### Notes to Provide Clarification of ACSA Standards

**Please be advised that:**
- only certain parts of the cited GPAS reference text may be applicable to the ACSA Standard
- the term ‘appropriately trained’ refers to someone who has had specific training in the knowledge and skills required to undertake their designated role
- areas that do not have any anaesthetic input will not be assessed during the onsite review visit
- the obstetric unit only refers to units led by an obstetrician; midwife-led units are not reviewed by ACSA.

| Note 1 | On the prioritisation of standards | Every ACSA standard has been assigned a priority. Standards are assigned priority 1 if they must be achieved in order for accreditation to be awarded. Priority 2 standards should be achievable by most departments. Priority 3 standards will aspirational for most, however they will provide targets for the highest performing departments to achieve. All new standards are assigned to Priority 2 in their first year but may become Priority 1 after that. |
| Note 2 | On the use of the term ‘policies’ | Whilst the ACSA standards utilise the term ‘policies’, it should be noted that the term is used as an umbrella to refer to a form of locally agreed process that is maintained, kept up-to-date (reviewed at least every three years), can be used as a reference and is used during induction. This could be in the form of a policy document, practice document or even a piece of software that fulfils the function of the standard. The important criteria are that everyone knows the reference point exists and where to find it, and that the reference point is kept up to date in accordance with the trust/board policies. Policy documents should be standardised in format, have clear review dates and have been ratified in accordance with trust/board policies. |
| Note 3 | For hospitals that do not provide services for children | If your department does not treat children it is acceptable to mark child specific standards as ‘N/A’. Where the standard refers to both children and adults, you may disregard the paediatric aspect and mark the standard as ‘met’ if you feel you meet that standard for adult care, or ‘not met’ if that isn’t the case. |
| Note 4 | On Staff Grade, Associate Specialist and Specialty (SAS) Doctors | The diverse nature of these posts means that the standards of education, training and experience that can be expected from post holders can vary quite widely. The degree of supervision a SAS doctor requires should be agreed via a robust, local governance process and follow the RCoA guidance on ‘Supervision of SAS and other non-consultant anaesthetists’. Where the standard refers to a consultant anaesthetist, it is acceptable for SAS doctors whom this process has agreed can practice without consultant supervision, to fulfil this role. |
STANDARD
5.2.1.1 There is a named lead clinician responsible for ophthalmic anaesthesia

EVIDENCE REQUIRED
Documented evidence provided e.g. Job plan or rota

PRIORITY
1

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Management and leadership

HIS Domains
Workforce management and support

GPAS REFERENCES
13.1.3 Each department or facility that provides ophthalmic anaesthesia services should have a consultant with nominated responsibility for ophthalmic anaesthesia.
STANDARD

5.2.1.2 All patients undergoing ophthalmic anaesthesia or sedation are assessed preoperatively by appropriately trained staff underpinned by guidelines on patient selection and perioperative management.

EVIDENCE REQUIRED
Copy of policy provided. Staff should be able to give verbal confirmation that this assessment takes place.

PRIORITY
1

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

13.1.5 Many ophthalmic patients have significant co-morbidities that may require optimisation and co-ordination prior to surgery. There should be a lead anaesthetist (with an appropriate number of programmed activities in their job plan and appropriate secretarial support) for pre-operative assessment, who works closely with an appropriately trained preoperative assessment team.

13.2.8 Patients having ophthalmic surgery should undergo pre-operative preparation, where there is the opportunity to assess medical fitness and impart information about the procedure.

13.2.9 As part of pre-operative preparation, the plan for the perioperative management of any existing medications, such as anticoagulant drugs and diabetic treatment, should be agreed, taking into account the relative risks of stopping any medication in the light of the patient’s medical condition and the anaesthetic technique required. Advice should be sought from the multiprofessional team (e.g. medical colleagues, clinical pharmacists, specialist nurses) as required, in particular for complex patients.

13.2.10 The majority of ophthalmic surgery is done as day-case procedures under local anaesthesia. Pre-operative assessment should identify those patients who are not suitable for this approach and who might require general anaesthesia or intravenous sedation.

13.2.11 Patients who require anaesthesia or intravenous sedation should undergo pre-operative anaesthetic assessment.
STANDARD
5.2.1.3 The WHO checklist should be adhered to including a robust procedure for checking the laterality of the eye to be operated on and that it is marked clearly with indelible ink, prior to local anaesthetic block or general anaesthesia. Where bilateral surgery is planned, there is a policy in place to ensure that each eye receives the correct operation.

EVIDENCE REQUIRED
Documented evidence that this occurs. Copy of policy provided. Verbal confirmation from staff. Audit of evidence

PRIORITY

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES
13.5.6 National safety standards for invasive procedures (NatSSIPs) should be adapted for local use as local safety standards for invasive procedures. The WHO process, for example, could be adapted to incorporate intraocular lens selection to help prevent ‘wrong lens’ errors.

13.5.7 There should be a robust procedure for checking the laterality of the eye to be operated on prior to local anaesthetic block or general anaesthesia. This should include the eye being marked with an indelible mark by the responsible surgical team prior to admission to the operating theatre. The RCoA/ NPSA ‘Stop before you block’ protocols should be adhered to.
STANDARD
5.2.1.4 The RCoA 'STOP before you block' protocol is adhered to

EVIDENCE REQUIRED
Documented evidence that this occurs. Copy of policy provided. Verbal confirmation from staff. Audit of evidence

PRIORITY
1

CQC KLoEs
Safe, Effective

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery

GPAS REFERENCES
13.5.7 There should be a robust procedure for checking the laterality of the eye to be operated on prior to local anaesthetic block or general anaesthesia. This should include the eye being marked with an indelible mark by the responsible surgical team prior to admission to the operating theatre. The RCoA/ NPSA ‘Stop before you block’ protocols should be adhered to.
STANDARD
5.2.1.5 There is a policy on patient selection for ophthalmic day case procedures

EVIDENCE REQUIRED
Copy of policy provided. Verbal confirmation from staff that policy is followed

PRIORITY
1

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES
13.2.10 The majority of ophthalmic surgery is done as day-case procedures under local anaesthesia. Pre-operative assessment should identify those patients who are not suitable for this approach and who might require general anaesthesia or intravenous sedation.
STANDARD
5.2.1.6 There is a policy on patient selection for ophthalmic procedures under local anaesthetic

EVIDENCE REQUIRED
Copy of policy provided. Verbal confirmation from staff that policy is followed

PRIORITY
1

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES
13.2.10 The majority of ophthalmic surgery is done as day-case procedures under local anaesthesia. Pre-operative assessment should identify those patients who are not suitable for this approach and who might require general anaesthesia or intravenous sedation.
5.2.1.7 There is a formal system in place for assessing and recording the cognitive status of patients during preoperative assessment

EVIDENCE REQUIRED
Documented evidence, e.g. Preoperative assessment records such as Mini Mental State Evaluation or Abbreviated Mental Test

PRIORITY
2

CQC KLoEs
Safe, Caring, Responsive

HIW Domains
Safe and effective care; Quality of patient experience

HIS Domains
Safe, effective and person-centred care delivery; Policies, planning and governance; Impact on patients, service users, carers and families

GPAS REFERENCES
13.3.5 Older patients should be assessed for risk of postoperative cognitive dysfunction and pre-operative interventions undertaken to reduce the incidence, severity and duration. Hospitals should ensure guidelines are available for the prevention and management of postoperative delirium and circulated pre-operatively to the relevant admitting teams.

13.3.6 Postoperative cognitive dysfunction is a particular concern and can disrupt otherwise stable home circumstances. The risk should be reduced as far as possible by minimising interventions and using local anaesthesia alone when feasible.
STANDARD
5.2.1.8 There is a policy for sedation of patients for ophthalmic procedures, including specifications of the facilities provided

EVIDENCE REQUIRED
Copy of policy provided

PRIORITY
1

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES
13.2.13 In units where ophthalmic surgery is performed, including locations that may be isolated from main theatre services, facilities provided should allow for the safe conduct of anaesthesia and sedation. This would include monitoring equipment, oxygen, availability of opioid and benzodiazepine antagonist drugs, a recovery area, and drugs and equipment to deal with emergencies such as cardiac arrest, anaphylaxis and local anaesthesia toxicity.

13.3.16 Patients exhibit extremely wide variation in response to drugs used for sedation. Coupled with this uncertain pharmacodynamic response, patient access during ophthalmic surgery is often very limited and airway manipulation may be difficult should a state of deep sedation occur. In view of these safety concerns, administration of intravenous sedation during ophthalmic surgery should only be undertaken by an anaesthetist whose sole responsibility for the duration of the surgery is to that patient.

13.3.17 Patients do not need to be starved when sedative drugs are used in low doses to produce simple anxiolysis. Patients should be starved when deeper planes of sedation are anticipated or sedative infusions employed.
STANDARD

5.2.1.9 There is a policy for scheduling of urgent procedures in and out-of-hours with particular regard to the condition of the eye, the proposed operation, the ASA grade and age of the patients.

EVIDENCE REQUIRED
Copy of policy provided. Audit data available.

PRIORITY
1

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES
13.5.3 Many procedures do not have to be performed out of hours. Anaesthetists and surgeons together should devise departmental protocols for the handling of patients requiring urgent procedures, to allow prioritisation from both surgical and anaesthetic perspectives.
STANDARD
5.2.1.10 There is a policy for the transfer of patients who become sick unexpectedly to an appropriate higher level of care

EVIDENCE REQUIRED
Copy of policy provided. Audit data available

PRIORITY
1

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES
13.3.11 Protocols should be in place for the transfer of patients from isolated units who become ill unexpectedly. They should be moved safely and rapidly to a facility which provides an appropriate higher level of care.
STANDARD
5.2.1.11 Guidelines are in place for the prevention and management of postoperative cognitive dysfunction and postoperative delirium

EVIDENCE REQUIRED
Copy of guidelines provided. Verbal confirmation from staff that guidelines are followed

PRIORITY
2

CQC KLoEs
Safe, Effective, Responsive, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES
13.3.5 Older patients should be assessed for risk of postoperative cognitive dysfunction and pre-operative interventions undertaken to reduce the incidence, severity and duration. Hospitals should ensure guidelines are available for the prevention and management of postoperative delirium and circulated pre-operatively to the relevant admitting teams.

13.3.6 Postoperative cognitive dysfunction is a particular concern and can disrupt otherwise stable home circumstances. The risk should be reduced as far as possible by minimising interventions and using local anaesthesia alone when feasible.
5.2.2.1 Appropriate staffing levels and skill mix is provided in all units delivering ophthalmic anaesthesia (multidisciplinary general hospitals, isolated units and large single specialty centres)

EVIDENCE REQUIRED
Documented evidence provided e.g. Rota. Verbal confirmation from staff

PRIORITY
1

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care; Management and leadership

HIS Domains
Safe, effective and person-centred care delivery; Workforce management and support

GPAS REFERENCES
13.1.1 Appropriate staffing levels and skill mix should be provided in all units, multispecialty general hospitals, isolated units and large single-specialty centres, delivering ophthalmic anaesthesia. For most operating sessions, this should include surgeon, anaesthetist, two theatre-trained scrub practitioners, one trained nurse or operating department practitioner to assist with local anaesthesia/patient monitoring, and one theatre-support worker/runner.
STANDARD
5.2.2.2 An anaesthetist is present in the operating theatre at all times when intravenous sedation is administered for ophthalmic procedures

EVIDENCE REQUIRED
Policy on provision of sedation. Verbal confirmation from staff

PRIORITY
1

CQC KLoEs
Safe, Responsive, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery

GPAS REFERENCES
13.3.16 Patients exhibit extremely wide variation in response to drugs used for sedation. Coupled with this uncertain pharmacodynamic response, patient access during ophthalmic surgery is often very limited and airway manipulation may be difficult should a state of deep sedation occur. In view of these safety concerns, administration of intravenous sedation during ophthalmic surgery should only be undertaken by an anaesthetist whose sole responsibility for the duration of the surgery is to that patient.
STANDARD
5.2.2.3 Needle blocks are administered only by trained surgeons or anaesthetists, or under the direct supervision of an experienced surgeon/anaesthetist

EVIDENCE REQUIRED
Copy of policy provided. Verbal confirmation from staff

PRIORITY
1

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery

GPAS REFERENCES
13.3.14 Owing to the risk of life threatening complications, sharp needle-based blocks (e.g. peribulbar or retrobulbar block) should not be administered by non-medically-qualified personnel. Intravenous access should be established prior to performing sharp needle blocks and for any patient deemed to be high risk due to severe co-morbidity.
STANDARD
5.2.2.4 Where general anaesthesia is administered, monitoring and anaesthetic equipment, and appropriate lighting is provided to enable safe delivery of the full range of anaesthesia

EVIDENCE REQUIRED
Verbal confirmation from staff especially if they feel that any equipment is lacking based on the procedures undertaken

PRIORITY
1

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery

GPAS REFERENCES
13.2.5 All necessary anaesthetic equipment should be available. Devices and equipment should be suitable for the task for which they are used, and should conform to verified standards. Equipment should be maintained and serviced regularly.
STANDARD

5.2.2.5 There is an identified group of senior anaesthetists who manage and deliver a comprehensive ophthalmic anaesthesia service, including the use of orbital regional anaesthetic techniques

EVIDENCE REQUIRED
Documented evidence provided, e.g. job plan or rota

PRIORITY
2

CQC KLoEs
Safe, Responsive, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery; Workforce management and support

GPAS REFERENCES
13.1.4 There should be an identified group of senior anaesthetists who manage and deliver a comprehensive ophthalmic anaesthesia service, including the use of orbital regional anaesthetic techniques.
STANDARD
5.2.2.6 When lasers are in use for ophthalmic surgery, the correct safeguards are in place

EVIDENCE REQUIRED
Copy of policy provided. Verbal confirmation from staff that policy is followed

PRIORITY
2

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery

GPAS REFERENCES
13.2.7 Where lasers are in use for ophthalmic surgery, the correct safeguards must be in place.
STANDARD
5.2.3.1 There is comfortable access to the theatre suite and equipment is available to adjust patient position to ensure maximum comfort and optimum surgical access

EVIDENCE REQUIRED
Verbal confirmation from staff. Equipment should be seen

PRIORITY

CQC KLoEs
Safe, Caring, Responsive

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery

GPAS REFERENCES
13.2.16 Optimal patient positioning is critical to the safe conduct of ophthalmic surgery and for patient comfort. Adjustable trolleys/operating tables which permit correct positioning should be available.

13.2.17 Some patients, for example those with restricted mobility, may require specific equipment such as hoists to position them. Preoperative planning should ensure that such equipment is available, and allow for the extra time and staff needed to position these patients safely.
STANDARD
5.2.3.2 Staff are trained to safely help patients on and off operating tables with care and dignity

EVIDENCE REQUIRED
Verbal confirmation from staff. Documented evidence provided, e.g. policy or staff training records

PRIORITY
1

CQC KLoEs
Safe, Caring, Responsive

HIW Domains
Safe and effective care; Quality of patient experience

HIS Domains
Safe, effective and person-centred care delivery; Impact on patients, service users, carers and families

GPAS REFERENCES
13.2.17 Some patients, for example those with restricted mobility, may require specific equipment such as hoists to position them. Preoperative planning should ensure that such equipment is available, and allow for the extra time and staff needed to position these patients safely.
STANDARD

5.2.3.3 Specific patient information regarding procedures for the day of admission and explanation of local or general anaesthetic techniques is available prior to admission

EVIDENCE REQUIRED
Copies of written information should be provided

PRIORITY
1

CQC KLoEs
Caring, Responsive

HIW Domains
Safe and effective care; Quality of patient experience

HIS Domains
Safe, effective and person-centred care delivery; Impact on patients, service users, carers and families

GPAS REFERENCES
13.9.3 Information should be made available to patients, which gives details of the surgery and local and general anaesthesia for ophthalmic procedures, as well as advice on what to expect on the day of admission. The Royal College of Anaesthetists and the Royal College of Ophthalmologists have a range of booklets available on their websites to help to inform patients.
STANDARD
5.2.4.1 All ophthalmic theatre nurses, anaesthetic nurses and ODPs must have up-to-date appropriate life support training and ophthalmic nurses are trained in cardiopulmonary resuscitation

EVIDENCE REQUIRED
Documented evidence of training provided. Verbal confirmation from staff

PRIORITY
1

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery

GPAS REFERENCES
13.1.7 Staff should be trained in basic life support and there should be immediate access to a medical team with advanced life-support capabilities.
STANDARD
5.2.4.2 Ophthalmic anaesthesia is included in departmental audit programmes, including on-going audit of patient satisfaction, elective and emergency anaesthesia activities, complications and adverse events

EVIDENCE REQUIRED
Written and verbal evidence should be provided

PRIORITY
1

CQC KLoEs
Safe, Responsive, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery; Quality improvement focussed leadership

GPAS REFERENCES
13.7.2 Ophthalmic anaesthesia should be included in departmental audit programmes, which may include patient satisfaction, complications and adverse events.
STANDARD
5.2.4.3 Structured training in regional orbital blocks is provided to all inexperienced doctors who wish to learn any of these techniques. This includes the applied knowledge of anatomy, and recognising and minimising the risks of complications.

EVIDENCE REQUIRED
Documented evidence of training provided e.g. clinical governance meeting minutes. Verbal confirmation from staff.

PRIORITY
1

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery

GPAS REFERENCES
13.4.3 Structured training in regional orbital blocks should be provided to all inexperienced practitioners who wish to learn any of these techniques. This should include an understanding of the relevant ophthalmic anatomy, physiology and pharmacology, and the prevention and management of complications. Where possible, trainees should be encouraged to undertake ‘wetlab’ training or use simulators to improve practical skills.
STANDARD
5.2.4.4 Doctors learning orbital regional anaesthesia are directly supervised by an expert until assessed to be competent

EVIDENCE REQUIRED
Documented evidence of training provided. Verbal confirmation from staff

PRIORITY
1

CQC KLoEs
Safe, Effective, Well-led

HIW Domains
Safe and effective care

HIS Domains
Safe, effective and person-centred care delivery

GPAS REFERENCES
13.4.3 Structured training in regional orbital blocks should be provided to all inexperienced practitioners who wish to learn any of these techniques. This should include an understanding of the relevant ophthalmic anatomy, physiology and pharmacology, and the prevention and management of complications. Where possible, trainees should be encouraged to undertake ‘wetlab’ training or use simulators to improve practical skills.

Royal College of Anaesthetists
Royal College of Anaesthetists, Churchill House, 35 Red Lion Square, London WC1R 4SG 020 7092 1500 | www.rcoa.ac.uk/acsa | acsa@rcoa.ac.uk

© Royal College of Anaesthetists (RCoA)