AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Care Standards

INFORMATION
for health service organisations

Cataract

Clinical Care Standard

The *Cataract Clinical Care Standard* is relevant to all healthcare settings where care is provided to patients with cataract including primary care, Aboriginal and Torres Strait Islander Health Services, hospitals and privately-operated eye clinics.

1 Primary care assessment and referral

What the standard says

A patient with visual problems and suspected cataract has an initial assessment in primary care of their visual impairment, vision-related activity limitations, comorbidities and willingness to have surgery. When referral is appropriate based on these criteria, the patient is referred for consideration for cataract surgery, and this information is included in the referral form.

What this means for health service organisations

Primary care services making referrals should maintain awareness of any local referral guidelines or criteria for referral to ophthalmology or other eye services and have protocols to ensure that relevant information is included in the patient referral. Patient information about cataract and its management should be available for primary care clinicians to provide to patients. Information on any alternative community-based referral options should also be available.

Ophthalmology services receiving referrals should have guidelines that describe what information is required in referrals from primary care, and, where relevant, describe any criteria for accepting and prioritising referrals. This will usually be determined locally and take into account the availability of services, particularly in regional locations. Box 2 of the Cataract Clinical Care Standard provides some of the components to consider in referral guidelines. Referral guidelines should be published online in an accessible, relevant location, and made readily available to referring clinicians and through Primary Health Networks.

A standardised referral template can be effective for improving the appropriateness of referral, as well as improving the quality of information needed to triage patients for ophthalmology appointments.

2 Patient information and shared decision making

What the standard says

A patient with suspected or confirmed cataract receives information to support shared decision making. Information is provided in a way that meets the patient's needs, and is easy to use and understand. The patient is given the opportunity to discuss the likely benefits and potential harms of the available options, as well as their needs and preferences.

What this means for health service organisations

Ensure that policies support shared decision making and the competence of clinicians, who should be appropriately trained in shared decision making and have access to suitable resources. Ensure that any patient information resources provided are clinically accurate, balanced and evidence-based, and suitable to your patient population. These resources should include information about surgical and non-surgical options, be easy to understand, and be presented in a format that is easy to use for patients with impaired vision.

Provide a culturally safe environment for your patient community.[55] The level of comorbidities in Aboriginal and Torres Strait Islander people, their age at diagnosis and disparities in their health outcomes means that health care for this population needs to be refocused to meet the unique needs of each patient.

3 Access to ophthalmology assessment

What the standard says

A patient who has been referred for consideration for cataract surgery is prioritised for ophthalmology assessment according to clinical need, based on a locally approved protocol and following receipt of a detailed referral.

What this means for health service organisations

When patients are referred for consideration for cataract surgery, appointments are allocated using protocols that prioritise patients based on clinical need, including social circumstances, based on adequate information about the referred patient. This is particularly important in health service organisations that have substantial waiting lists for the first specialist assessment.

These protocols should describe criteria for accepting referrals and prioritising patients for ophthalmology assessment. They should include any tools to be used for providing standardised information, and allow for a credentialed ophthalmic clinician to review referrals to determine the priority and timing of ophthalmology assessments. In some states and territories, these protocols may be determined at a health department level for public hospital clinics.

Where referral criteria apply, these should be readily available and communicated to referring clinicians and patients. Consider providing a standardised referral template for referrals from the community to help ensure that adequate information is provided.

Protocols should include pathways for patients who do not meet referral criteria, who choose non-surgical options, or for whom surgery is considered unsuitable or inappropriate at ophthalmologic assessment. These pathways may include reassessment or follow-up, or referral to other services such as optometry, orthoptist, occupational therapy providers of low-vision services or vision clinics. Provide information back to the referring clinician.

Processes should be in place to monitor patients waiting for first ophthalmology appointments in case their clinical needs and priority change.

Monitor and audit outcomes within a quality improvement framework to assess whether desired outcomes are being achieved, including the time frame from referral to assessment and surgery.

4 Indications for cataract surgery

What the standard says

A patient is offered cataract surgery when they have a lens opacity that limits their vision-related activities and causes clinically significant visual impairment involving reduced best corrected visual acuity, disabling glare or contrast sensitivity.

What this means for health service organisations

Ensure that protocols support the use of suitability criteria for cataract surgery, and that cataract surgery is offered to patients who meet agreed criteria. Protocols should allow other compelling indications for surgery to be considered, based on clinical judgement, and should cater for patients who choose non-surgical options.

Consider implementing common clinical criteria or tools into protocols to enable standardised assessment, documentation and prioritisation. (Box 2 in the Cataract Clinical Care Standard provides examples of tools that could be considered). Implement tools and protocols within a quality improvement framework, monitoring their use and impact to ensure that desired outcomes are being achieved. Such outcomes may include whether criteria are being consistently applied, equity of access, timeliness of access and patient-reported outcomes.

5 Prioritisation for cataract surgery

What the standard says

A patient is prioritised for cataract surgery according to clinical need. Prioritisation protocols take into account the severity of the patient's visual impairment and vision-related activity limitations, the potential harms of delayed surgery, any relevant comorbidity and the expected benefits of surgery.

What this means for health service organisations

Ensure that protocols are in place to support prioritisation of patients according to their clinical needs and other key factors, based on a full ophthalmology assessment. Prioritisation protocols should include consideration of the patient's visual impairment and vision-related activity limitations, comorbidity, potential harms from delayed surgery and potential to benefit. Social factors that may affect the ability of patients to access care should also be considered in protocols where relevant locally, including remoteness, language and culture. Surgery is scheduled based on this protocol. Monitor and, if necessary, reassess patients while they are on the waiting list in case their circumstances change.

Consider using validated tools or agreed clinical criteria to enable standardised assessment and documentation. Implement prioritisation protocols as per the requirement of the health service, or the state or territory health department. Examples of tools that could be considered and adapted are listed in Box 3 of the Clinical Care Standard. Implement tools and protocols within a quality improvement framework, monitoring their use to ensure that desired outcomes are being achieved. These include whether criteria are being consistently applied, timeliness of surgery, clinician perceptions and patient-reported outcomes. Where there is variation, assess the effectiveness of prioritisation protocols in the context of Action 1.28 of the National Safety and Quality Health Service Standards.

6 Second-eye surgery

What the standard says

Options for a patient with bilateral cataract are discussed when the decision about first-eye surgery is being made. Second-eye surgery is offered using similar criteria as for the first eye, but the potential benefits and harms of a delay in second-eye surgery are also considered, leading to a shared decision about second-eye surgery and its timing.

What this means for health service organisations

Provide access to current evidence-based guideline recommendations for second-eye surgery and support use of these recommendations by clinicians. Ensure the availability of protocols relating to decisions about second-eye surgery and its timing. For patients having delayed second-eye surgery, prioritise surgery according to clinical need.

If second-eye surgery on the same or next day is carried out in the health service, ensure that facilities are appropriately equipped, and that local protocols are in place to minimise the risk of complications and manage them should they occur.

7 Preventive eye medicines

What the standard says

A patient receives an intracameral antibiotic injection at the time of cataract surgery, in preference to postoperative topical antibiotics and according to evidence-based guidelines. After surgery, a patient receives anti-inflammatory eye drops when indicated.

What this means for health service organisations

Ensure that clinicians have access to current evidence-based guideline recommendations for intracameral antibiotics and other postoperative eye drops, such as *Therapeutic Guidelines: Antibiotic*. Develop processes to measure compliance with guidelines.

Intracameral use of cefazolin is off-label, and its addition to the formulary will need to be approved by the local Drugs and Therapeutics Committee under routine use of an off-label medicine.

8 Postoperative care

What the standard says

A patient receives postoperative care that ensures the early detection and treatment of complications of cataract surgery, and the patient's visual rehabilitation. Postoperative care is provided by the operating ophthalmologist or a designated team member. The patient is informed of the arrangements for postoperative care.

What this means for health service organisations

Ensure that clinicians have access to local guidelines or protocols for appropriate postoperative care, and that processes are in place to promptly identify and manage complications.

When postoperative care will be provided by a clinician other than the operating ophthalmologist, ensure appropriate handover of clinical information required to provide postoperative care. Ensure that systems are in place to provide patients with access to emergency specialist ophthalmology services as needed.

Ensure that policies and procedures for information management and communication support the reporting of surgical outcomes to referring clinicians, other relevant clinicians and the patient, and that responsibilities are clearly delineated.

Indicators for local monitoring

The following indicators will support health service organisations to monitor how well they are implementing the care recommended in this clinical care standard and are intended to support local quality improvement activities.

Access to ophthalmology assessment

Indicator 3a: Evidence of a locally approved protocol to allocate appointments for patients considering cataract surgery. The protocol should define the:

- Patient information required to be included in incoming referrals
- Criteria for accepting referrals for ophthalmology assessment
- Pathways for patients who do not meet the referral criteria
- Criteria for prioritising appointments for ophthalmology assessment.[2]

Indicator 3b: Proportion of referrals for consideration for cataract surgery received that included the required patient information.

Indicator 3c: Proportion of patients referred for consideration for cataract surgery that did not meet the criteria for referral.

Indicator 3d: Proportion of patients referred for cataract surgery who had cataract surgery.

Prioritisation for cataract surgery

Indicator 5: Evidence of a locally approved protocol to prioritise patients for cataract surgery according to clinical need.

Preventive eye medicines

Indicator 7: Proportion of patients who received intracameral administration of antibiotics at the end of surgery.

More information about these indicators and the definitions needed to collect and calculate them can be found online at METeOR: **https://meteor.aihw.gov.au/content/index.phtml/itemId/711408**

Questions?

For more information, please visit: **www.safetyandquality.gov.au/cataract-ccs**

You can also contact the Clinical Care Standards team at: **ccs@safetyandquality.gov.au**