1. Introduction

The purpose of the interim blood monitoring of myeloma is to provide patients with a safe guideline-based service to monitor their myeloma and blood results because of treatment or as part of a 'watch & wait' monitoring strategy.

A nurse led interim blood monitoring service has been established in response to several factors.

- Improved survival and prognosis of myeloma has increased the numbers of patients living with and beyond treatments, but these patients require surveillance of their condition to recognise early signs of progression or complications of treatment regimens.
- The growing numbers of patients attending the myeloma clinics can lead to lengthy waits for patients who do not necessarily require a medical review.
- Nurse-led clinics are supported by recent government and nursing policy which encourages new ways of working across professional boundaries to make effective use of resources.

This document outlines the arrangements for the remote monitoring of patients with Myeloma and to formally set out the management of such patients by the myeloma CNS (Clinical Nurse Specialist).

The role of the CNS in this clinic is to

- Monitor the patient's condition remotely by interpreting blood results, with access and discussion with myeloma specialist clinicians as required
- Providing timely communication to patients with regards to their results either by letter (if bloods are stable) or via telephone (if intervention is required because of the results).

The following clinic lists are set up for this purpose and bloods are evaluated within the clinic environment ensuring the presence of a myeloma specialist clinician in case advice or treatment decisions are required.

TELMKG1	Tuesday afternoon	10 slots
TELLMB	Thursday morning	10 slots

The above numbers apply if there are a full complement of the CNS team on duty i.e. 3 members of the Myeloma CNS team 1.5WTE band 7 and 0.5WTE band 6. In case of sickness or absence it may be necessary to reduce these slots to enable the core roles of the cancer CNS role to be met.

2. Scope

This document applies to all consultants, junior medical staff, and clinical nurse specialists (CNS) involved in the care of Myeloma patients within the University Hospitals of Leicester NHS Trust.

3. Recommendations, Standards and Procedural Statements

Myeloma is a malignant condition of the plasma cells occurring primarily within the bone marrow, there are a range of other associated conditions namely solitary plasmacytoma and AL Amyloidosis which are also covered by this document.

MGUS monitoring is not included in this document, as all MGUS patients should be monitored within the remote DAWN monitoring service.

The Myeloma CNS team also must provide the more traditional CNS role to all patients with myeloma within the clinic timeframe and so the number of patients that can be monitored on each Interim blood monitoring list must be capped. To maintain clinical safety and deliver a high-quality service for all parts of the CNS role the maximum number of patients the interim clinic can accommodate is 10- if both members of the CNS team are present in the clinic.

The band 6 CNS is not able to undertake the interim list independently and so must do the list in conjunction with a myeloma specialist clinician in the absence of the band 7 CNS.

There are several reasons that a patient with myeloma may benefit from remote monitoring to enable them to be monitored safely without attending the clinic, examples are below:

- Stable myeloma patients currently off treatment or post autologous transplant
- Asymptomatic myeloma monitoring of patients
- Patients on first course of treatment such as lenalidamide or pomalidamide (immune modulatory drugs) to monitor for associated pancytopenia
- Patients who are stable on long term treatments.
- Patients follow up post infection to ascertain CRP reducing so that next course of chemotherapy can commence
- Patients started on GCSF or Erythropoietin to assess response or establish dosing of drug regimen.

<u>Inclusion criteria for CNS Interim blood clinic</u>

1 The patient must have been informed of the purpose of the remote monitoring and must have verbally agreed to having bloods monitored by the CNS

2 The referring doctor must have documented the rationale for remote monitoring and the required interval and booked the interim blood appointment by completing an outcome form identifying which interim blood clinic either TELMKG1 or TELLMB on the outcome form.

3 The patient must have been provided with relevant blood forms with the date of the blood test CLEARLY marked on the form.

> It is recommended that stable myeloma patients on ‘watch and wait’ have their bloods taken at their GP practice AT LEAST one week prior to the date of the interim blood review to ensure paraprotein and serum free light chain results are processed.
>
> Patients who are having bloods monitored for side effects of treatment or disease e.g. fbc, u&e, CRP should be informed to have their bloods taken at their GP practice the morning before the review i.e. 24 hours prior to the clinic review of bloods.

4 There should be clear guidance as to the required actions required by the CNS, especially in the case of monitoring for side effects of treatment.

5 The patient must have a confirmed diagnosis of myeloma, AL amyloidosis, or plasmacytoma.

<u>Exclusion Criteria for CNS interim blood monitoring</u>

1 The patient does not have a confirmed diagnosis of myeloma, AL amyloidosis, or plasmacytoma.

2 The patient has been admitted to hospital- these patients will be removed from the interim list.

3 The patient has significant co-morbidities or is receiving treatment for the same that may confound the interpretation of blood results by the CNS.

4 The patient has consistently failed to have a blood test done on more than 2 consecutive occasions despite reminder by letter.

Process for Interim remote monitoring by CNS

1. The CNS will have a maximum of 10 patients in one session if both CNSs are present in the clinic, it is not possible to maintain other functions of the CNS role if the number of patients exceeds this level.
2. If a band 7 CNS is not available in the clinic, due to sickness, study, or annual leave the interim remote monitoring can only be undertaken by the band 6 CNS in conjunction with one of the myeloma specialist clinicians.
3. In the absence of the CNS team the interim blood reviews will be undertaken by the myeloma specialist clinicians.
4. The CNS interim blood monitoring clinic will always run in parallel with the consultant clinic.
5. The clinic co-ordinator will arrange for the medical notes to be brought to the clinic and the list of patients for CNS review will be managed by the clinic co-ordinator. The CNS should be made aware of any overbooking of lists > 10 patients per list at the time of overbooking the clinic, so he/she can negotiate with the specialist myeloma clinicians assistance with the list.
6. The CNS will check the latest blood results for each patient on the clinic list and compare these to the previously documented blood results to ascertain whether there have been any dramatic changes in blood counts, renal function, adjusted calcium, paraprotein or serum free light chains/ratio.
7. Where monitoring parameters are documented in the patient's case notes by a consultant/SpR, the CNS should ensure any decisions made comply with these parameters.
8. Where blood results are stable and the patient has no new problems, and no treatment decisions are required, referral to the consultant/SpR is not necessary and the CNS will complete a letter to the patient to communicate that their bloods are stable.
9. If blood results of patients show deterioration see appendix 1, the results will be discussed with the myeloma specialist clinician and the patient will be telephoned to ascertain any new symptoms and informed of any changes to treatment or follow-up. If follow up is to be brought forward to see the specialist myeloma team the CNS will liaise directly with the myeloma clinic co-ordinator to ensure a new rescheduled appointment is sent out to the patient with blood forms if necessary.
10. Where no blood test is done on the first occasion the CNS will send a reminder and repeat forms to the patient. The subsequent interim remote monitoring appointment will be scheduled as appropriate for the reason of monitoring. If the patient fails to provide blood tests despite one reminder an attempt will be made to contact the patient by telephone to remind them of their remote monitoring appointment. If the patient subsequently fails to provide blood samples this will be documented in the patient case notes and they will be rescheduled onto the consultant list. Such failure to comply with remote monitoring will preclude the patient being offered further interim remote monitoring due to the limited availability of slots on each clinic.
11. The nurse will complete an outcome sheet for every patient reviewed and will determine that the patient has further follow-up in place. The outcome sheets will be given to the myeloma clinic co-ordinator so outcomes for the interim blood review can be documented on HISS.

4. Education and Training

The CNS responsible for the interim blood monitoring clinic will have specialist knowledge, skills, and experience in caring for patients with myeloma and associated conditions. This will be

obtained by shadowing the medical team and running the clinic parallel with the haematology consultant/specialist myeloma clinicians.

This will include discussing and validating decisions with the consultant for a minimum of 20 decisions or until the lead consultant confirms the CNS is clinically competent to manage this patient group and a record of competence is completed. Appendices 2 & 3

The CNS must ensure that they adhere to the NMC (Nursing and Midwifery Council) Code (2015) and recognise and work within the limits of their competence.

CPD (Continued Professional Development) will be undertaken to increase knowledge of Myeloma and associated conditions and develop clinical expertise. This can be achieved through the following:

- Attending relevant study days/course/conferences
- Visits to observe practice at other centres
- Feedback/audit from colleagues and users
- Reflective practice

5. Monitoring and Audit Criteria

Regular and systematic audit of the monitoring services must be undertaken to ensure patient safety and to ensure adherence to guidelines and to ensure the CNS and medical team maintain skills and knowledge. Audit is proposed every third year, reviewing a sample of 20 patient records, and including a patient experience survey. Results would be evaluated and presented to Haematology Group.

Key Performance Indicator	Method of Assessment	Frequency	Lead
Number of Complaints	Analysis	Annual	CNS/Clinical Lead
DNA rates	Analysis	Annual	CNS/Clinical Lead
Patient satisfaction	Compliments/survey	Annual	CNS/Clinical Lead
Impact on service delivery	Analysis	Annual	CNS/Clinical Lead

6. Legal Liability Guideline Statement

The University Hospital of Leicester NHS Trust as an employer will assume vicarious responsibility for the nurse providing that the CNS has undergone adequate preparation for the development of this practice

8. Key Words

CNS	Clinical Nurse Specialist
FLC	Free Light Chain
GP	General Practitioner
Igs	Immunoglobulins
MGUS	Monoclonal Gammopathy of Undetermined Significance
SFLCR	Serum Free Light Chain ratio
UHL	University Hospitals of Leicester NHS Trust

This line signifies the end of the document

This table is used to track the development and approval and dissemination of the document and any changes made on revised / reviewed versions

DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT		
Author / Lead Officer:	Cath Morrow Corinne Farrow	**Job Title:** Myeloma CNS
Reviewed by:		
Approved by:		**Date Approved:**

REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**

DISTRIBUTION RECORD:			
Date	**Name**	**Dept**	**Received**
	Haematology Consultants	Haematology	
	Head of and Deputy Head of Nursing	CHUGGS CMG	
	Administrator	Haematology	

Recommended Actions for CNS Interim monitoring of myeloma patients APPENDIX **1**

Patient Result	**Action**
Adverse medication effects or disease complication highlighted by patient	Discuss with referring consultant
FBC normal, U&Es normal, Adjusted Calcium Normal	No Action
Paraprotein stable within 5g/L of baseline paraprotein or last current trend of 3 results unless paraprotein > 30g/L	No Action
Serum Free Light chains (Kappa or Lambda) stable within 100mg/L of baseline or last current trend of 3 results	No Action
Paraprotein showing rising trend > 5 g/L from monitoring baseline after presentation (AMM) or last treatment (if previously treated) or if > 30g/L Rise in Serum Free light chains > 100mg/L or if >1000mg/L	Discuss with referring consultant
Haemoglobin drop by 20 (e.g. 120 to 100) or 1st reading <100 Neutrophils <1.0 Adjusted Calcium > 2.60 Adjusted Calcium < 2.10 Rise in creatinine either 1st recording >120 or change in result > 20 (e.g. from 120 to 140) Decrease in eGFR > 20 (e.g. from 60 to 40 on 1st occasion)	Discuss with referring consultant
Monitoring of neutrophils or haemoglobin if patient is on GCSF or Erythropoietin	Discuss with referring Consultant to review dose/frequency of drug
CRP > 20 in patients on chemotherapy	Discuss with referring consultant
Other tests – LFTs, Urine ACR/PCR, Haematinics, Cholesterol, HbA1, cancer markers etc. cannot be evaluated by the CNS	Referring consultant to review results

Record of Haematology Clinical Nurse Specialist Competence APPENDIX 2

Demonstrate in-depth knowledge of the disease group through discussion and reflective learning for a minimum of 20 individual cases (depending on individual level of competence) which includes:

Number	Competence	CNS sign/Date	Consultant Sign/Date
1	Triaging patients that are suitable for the nurse led clinic		
2	Interpreting results and develop management plan		
3	Escalating when appropriate with a clear rationale		
4	Communicating with a patient in an appropriate and sensitive manner when explaining results either face to face or over the telephone		
5	Documenting clearly the patients management plan in medical notes		
6	Communicating with patients/GP via concise and accurate letters		
7	Adhering to the NMC Code (2015) and recognise and work within the limits of their competence		

Competence Record Review of Haematology bloods **APPENDIX 3**

Date	Bloods reviewed/Issues Identified	Action	Reviewed with

APPENDIX 4

Checklist for the Review and Approval of P&G Documents

Title of P&G Document Being Reviewed:		Yes / No / Unsure	Comments
1.	**Title and Format**		
	Is the title clear and unambiguous?		
	Is type of document clear (e.g. policy, guideline, procedure)		
	Does the document follow UHL template format? *If no document will be returned to author*		
3.	**Development Process**		
	Are the reasons for developing described (usually as part of introduction)		
4.	**P&G Content**		
	Does the P&G have an introduction and aims?		
	Is the P&G scope clear?		
	Does the P&G set out clear roles and responsibilities?		
	Are P&G Statements/Standards clear and easy to follow?		
5.	**Associated policies and supporting references**		
	Are associated policies listed and key references clearly cited?		
6.	**Consultation and Endorsement**		
	Has there been appropriate consultation? (see the consultation proforma)		
	Does the Document identify which who has endorsed it?		
7.	**Dissemination and Implementation**		
	Has the dissemination plan been completed? (see Admin Proforma)		
	Have all implementation issues been addressed?		
8.	**Equality and Benefits Realisation**		
	Has an Equality Impact Assessment Screening Tool been completed?		
	Have potential costs / benefits been considered or anticipated outcomes described?		
9.	**Process to Monitor Compliance**		
	Are there measurable outcomes / key indicators to support the monitoring of compliance?		
	Is there a plan to audit compliance with the document?		
	Have audit timescales and audit lead been identified?		
10.	**Document Control, Archiving and Review**		
	Have details regarding document control and archiving been provided?		
	Is the review date and reviewer identified?		
	If reviewed document, are changes identified or is there a statement that no changes required and 'fit for purpose'?		
11.	**Overall Responsibility for the Document**		
	Is it clear who is responsible for co-ordinating the dissemination, implementation?		

Initial Equality Impact Assessment Tool

Pro-forma for the Initial Assessment

Name of Policy / guidance Document :……

To be completed and attached to any procedural document (e.g. policies, guidance notes, etc) when submitted to the appropriate committee for consideration and approval.

An Equality Impact Assessment must always be carried out when there is a proposal to develop or change a function, e.g. Service Development within the Organisation.

		Comments	
1.	**What is the purpose of the proposal/ Policy**		
2.	**Could the proposal be of public concern?**		
3.	**Who is intended to benefit from the proposal and in what way?**		
4.	**What outcomes are wanted for the proposal?**		
		Yes/No	**Comments**
5.	**Is there a possibility that the outcomes may affect one group less or more favourably than another on the basis of:**		
	• Race		
	• Ethnic origins (including gypsies and travellers)		
	• Nationality		
	• Gender		
	• Culture		
	• Religion or belief		
	• Sexual orientation including lesbian, gay and transsexual people		
	• Age		
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems		
6.	Is there any evidence that some groups are affected differently?		

		Comments	
7.	If you have identified that some groups may be affected differently is the impact justified E.g. by Legislation: National guidelines that require the Trust to have a policy, or to change its practice.		
8.	Is the impact of the proposal / policy likely to be negative?		
9.	If so, can the impact be avoided?		
10.	What alternatives are there to achieving the proposal/ policy without the impact?		
11.	Can we reduce the impact by taking different action?		

If you have identified a potential discriminatory impact; please ensure that you do a Full Impact Assessment.

Initial Assessment completed by:

Name:	
Signed:	
Date:	
Contact number:	

If you require further advice, please contact Service Equality Manager on 0116 2584382.

POLICY AND GUIDANCE CONSULTATION PROFORMA

(To be completed and attached to Policy and Guidance documents when submitted to the UHL Policy & Guidelines Committee)

Elements of the Policy or Guidance Document to be considered (this could be at either directorate or corporate level or both)	**Implications** (Yes/ No)	**Local or Corporate**	**Consulted** (Yes/ No)	**Agree with P/G content** (Yes/No)	**Any Issues** (Yes / No)	**Comments / Plans to Address**
Education (i.e. training implications)						
Corporate & Legal						
• Clinical Risk						
• Health & Safety						
• Manual Handling						
• Legal Issues						
IM&T (i.e. IT requirements)						
Infection Prevention and Control						
Human Resources						
Operations (i.e. operational implications)						
Facilities (i.e. environmental implications)						
Finance (i.e. cost implications)						
Staff Side (where applicable)						
Patients/Carers (where appropriate)						
Relevant CBUs or Divisions:						

Committee or Group (i.e. Directorate Board) that has formally reviewed the Policy or Guidance document	**Date reviewed**	**Outcome / Decision**

Lead Officer(s) (Name and Job Title)	**Contact Details**

Reviewer	**Contact Details**	**Review Date**

Please advise of other policies or guidelines that cover the same topic area:

Title of Policy or Guideline:

POLICY AND GUIDANCE ADMIN PROFORMA

(To be completed and attached to Policy and Guidance documents when submitted to the UHL Policy & Guidelines Committee)

Title of Policy / Guideline:
Policy / Guideline Lead:
Date for P&G Review:

IMPLEMENTATION Please advise how any implications around implementation have been addressed:	
Financial	
Training	
Benefits realisation	How will the organisation benefit from implementing this policy (e.g. in terms of cost saving, improved governance)

REVIEW OF PREVIOUS P&G DOCUMENT		
Previous P&G already being used? Yes /No?		**Trust Ref No:**
If yes, Title:		**SharePoint No:**
Changes made to P&G? Yes / No?	**If yes, are these explicit** Yes / No? **If no, is P&G still 'fit for purpose?** Yes / No?	
Supporting Evidence Reviewed? Yes / No?	**Supporting Evidence still current?** Yes / No?	

VERSION CONTROL AND ARCHIVING
Where will previous versions be archived?
Proposed action to retrieve expired paper copies of P&G:

DISSEMINATION PLAN			
Date Finalised:	**Dissemination Lead (Name and contact details)**		
To be disseminated to:	**How will be disseminated, who will do and when?**	**Paper or Electronic?**	**Comments**

CATEGORY 'C' POLICIES OR GUIDELINES ONLY **Divisional/CBU Approval Process**:	
Approving Group / Committee:	
Any comments?	
Date of Approval:	