Diagnostic Testing Procedures for Ophthalmic Science

V4.0

01/08/17
Table of Contents

1. Introduction ................................................................................................................... 3
2. Purpose of this Policy ................................................................................................... 3
3. Scope .......................................................................................................................... 3
4. Definitions / Glossary..................................................................................................... 3
5. Ownership and Responsibilities .................................................................................. 3
   5.2. Role of the Managers .................................................................................... 3
   5.3. Role of the Surgical Divisional Governance Management Board .................. 4
   5.4. Role of Individual Staff ................................................................................... 4
6. Standards and Practice ................................................................................................. 4
   6.1. Content .............................................................................................................. 4
   6.2. Diagnostic tests provided by the service ........................................................... 4
   6.3. How diagnostic testing procedures are risk assessed ....................................... 5
   6.4. Measures that need to be in place for the diagnostic test to enable any preparation of the patient (e.g. fasting) required ............................................................... 5
   6.5. Identifying the process for ensuring that informed consent is obtained prior to a diagnostic test ................................................................. 5
   6.6. How the diagnostic test is requested ................................................................ 5
   6.7. Ensuring that diagnostic tests are received within agreed time frames .......... 5
   6.8. How the clinician treating the patient is informed of the result, including timescales ........................................................................................................... 6
   6.9. How the patient is informed of the result, including timescales ....................... 6
   6.10. Actions to be taken by the clinician, including timescales ................................ 6
   6.11. How the minimum requirements are recorded .............................................. 6
7. Dissemination and Implementation ............................................................................. 7
8. Monitoring compliance and effectiveness .................................................................... 7
9. Updating and Review .................................................................................................... 8
10. Equality and Diversity ................................................................................................. 8
    10.1. Equality Impact Assessment ......................................................................... 8
Appendix 1. Governance Information ................................................................................ 9
Appendix 2. Initial Equality Impact Assessment Screening Form .................................... 11
1. **Introduction**

1.1. Diagnostic testing information supports many clinical decisions both in the identification of new conditions and the monitoring and treatment of existing ones. As such it sits within the overall patient clinical pathway. The diagnostic pathway begins when a test is indicated such that a request is generated, progresses via the diagnostic process and ends when a report is received by the requester and acted upon. Failures at any point in this pathway may lead to delays in the care of the patient, sometimes with serious clinical consequences.

1.2. This version supersedes any previous versions of this document.

2. **Purpose of this Policy**

2.1 This policy sets out an approved documented process whereby the risks associated with ophthalmic science tests within the Ophthalmology Department are managed through the provision of local policies and procedures that are implemented and monitored. It has been developed to ensure these risks are minimised and give assurance to external bodies, specifically the NHSLA (Standard 5 – Criterion 7: Diagnostic Testing Procedures). No patient’s treatment should be delayed because of delays in the availability of Diagnostic information and the objective of this document is to ensure that this does not happen, recognising that communication problems are often the root of such delays; there is an absolute need for clear pathways that identify how, when and to whom the results should be communicated. **This policy is aimed at those who provide and those who request ophthalmic science tests within the Ophthalmology Department.**

3. **Scope**

3.1. This policy applies to all those who request Ophthalmic Science tests and those who receive, process or need to act on the results of these.

4. **Definitions / Glossary**

4.1. NHSLA: National Health Service Litigation Authority
4.2. GP: General Practitioner
4.3. RCHT: Royal Cornwall Hospitals NHS Trust

5. **Ownership and Responsibilities**

5.1. The strategic and operational roles responsible for the development, management and implementation of the policy are shown below.

**5.2. Role of the Managers**

Line managers are responsible for:

5.2.1 Conducting stringent recruitment checks to ensure that only appropriately qualified and registered staff undertake and authorise test results and ongoing checks of professional registration

5.2.2 Ongoing checks of Training & competence to perform those tests within the scope of activity of individual staff
5.2.3 Ensuring that staff follow those processes and procedures described in the Standards and Practice section relevant to the part they play in the diagnostic pathway.

5.3. **Role of the Surgical Divisional Governance Management Board**
The Surgical Division Governance Committee is responsible for:

- 5.3.1 The Surgical Divisional Governance Management Board is responsible for the development, approval and communication of this policy and monitoring compliance with it.

5.4. **Role of Individual Staff**
All staff members are responsible for:

5.4.1 The diagnostic pathway begins when a request is generated and the required procedure is undertaken; it progresses via the diagnostic testing process and ends when a report is received by the requester and when necessary acted upon. Various healthcare staff are involved in this pathway including Doctors, Nurses, Healthcare Assistants/Support workers and Professions Allied to Medicine.

Administrative staffs in Ophthalmology have a role to play in ensuring diagnostic testing appointments are booked and appropriate preparation instigated in accordance with agreed operating policies.

5.4.2 All staff members are responsible for:

- Being aware of this policy and any documents referred to within it pertaining to their part in the diagnostic pathway.

- Adhering to any requirements described within this policy and documents described in the standards and practice section pertaining to their role in the diagnostic pathway.

6. **Standards and Practice**

6.1. **Content**
The content of this section takes account of the information provided in the overarching Trust-wide policy which in turn is informed by the document and template provided by the NHSLA (amended to incorporate revisions to the Standards in January 2012) for Standard 5 – Criterion 7: Diagnostic Testing Procedures, and is used to provide details and information describing the practices, systems, and processes staff are expected to follow in order to comply with this document.

6.2. **Diagnostic tests provided by the service**
Refraction
Corneal Topography
Diagnostic Ultrasonography
Fluorescein Angiography and Indocyanine Green Angiography
OCT
6.3. How diagnostic testing procedures are risk assessed

Departments need to focus on the degree of intervention required, the consequence of missed diagnosis and the impact for the trust. Information sources include a trawl of the complaints, claims and incidents data to see if there are common themes as this would also indicate an area of increased risk for the organisation.

6.4. Measures that need to be in place for the diagnostic test to enable any preparation of the patient (e.g. fasting) required

For fluorescein angiography (FFA) and Indocyanine Green Angiography (ICG), specific information is posted to the patient with the appointment letter. For OCT and colour photographs, the patient appointment letter states that dilating eye drops may be required on the day and that these will be instilled at the clinic. For refraction, the parents/guardians are provided with the dilating drops along with a patient information sheet by the Orthoptist when the Optometry appointment is made. On occasions when the drops are instilled on the day of the appointment, the parents are advised, verbally that the drops take 30 mins for them to be fully effective.

6.5. Identifying the process for ensuring that informed consent is obtained prior to a diagnostic test

Consent for investigations is assumed consent, by way of the patient attending for the appointment for the test procedure. For Fluorescein Angiography verbal consent is taken on the day and this is recorded in the patients hospital notes.

6.6. How the diagnostic test is requested

6.6.1 It is important that requests are generated, received and processed correctly in order for the diagnostic process to be initiated in the first place.

6.6.2 Requesting Ophthalmic diagnostic procedures is currently done using completed paper request forms/cards, appointment outcome form and referral letters. The process for fluorescein angiography and indocyanine green angiography is documented in the department protocol. Both documents are available on the Document Library.

It is the responsibility of the requesting Clinician to complete the request form/card, appointment outcome form or referral letter accurately clearly indicating the diagnostic procedure requested.

The professional expectation is that anyone requesting a test should have the training, experience and authority to explain the result to the patient. The examiner has a duty to carry out reasonable tests on the assumption that they have been legitimately requested. Some specialised tests may only be performed if requested by a Consultant.

6.7. Ensuring that diagnostic tests are received within agreed time frames

It is the responsibility of the Ophthalmology Department to ensure that patients present for testing within any cut-off times quoted in published User information or Policies.
6.8. How the clinician treating the patient is informed of the result, including timescales

6.8.1 All results from Ophthalmic diagnostic tests are recorded/documented in the patient's hospital records or uploaded onto Synergy and are available for the patient's Consultation with the Doctor. It is the examiner's responsibility to ensure that the patient has an appointment with the Doctor.

6.8.2 If the request has been received from a Doctor from another department e.g. the Stroke team, Neurology then a copy of the results will be also be sent directly to the referrer.

6.8.3 If possible and if appropriate the results will be given to the patient by the examiner at the time of undergoing the test.

6.9. How the patient is informed of the result, including timescales

6.9.1 Patients must be made aware of the reason for tests being requested and the approximate timescale for availability of the results so that they may request an update on results as necessary. Results which have significant implications for the patient must be discussed with them in the appropriate timescale.

6.9.2 There is an expectation that patients are informed of results by the requesting clinician in a timely fashion.

6.9.3 The mechanisms and timescales for informing patients of results are the responsibility of the requesting clinician but may include, according to the nature of the test, availability of result and the significance of the result:

- Telling patients
- Writing to patients
- Discussing with patients at Outpatient or pre-op assessment clinics
- Writing to their GP

6.9.4 Every opportunity should be taken to check for/flag outstanding results at Outpatient and GP appointments.

6.10. Actions to be taken by the clinician, including timescales

6.10.1 The person receiving the results should ensure the results are brought to the attention (urgently if necessary) of the clinical team currently caring for the patient.

6.10.2 The referrer will take responsibility for ALL investigations requested by them or in their name, but the responsibility for signing off a result can be appropriately delegated. It does not have to be the responsible clinician who signs off the result. Ultimately though the responsibility will fall back on the responsible clinician if nobody else accesses the result.

A person with clinical responsibility for the patients should review and interpret the results and ensure a management plan is recorded as required.

6.11. How the minimum requirements for are recorded

6.11.1 Requesting
Requests for Ophthalmic diagnostic tests/procedures are recorded in the patients hospital notes or via a referral letter/form.

6.11.2 Informing the clinician

At present there is no record of clinicians being informed of the result other than the printing of reports and those that are telephoned. Practices vary as to what the requester records and where.

Communication of test results between clinical staff who have received results and other healthcare staff or patients must be recorded in the notes.

6.11.3 Informing the patient

Records are kept of any written correspondence with the patient or their Doctor in the notes. Records are kept of discussions (in person or over the telephone) in the notes.

6.11.4 Actions taken

Actions taken are documented in the notes.

6.11.5 When recording results within the patient’s record the minimum information which must be included is:

- Forename and surname
- NHS/Hospital number
- For unknown patients a coded identifier may be used
- Test or procedure
- Date investigation was performed
- Interpretive comments made/conclusion reached may be recorded

The method of communication of the actions must be recorded, i.e. face to face contact, phone call, letter, email, fax, etc.

Hospital discharge summaries should record confirmed diagnosis and any outstanding investigations.

7. Dissemination and Implementation

7.1 The document will be placed on the Cornwall & Isles of Scilly Health Community Documents Library with notification of all users via email. It will also appear on the Ophthalmology A-Z of Services Intranet pages.

8. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>1. Informing the clinician treating the patient of the result; ensuring they are looked at/acknowledged</th>
<th>2. Reporting timescales</th>
<th>3. Acting on, documenting &amp; Informing the patient of the result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tool</td>
<td>1. Documentation audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Documentation audit</td>
<td>3. Documentation audit</td>
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<tr>
<td>------------------------</td>
<td>------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td><strong>Annually</strong></td>
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<td></td>
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<tr>
<td></td>
<td><strong>Annually</strong></td>
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<td></td>
</tr>
<tr>
<td></td>
<td><strong>Annually</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting arrangements</strong></td>
<td>Reports will be reviewed by the Ophthalmology team.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Each report should contain a summary and action points to enable these to be readily identified; these should be discussed and recorded in meeting minutes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The lead or committee is expected to read and interrogate the report to identify deficiencies in the system and act upon them.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acting on recommendations and Lead(s)</strong></td>
<td>The Committee which reviews the report will delegate recommendations and action planning, for any or all deficiencies and recommendations within reasonable timeframes, to the appropriate committee, department or lead.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Required actions will be identified and completed in a specified timeframe.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Change in practice and lessons to be shared</strong></td>
<td>Required changes to practice will be identified and actioned within the minimum achievable timescale. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. **Updating and Review**
This policy will be reviewed every two years or sooner if circumstances suggest this may be necessary.

10. **Equality and Diversity**
This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

10.1. **Equality Impact Assessment**
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Diagnostic Testing Procedures for Ophthalmic Science</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>June 2015</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>August 2017</td>
</tr>
<tr>
<td>Date for Review:</td>
<td>August 2019</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Faye Gibson, Head Orthoptist</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 253287</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This policy sets out an approved documented process whereby the risks associated with diagnostic testing procedures for Ophthalmic Science are managed.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Ophthalmology, Diagnostic, Testing, Eyes</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>New Document</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>New Document</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>David Jones, Clinical Lead for Ophthalmology</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Vicky Peverelle</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical / Ophthalmology</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>NHSLA Risk Management Standards, Criterion 5.6</td>
</tr>
<tr>
<td>Related Documents:</td>
<td>Organisation Wide Policy For The Management Of Diagnostic Testing</td>
</tr>
</tbody>
</table>
Training Need Identified?  No

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 May 12</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Faye Gibson, Head Orthoptist</td>
</tr>
<tr>
<td>23 May 13</td>
<td>V2.0</td>
<td>Amended version</td>
<td>Faye Gibson, Head Orthoptist</td>
</tr>
<tr>
<td>09/06/15</td>
<td>V3.0</td>
<td>Amended version</td>
<td>Faye Gibson, Head Orthoptist</td>
</tr>
<tr>
<td>01/08/17</td>
<td>V4.0</td>
<td>Amended version</td>
<td>Faye Gibson, Head Orthoptist</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
### Appendix 2. Initial Equality Impact Assessment Screening Form

<table>
<thead>
<tr>
<th>Name of service, strategy, policy or project (hereafter referred to as policy) to be assessed: Diagnostic Testing Procedures for Ophthalmic Science</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong> Head and Neck, Ophthalmology</td>
</tr>
<tr>
<td><strong>Is this a new or existing Procedure?</strong> New</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong> Faye Gibson</td>
</tr>
<tr>
<td><strong>Telephone:</strong> 01872 253287</td>
</tr>
</tbody>
</table>

1. **Policy Aim**
   - Sets out an approved documented process whereby the risks associated with diagnostic testing procedures are managed through the provision of local policies which are implemented and monitored.

2. **Policy Objectives**
   - The risks associated with diagnostic testing procedures are minimised; compliance with NHSLA Standard 4 – Criterion 4: Diagnostic Testing Procedures is achieved.

3. **Policy – intended Outcomes**
   - To ensure that the diagnostic process contributes the maximum benefit to the treatment of patients.

4. **How will you measure the outcome?**
   - As described in Section 8.

5. **Who is intended to benefit from the Policy?**
   - All patients

6a. **Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?**
   - No

b. **If yes, have these groups been consulted?**
c. **Please list any groups who have been consulted about this procedure.**

*Please see Glossary*

### 7. The Impact

Please complete the following table using ticks. You should refer to the EA guidance notes for areas of possible impact and also the Glossary if needed.

- Where you think that the *policy* could have a **positive** impact on any of the equality group(s) like promoting equality and equal opportunities or improving relations within equality groups, tick the ‘Positive impact’ box.
- Where you think that the *policy* could have a **negative** impact on any of the equality group(s) i.e. it could disadvantage them, tick the ‘Negative impact’ box.
• Where you think that the policy has no impact on any of the equality group(s) listed below i.e. it has no effect currently on equality groups, tick the ‘No impact’ box.

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>No Impact</th>
<th>Reasons for decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>✓</td>
<td>All requests for diagnostic tests are treated in the same way</td>
</tr>
<tr>
<td>Disability</td>
<td></td>
<td></td>
<td>✓</td>
<td>All requests for diagnostic tests are treated in the same way</td>
</tr>
<tr>
<td>Religion or belief</td>
<td></td>
<td></td>
<td>✓</td>
<td>All requests for diagnostic tests are treated in the same way</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td>✓</td>
<td>All requests for diagnostic tests are treated in the same way</td>
</tr>
<tr>
<td>Transgender</td>
<td></td>
<td></td>
<td>✓</td>
<td>All requests for diagnostic tests are treated in the same way</td>
</tr>
<tr>
<td>Pregnancy/ Maternity</td>
<td></td>
<td></td>
<td>✓</td>
<td>All requests for diagnostic tests are treated in the same way</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td>✓</td>
<td>All requests for diagnostic tests are treated in the same way</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td></td>
<td></td>
<td>✓</td>
<td>All requests for diagnostic tests are treated in the same way</td>
</tr>
<tr>
<td>Marriage / Civil Partnership</td>
<td></td>
<td></td>
<td>✓</td>
<td>All requests for diagnostic tests are treated in the same way</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
• A negative impact and
• No consultation (this excludes any policies which have been identified as not requiring consultation).

8. If there is no evidence that the policy promotes equality, equal opportunities or improved relations - could it be adapted so that it does? How?

<table>
<thead>
<tr>
<th></th>
<th>Full statement of commitment to policy of equal opportunities is included in the policy</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Please sign and date this form.

Keep one copy and send a copy to Matron, Equality, Diversity and Human Rights,
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Chyvean House, Penventinnie Lane, Truro, Cornwall, TR1 3LJ

A summary of the results will be published on the Trust’s web site.

Signed ________________________________________

Date _________________________________________