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Letter to Editor

Phone Triage System is an Effective and Safe Way to Manage Patients in Eye Casualty during the COVID-19 Lockdown

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The recent COVID-19 pandemic led the UK government to issue guidelines on social distancing and home confinement. In accordance with the Royal College of Ophthalmologists guidance on the management of services during the pandemic [1], our unit halted all routine clinical activity and restricted emergency access services. Nottingham University Hospitals trust (NUH) has the largest tertiary walk in eye casualty centre in the East Midlands with 24 hour on-call cover. Following lockdown, all walk-ins to eye casualty were stopped and patients were encouraged to self-refer via a new phone triage system aiming to prioritise patients with acute symptoms who needed face to face review and providing verbal advice over the telephone where possible. Walk-in patients were triaged in the same manner and only selected patients were admitted to the department. Both phone and presential triage were carried out following an existing risk assessment triage tool developed for eye casualty.

During the first 2 weeks of April 2020, 352 patients were seen in eye casualty. Of the 187 phone calls received by the eye casualty triage line, 127 patients were advised to attend eye casualty for a face to face consultation and 60 were given advice and asked to make contact again should the condition not improve or get worse. Of those given verbal advice only, seven patients (11.7%) phoned back and were given a face to face assessment. Three of these patients (5%) required prescriptions following face to face assessment and were diagnosed with mild diffuse scleritis, AAU and post-operative uveitis. None of these patients had visual loss during this process and they all phoned back within 3 days. The four remaining patients had the same symptoms as at the time of triage and the provisional diagnosis was confirmed when they were examined.

The phone triage service implemented in response to the lockdown was an effective tool to filter patients with non-acute conditions who would have otherwise come to hospital and increased the risk of exposure and contamination and made social distancing in the department more challenging. We found that mild ophthalmic conditions such as dry eye syndrome and conjunctivitis had a 60% to 80% reduction in attendance and we believe that this was partly influenced by the phone triage line as patients who described mild symptoms were given verbal advice and reassurance. It successfully reduced potential attendance by 30% and it allowed maximum utilisation of nurses who had to shield and could not participate in patient facing activities. The low number of patients who attended following verbal advice from telephone triage coupled with the fact that no harm occurred related to the delay between the verbal advice and being seen in eye casualty suggests that following easing of lockdown or in the event of a second wave this can be an effective strategy to prevent patients from eye casualty attendance and re-

duce unnecessary face to face appointments. Successful collaboration with GPs and community optometrists will be crucial to make this tool even more effective.

Conflict of Interests

The authors declare no conflict of interests.

Bibliography

1. RCOPhth guidelines on management of ophthalmology services following COVID-19 pandemic (2020).

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