Date	Brief Summary of Change	Author
0.2	15/11/19	Guideline created based on iSBCS General Principles for Excellence in ISBCS 2009[1] and the British Columbia Accreditation Standards for Immediately Sequential Bilateral Cataract Surgery 2018[2]	[redacted]
1.01	04/06/20	Minor edits and formatting changes for internal review	[redacted]

For more information on the status of this document, please contact:	Alex Day Consultant	
Document author	[redacted]	
Document owner	[redacted]	
Accountable director	[redacted]	
Department	Cataract/ Operating Theatres	
Applies to (audience):	Staff working at City Road and satellite sites, particularly all medical staff engaged in intraocular surgery	
Groups / individuals who have overseen the development of this document	[redacted]	
Committees which were consulted and have given approval (name | date)	Cataract department	12 June 2020
Responsible committee/group for approval	Policy and Procedure Review Group	
Ratified by (name | date)	Policy and Procedure Review Group	15 June 2020
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Date of next formal review	June 2021	

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1. Introduction

Theatre standard operating protocol for immediate sequential bilateral cataract surgery (ISCBS).

2. Patient selection and consent.

2.1. Cataract surgery for visual improvement, or refractive lens exchange should be the indication for each eye.

2.2. Each eye should be expected to be a routine phacoemulsification and IOL procedure ie. there is no significant unilateral or bilateral ocular co-pathology and the case is not combined with another procedure eg. MIGS.

2.3. The patient has been fully informed and consented about the options of immediate sequential bilateral cataract surgery and the alternative being the standard practice of the second eye surgery being performed on a different day.

2.4. Latest ocular biometry formulae should be used whenever possible eg. Barrett or https://iolsolver.com. The surgeon should pay particular attention to factors that affect ocular biometry quality such as presence of ocular surface disease.

3. Surgeon, theatre staff and operating room criteria.

3.1. The operating surgeon must be a consultant ophthalmic surgeon with appropriate experience for the procedure.

3.2. Anaesthesia must be in accordance with the Royal College of Anaesthetists and Ophthalmologists Local Anaesthesia for Ophthalmic Surgery guidelines.[3]

3.3. The operating theatre must be appropriately staffed meeting the minimum requirements of the Association for Perioperative Practice.[4]

3.4. The operating theatre is approved for intraocular surgery.

3.5. The biometry must be readily available and clearly detail the patient name, date of birth, hospital number, laterality, IOL type and power, IOL power formula used and astigmatism correction for each eye.

4. Each cataract surgery must be a completely independent procedure.

4.1. A separate WHO checklist, and ocular biometry check must be performed before each surgery.

4.2. Right and left eye anaesthetic blocks ie. subtenons if performed, must be should be staggered to allow for any complications to be identified and managed.[3]

4.3. The operating microscope sterile handle covers must be changed between eyes and be from separate sterilization batches.

4.4. The instrument trays for each eye must be completely separate and from different sterilization cycles (this includes the phacoemulsification handpieces). Any disposable instruments from different batches.

4.5. All ocular devices used such as viscoelastics, balanced salt solution and perioperative drugs must be from different batches.

4.6. The surgical technique should be that routinely performed by the surgeon, no difference is indicated as the procedure is part of an ISBCS procedure.

4.7. All patients must have intracameral cefuroxime given at the end of the procedure as per standard operating practice.

4.8. The used operating theatre trolley and all instruments, microscope covers etc must be removed from the operating room before a sterile field is setup for the second eye surgery.

4.9. Between sides, the operating surgeon must rescrub.

4.10. Ideally there should be a different scrub nurse for the second eye surgery.

4.11. The second eye must be cleaned and draped as per a separate procedure.

4.12. If there is any significant intraoperative complication eg. posterior capsule tear, or zonular dialysis; the second eye surgery should not be performed until the surgeon is satisfied that the first eye has been treated satisfactorily.

5. Postoperative review.

5.1. Clear postoperative instructions must be given to the patient including a 24 hour contact to a health care professional in the case of any emergency queries.

6. Audit.

6.1. The operating records should list the batch numbers and sterilisation cycle details if appropriate of all instruments, devices and perioperative drugs used.

6.2. All significant postoperative complications or expected patient contact or attendances must be fed back to the operating surgeon.

6.3. There must be a separate, mandatory patient safety reporting system in place for the reporting of confirmed or suspected endophthalmitis cases.

7. Monitoring and Review

The relevance and effectiveness of this operational SOP will be informed by clinical incident feedback.

8. Stakeholder Engagement and Communication

This document has been developed in consultation with the following trust staff: [redacted]

9. Consultation, Approval and Ratification

The SOP has been approved locally by the above trust staff. It is approved and ratified by the Policy and Procedure Review Group.

10. Dissemination and Implementation

The SOP will be available on the trust internet.

11. Review and Revision Arrangements

This procedure will be reviewed in 12 months after first issue, then every three years there after.

12. Document Control and Archiving

The current and approved version of this document can be found on the Trust's intranet site. Should this not be the case, please contact the Quality and Compliance team.

Previously approved versions of this document will be removed from the intranet by the Quality and Compliance team and archived in the policy repository. Any requests for retrieval of archived documents must be directed to the Quality and Compliance team.

13. Monitoring Compliance with this SOP

Any serious incident reports for ISBCS cases will trigger a procedure review if there is evidence that the procedure is unable to meet its stated objectives.

14. References

1. iSBCS General Principles for Excellence in ISBCS 2009. http://www.isbcs.org/wp-content/uploads/2011/03/2010-07-20-FINAL-ISBCS-SBCS-suggestions-from-ESCRS-Barcelona.pdf. Published July 20, 2010. Accessed November 11, 2019.

2. The College of Physicians and Surgeons British Columbia. Accreditation Standards Immediately Sequential Bilateral Cataract Surgery. https://www.cpsbc.ca/files/pdf/NHMSFAP-AS-ISBCS.pdf. Accessed November 11, 2019.

3. The Royal College of Anaesthetists and the Royal College of Ophthalmologists. Local anaesthesia for ophthalmic surgery, Joint guidelines from the Royal College of Anaesthetists and the Royal College of Ophthalmologists. https://www.rcophth.ac.uk/wp-content/uploads/2014/12/2012-SCI-247-Local-Anaesthesia-in-Ophthalmic-Surgery-2012.pdf. Published 2012. Accessed November 11, 2019.

4. The Association for Perioperative Practice. Staffing Policy. The Association for Perioperative Practice. https://www.afpp.org.uk/careers/Standards-Guidance. Accessed November 11, 2019.