University Hospitals of Leicester NHS
NHS Trust

Policy Title

Nurse Led Immunosuppressant Patient Education Clinic Operational Policy for Specialist Nurses Within the Ophthalmology Department.

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CONTENTS

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

KEY WORDS

Immunosuppressant patient education clinic

1 INTRODUCTION AND OVERVIEW

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS (National Health Service) Trusts Policy and Procedures and offers guidance to enable qualified Uveitis specialist nurse and trained specialist nurses in the Uveitis team to run a nurse led patient education clinic in Ophthalmology.

Over the past 27 years, many professional and legislative documents have provided the impetus for expanding nurse-led services. This began with the 'New Deal' for junior medical staff (NHSME, 1991), which resulted in the reduction in the number of junior doctor's hours, and the subsequent re-allocation of some routine medical duties to nursing staff. This in turn was facilitated by the Royal College of nursing document. 'The nature, scope and value of ophthalmic nursing Royal College of Nursing (2016), which allowed nurses to expand their roles within their own and the organizations capabilities. More recently, the Department of Health (DOH 2018) published several papers emphasizing the expanded role of nurses in increasing the efficiency and quality of service provision within the National Health Service (NHS). According to Royal College of Nursing (2018). Clinical Nurse Specialist have significantly expanded roles in the health care setting, such as consultation and physical assessment, which can significantly enhance patient care. Health Education England (2017) promotes healthcare professionals who are educated and have achieved the competencies to expand their roles of undertaking consultation and physical examination. The NHS five-year plan (2019) emphasis is that new NHS roles and careers will be shaped to reflect future needs and priorities and will be supported by Health Education England (2017).

1.2 Background

Uveitis is the inflammation of the middle layer of the eye called the uvea or uveal tract. The uvea is made up of the iris (colored part of the eye), ciliary body (ring of muscle behind the iris) and the choroid (layer of tissue that supports the retina).

Anterior uveitis (the most common form of uveitis) — inflammation in the anterior segment of the eye; this includes iritis (inflammation in the anterior chamber alone), iridocyclitis (inflammation in the anterior chamber and anterior vitreous), and anterior cyclitis.

Intermediate uveitis — inflammation of the vitreous; this includes pars planitis, posterior cyclitis, and hyalitis.

Posterior uveitis — inflammation of the retina or choroid; this includes focal, multifocal, or diffuse choroiditis, chorioretinitis, retinochoroiditis, retinitis, and neuronitis.

Panuveitis — inflammation in the anterior chamber, vitreous and retina or choroid.

Uveitis is uncommon and it is estimated that 2-5 in every 10,000 people will be affected by uveitis in the UK every year. Uveitis usually affects people aged 20 to 59 but can also occur in children, men and women are affected equally.
Conversely, uveitis that is determined to be chronic and non-infectious in nature often requires the introduction of a corticosteroid-sparing immunomodulatory treatment to control inflammation and avoid undesirable complications associated with chronic use of high-dose corticosteroids. Corticosteroids may be administered either topically, as periocular injections, or systemically (primarily orally but also by the intravenous or intramuscular route).

However, in some patients' systemic corticosteroids are insufficient to control the disease, and immunosuppressive drug therapy is required. In other patients, corticosteroid side effects result in the need for a corticosteroid-sparing agent, and in many patients the long-term use of systemic corticosteroids at the dose required to suppress the ocular inflammation is sufficiently likely to produce side effects that a corticosteroid-sparing agent is warranted. In these situations, immunosuppressive drugs have a role to play in the management of patients with ocular inflammatory disease.

Because of the potential for side effects, treatment must be individualized, and regular monitoring performed. With careful use of immunosuppressive drugs for treatment of ocular inflammatory disorders, many patients will benefit from them either with better control of the ocular inflammation or with a decrease in corticosteroid side effects.

The Uveitis Clinic in Leicester Royal Hospital is one of the few units in the UK which provides expert in-house immunosuppression management for uveitis. The Uveitis Nurse Specialist will run the nurse-led clinic for patients on immunosuppressants screened and referred by the consultants ensuring safe, effective assessment, management and follow up using the UHL standard guidelines. This practice will take place in the Ophthalmology Outpatients Department within UHL.
This document offers guidance to enable qualified nurses with ophthalmic experience in uveits specialty to perform in a nurse-led immunosuppressant patient education clinic. The document applies to all appropriate immunosuppressant uveitis patients who meet the inclusion criteria as determined by the uveitis consultants.

2.0 POLICY SCOPE –WHO THE POLICY APPLIES TO AND ANY SPECIFIC EXCLUSIONS

Who does this policy apply to?

2.1 This policy applies to Ophthalmology specialist nurses and registered nurses who have satisfied the Trust that they are competent to expand their sphere of practice within ophthalmic specialty and undertake immunosuppressant nurse led clinics.

2.2 The policy applies to uveitis patients on immunosuppressants attending nurse led clinic who meets the inclusion criteria.

2.3 This policy outlines consent, prescribing and documentation required, the required procedural steps, including equipment required and the management of complications.

2.4 This policy provides details of minimum qualifications and training to carry out this procedure.

*2.*6 The qualified nurse undertaking these clinics must be a first level registered nurse with experience in uveitis specialty. This training relates only to registered nurses and does not incorporate any associated health care professionals.

2.7 The Uveitis Consultants, Service Manager, and the Head of Nursing support the expansion in advanced nursing practice.

2.8 It is essential that this policy is followed, as failure could result in the loss of the Trust's indemnity and could result in investigation and management action being taken as considered appropriate. This could include formal action in line with the Trust's disciplinary procedures for Trust employees and/or other action in relation to other workers, which may result in the termination of an assignment, placement, secondment, or honorary contract.

3 DEFINITIONS AND ABBREVIATIONS

CNS-Clinical Nurse Specialist

DMARDS- Disease-modifying antirheumatic drugs.

Anti-TNF are biologic agents that suppress the immune system by blocking the activity of TNF (Tumour Necrosis Factor)

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4.0 ROLES – WHO DOES WHAT

An overview of the individual, departmental and committee roles and responsibilities, including levels of responsibility and any education and training requirements

4.1 The executive director responsible for oversight of this policy is the Chief Nurse.

Line managers are responsible for:

a)Identifying and supporting the appropriate staff to attend the necessary training and complete the assessment of competence in practice

b) Verifying the competence of staff in nurse led immunosuppressant clinics

c)Maintaining a record of staff who are competent in the attending nurse led clinics ensuring that numbers of staff trained meet service need

d) The Uveitis Consultants will screen patients using the inculsion and exclusion criteria.

4.2 Authorized Staff

- All staff who attend nurse led clinics must be authorized by their line manager and Uveitis consultants and carry out this activity as an integral part of the key responsibilities within their role and not considered outside their scope of professional practice.
- Staff who undertake this role will normally be on a statutory register (e.g., Nursing and Midwifery Council (NMC) and the practice of uveitis specialist nurse will be within the normal scope of practice.
- Staff must have undertaken appropriate education and training (see section) identified through the appraisal process and included in their Personal Development Plan (PDP).
- There is no set time limit expected for staff to undertake this role, this is down to the discretion of the individual CMG however it is recommended that where appropriate staff should have at least two years acute ophthalmic experience, within the uveitis specialist nurse role.
- Staff moving between units or community setting remain competent to attend nurse-led clinics within their area of competence.

4.3 All members of staff involved in the management of uveitis immunosuppresant patients:

- The members of staff must follow the procedures laid down in this policy in the management of uveitis patients on immunosuppressants.
- Must accept responsibility for updating knowledge and skills to maintain competence.
- The Nurse-Led clinics nurses will cater for patients identified within the Uveitis specialty by consultants to support increased capacity in the consultant clinics.
- Maintain clear and legible patients records in accordance with the UHL Trusts and professional standards.

4.4 **ROLES AND RESPONSIBILITIES OF THE UVEITIS CLINICAL NURSE SPECIALIST**

- Provide patients with a nurse-led service which is easily accessible and can provide expert knowledge in management of uveitis, within the uveitis specialty.
- Counseling of patients, relatives and carer on immunosuppressant which tends to be difficult in a busy consultant clinic setting.
- Demonstrate a clear ability to provide an excellent environment for clinical learning, support, and development.
- Support the uveitis team by providing routine follow up for specific groups patients, which increases capacity within the Consultant clinic.
- The role provides resourceful expertise for ophthalmology and demonstrates a wide knowledge and understanding of uveitis service frameworks.
- Acts proactively as an educator and resource to others and uses expert knowledge to contribute to local and national information, data collection and networks.
- Function autonomously to deliver healthy outcomes, for the uveitis patients within a quality framework.
- Demonstrate an ability to competently perform specific ophthalmic clinical skills relevant to the role.
- Identifies and implements local and national guidelines/initiatives.
- Contributes toward audit and research within Uveitis specialist to measure effectiveness of the service.
- Monitoring efficacy Patients on biologic therapies should be monitored (routine blood tests and outcome measures) initially every three months to evaluate their response to treatment.
- Maintain a database of patients treated with biologics and immunosuppressants ensuring these patients are followed up according to NICE guidelines.
- Coordinate regular clinic follow-up, particularly postinduction therapy review, to assess response and plan future therapy accordingly.
- Participate in comprehensive disease management to control disease activity, reduce symptoms and improve patient-preferred outcomes; this leads to cost effective care.
- Develop roles and services to deliver care across hospital and community settings and address current health challenges. With appropriate training, education, and support, they can impact on areas such as patient flow and waiting list.

5.POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS –WHAT TO DO AND HOW TO DO IT

What is Patient Education?

Patient education is the process of providing patients with information relevant to their condition, such as symptoms and warning signs, available treatment plans, expected outcomes, side effects, and prevention guidelines. Patient education starts as soon as the patient is diagnosed or as early as possible. It helps patients better understand their condition and available options in terms of treatment. Patient education aims to increase patient engagement and involvement to improve the patient's physical and mental health.

The benefits of a nurse led patient education immunosuppressant clinic.

5.1 Patient Empowerment

Patient education helps patients understand their condition, available treatments, and side effects. Patients on immunosuppressants require complex and close monitoring, the major concern being the risk of infection hence monitoring efficacy of treatment is essential. Please refer Table 1, Table 2, Table 3, Table 4.

5.2 Better health outcome.

Patient education has a positive impact on patient engagement. Apart from being more knowledgeable, patients who receive health education are also more cooperative and well-disposed because they trust their practitioners and the treatment they are receiving. Therefore, they are more likely to follow their doctor's instructions, take their medication correctly, and successfully recover or maintain a good health status eventually.

5.3 Better Quality of Life

Health education is tremendously important for people with chronic uveitis. Chronic disease management takes place outside of medical facilities as the patient's needs are recurring, and often the patient needs to make permanent lifestyle changes. Patient education improves self-management and helps patients to maintain physical and mental wellness. Nurses should address psychosocial issues to reduce patients' symptoms of anxiety and depression

5.4 Better Healthcare Experience and Satisfaction.

Higher patient satisfaction is another benefit of healthcare education. Patients who are well informed feel more reassured and optimistic about their future. Patients and their carers require adequate advice to understand their conditions, treatment options, benefits, and treatment risks. Nurses tend to spend longer with the patient, providing education and support, to allow the patient to learn techniques to self-manage effectively.

5.5 Lower health cost

Patient education lowers health costs as patients are more compliant with treatment, reducing hospital admissions and doctors' consultations. The nurse-led clinics have evidence-based solutions to manage the amplified demand on our health service, to reduce waiting times, resources, and costs, while maintaining patient safety. Uveitis nurses will participate in comprehensive disease management to control disease activity, reduce symptoms, and improve patient-preferred outcomes using UHL Guidelines.

5.6 Expansion of nursing practice

The nurse led immunosuppressive patient education clinic is an expansion of nursing practice to increase capacity in the uveitis consultant's clinic within the uveitis specialty. However, complex cases will be seen by the consultant/fellows in the uveitis clinics. The nurse led uveitis clinic will provide services for referrals and follow up for patients who are on immunosuppressants and biologics.

5.7 What are the general principles of managing adults (DMARDs) (Nice Guidelines)

Disease-modifying anti-rheumatic drug (DMARD) should be initiated (and initial monitoring undertaken) by a specialist in secondary care. Individual DMARDs have different prescribing and monitoring requirements, and local protocols may vary:

When prescribing and monitoring a DMARD, always follow recommendations in local guidelines where they differ from those given in this CKS topic.

Whilst absolute values are useful indicators, trends are equally important. A rapid fall or rise, or a consistent downward or upward trend, in any parameter (for example, gradual decreases in white blood cells or albumin, or increasing liver enzymes) warrants extra vigilance.

DMARDs are prescribed as monotherapy or, more commonly, with other DMARDs. Monitoring of people on more than one DMARD should be based on the DMARD that requires the most frequent monitoring.

Monitor for side effects or complications of treatment. Ensure the person is aware of potential adverse effects of DMARDs and who to contact if these develop.

Liaise with the person's consultant regarding any adverse effects or complications.

Be aware that major toxicity with DMARDs can occur during intercurrent illness, particularly if there is impairment of renal function or sepsis. Seek specialist advice, as treatment may need to be temporarily discontinued.

People on DMARDs are more prone to infection, especially in the first 6 months of treatment. Advise the person to avoid contact with people who have shingles or chickenpox.

5.8 Starting Anti-TNF/ Biologics

- Patients need to understand the NICE eligibility, screening and monitoring requirements for biologic therapy, the choices they can make in relation to the preferred route of drug administration and the personal implications of this choice.
- A major concern with biologic therapy is the risk of infection. Patients on any biologic should be advised to avoid exposure to potential risk factors for infection, given information on the signs and symptoms of infection to watch for, and advised to report symptoms promptly to the uveitis nurse.
- As the reactivation of TB is a particular concern with anti TNF, patients must report any TB warning signs – such as persistent productive cough, hemoptysis, weight loss or fever.
- All patients and parent/caregivers should be advised to promptly report any development of any new or worsening symptoms – such as neurological, cardiac, pulmonary, skin, uveitis disorders/ symptoms and/or malignancies to their medical and/or specialist practitioner for advice and to stop any biologic treatment until their symptoms have been appropriately evaluated.
- All patients and parents/caregivers should be informed of the signs and symptoms of blood dyscrasias (persistent fever, bruising, bleeding pallor whilst on the treatment) and advised to seek immediate medical and/or specialist practitioner advice and STOP any biologic therapy until their symptoms have been appropriately evaluated and treated.
- Prior to surgery patients should be advised about the length of time their biologictherapy should be stopped pre-operatively (see following section) and that they should contact their specialist practitioner regarding the recommencement date of biologic therapy post operatively,
- Uveitis nurses need understanding of the importance of consent on patients who require Biologics / anti-TNF injections as a UHL guidelines.

5.9 Recommended Investigations before initiation of DMARDs

Pre-treatment chest X ray to rule out TB

Hepatitis B and C serology for all biologic indications (MHRA, 2013)

HIV screening and testing if risk factors identified via initial screening

FBC – neutrophil, leucocyte, and platelet count

ANA – if positive, suggest repeat test and order extractable nuclear antigen (ENA) and double stranded DNA (ds-DNA) to help exclude lupus, as some patients have developed positive ANA and anti-ds DNA antibodies following treatment with

some biologic therapies, hence the reason for pre-treatment positive ANA testing

Varicella zoster serology (varicella IgG levels)

Pre-treatment blood pressure check.

6 EDUCATION AND TRAINING REQUIREMENTS

- Specific information describing the use of each pen or pre-filled syringe is available from the manufacturer and provided with the drug on delivery. However, practitioners should be knowledgeable and competent about the nature, scope, and value of ophthalmic nursing.

- The Uveitis Consultant, Fellow, Specialist Registrar, Uveitis specialist nurse will facilitate the practice sessions, to ensure the nurse has achieved a satisfactory knowledge on uveitis and immunosuppression.

- The theoretical knowledge underpinning this procedure will be gained through working alongside medical/nursing colleagues. The competency framework developed for the uveitis specialist nurse will be used as the assessment tool.

- The nurse preparing for the role will undertake assessment under the supervision of the Consultant, Fellow, Specialist Registrar or Uveitis specialist nurse.

- At the end of a period of supervision, they will be deemed competent to manage uveitis patients independently.

6.1 Staff new to the Trust and / or who have been trained elsewhere must:

a. Provide evidence accepted by their line manager of the training and assessment of competence they have successfully completed. If a member of staff does not have any evidence of successful completion, then they may need to undertake the Nurse Uveitis booklet competency. This must be discussed with their line manager

b. Read the relevant Trust policies and undertake additional local training relating to equipment and documentation as required.

c. Undertake a final sign off practical assessment by a Uveitis Consultant

6.2 Theoretical training will be delivered in several ways:

- Attendance in-house teaching sessions.
- Locally delivered one to one training by consultants and non-medical health care professionals.

6.3 Topics which must be covered through these routes are as follows:

- Anatomy, physiology, and eye pathophysiology.
- Uveitis: Types, Classification, Causes, Symptoms and Treatment.
- Pharmacology update on management of uveitis.
- Risk and legal issues around extended role development.
- Latest clinical information on treatment and treatment delivery and up to date evidence underpinning this practice
- How to audit
- Recognition of when further support should be sought for patients, and what actions to take.
- Role of uveitis nurse in monitoring patients on immunosuppression for non-infectious uveitis.
- The practitioner needs to undergo an assessment with a trainer to record their knowledge competencies and understanding of key trust policies and national requirements and obtain sign off.

6.4 Practical training:

The practitioner will need to be able to demonstrate the ability to document the following:

- Patient status
- Previous Medical History
- Previous ocular history
- Family ocular history
- Current Medication (immunosuppressant)
- Allergies
- Visual acuity measurement
- IOP measurement
- Blood pressure
- Glucose check

6.5 Practical training: Final assessment

- The decisive step of the training pathway will be for the specialist nurse to be assessed by the Uveitis Consultant and deemed competent to undertake nurse-led clinics independently.
- If at this stage, the trainee is not yet ready to practice unsupervised they must continue supervised practice until the trainer feels they are ready for a further assessment. The trainer must also be confident that the

practitioner can undertake nurse-led clinics to the required safety and efficiency to practice independently.

- All the competencies must be completed and signed off and audit of practice must occur at this stage and be approved by a Uveitis consultant before undertaking independent practice. In addition, there should be evidence of reflective practice.
- At all stages, the trainee must not be signed off as a competent practitioner unless the trainer and consultant are fully confident in the practitioner's ability to run independent clinics.
- The first few clinics should occur with Uveitis Consultants nearby with some degree of supervision to ensure support is nearby and practitioners have gained the confidence to practice independently.
- After three months, the trainee should undergo a review of their independent practice with a trainer or consultant and should then undertake the required audit after the first 6 months or 100 cases and thereafter every year and regular reflective practice.

7.0 PROCESS FOR MONITORING COMPLIANCE

- Audits regarding Nurse Led Clinics must be identified for auditing the practice of the nurse
- This will be achieved by measuring outcomes through retrospective evaluation. Every year 30 patient notes will be reviewed at random, to be assessed by the Consultant. Following evaluation of the audit results, any necessary changes to practice will be made, thus ensuring safe management of uveitis patients in clinic.
- Patient satisfaction questionnaires will be utilized as a tool to monitor and adapt practice accordingly. This should help to maintain a positive experience of care by patients and their relatives/carers.
- Additionally, the nurse should ensure that they have a summary of performance and potential by having an appraisal every year, with line manager as well as a SMART (Smart, Measurable, Agreed, Realistic and Time) (**S**mart, **M**easurable, **A**greed, **R**ealistic and **T**ime Bound) personal development plan with a 6 monthly review. The nurse must ensure the appropriate action is taken to maintain standards.

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

Department of Health. (2019) *The NHS Long term Plan;* https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf Health Education England (2017)

Multi-professional framework for advanced clinical practice in England https://www.hee.nhs.uk/sites/default/files/documents/Multi-professional%20framework%20for%20advanced%20clinical%20practice%20in%20England.pdf

National Health Service Management Executive. (1991) Junior Doctors; The New Deal. NHSME.

Nursing and Midwifery Council (2018) *The Code*-Professional standards of practice and behavior for nurses, midwives, and nursing associates. NMC London.

Department of Health (2018) Career Framework for Specialist Nurses https://www.health-ni.gov.uk/publications/career-framework-specialist-nurses

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Health Education England (HEE) (2017) *Multi-professional Framework for Advanced Clinical Practice in England*, *Health Education England*, pp. 1–23. Available at: https://www.hee.nhs.uk/sites/default/files/documents/multi-professionalframeworkforadvancedclinicalpracticeinengland.pdf.

Holroyd, C.R. *et al.* (2018) 'The British Society for Rheumatology biologic DMARD safety guidelines in inflammatory arthritis', *Rheumatology*, 58(2), pp. e3–e42. Available at: https://doi.org/10.1093/rheumatology/key208.

Competency framework for rheumatology nurses | Publications | Royal College of Nursing (no date) *The Royal College of Nursing*. Available at: https://www.rcn.org.uk/professional-development/publications/pub-009004.

NICE. Available at: https://cks.nice.org.uk/topics/dmards/management/general-principles-of-managing-dmards/.

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This document will be uploaded onto SharePoint and available for access by Staff through InSite. It will be stored and archived through this system.

This policy will be reviewed every 5 years by the Uveitis Specialist Nurse in the Department and the Uveitis Consultants and Service Management.

The updated version of the Policy will then be uploaded and available through INsite Documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts PAGL system

POLICIES

UHL Core Training Policy for Statutory, Mandatory and Essential to Job Role Training. B21/2005
UHL Policy Patient Group Directions
B43/2005
00D12/P/a Infliximab (Remicade) and Adalimumab (Humira) Anti-TNF Treatment Options for Adult Patients with Severe Refractory Uveitis Superseded

Professional Guidelines

NMC (2018) The Code: Professional standards and behavior for nurses and midwives

POLICY MONITORING TABLE

The top row of the table provides information and descriptors and is to be removed in the final version of the document

Element to be monitored	Lead	Tool	Frequency	**Reporting arrangements Who or what committee will the completed report go to.**
Percentage of compliance to completion and documentation to policy of nurse-led clinics	Uveitis Specialist Nurse	Medical notes	1 year by Uveitis Consultant 1 year by Senior Uveitis Specialist Nurse	Uveitis Specialist Nurse Uveitis Consultants
Number of reported incidents per annum of missed opportunities to treatpatients appropriately for patient?	Uveitis Specialist Nurse	Medical notes	1 year by Uveitis Consultant 1 year by Uveitis Nurse specialist	Uveitis Specialist Nurse Uveitis Consultants
Medication Errors	Medicines Safety Officer	DATIX incident reporting	Quarterly	Medicines Optimisation Committee CMG Heads of Nursing
Adverse clinical outcomes	CMG Head of service/Matron/GM	DATIX incident reporting	As reported	Ophthalmology leadership triumvirate to assess severity of outcome and report appropriately as required to CMG board/Patient safety lead

Table 1. Primary care monitoring requirements for people on azathioprine.

Monitoring	Frequency
FBC Renal function: creatinine/calculated GFR (Glomerular Filtration Rate) LFTs (liver function tests): ALT and/or AST (aspartate transaminase) and albumin	• Every 2 weeks until dose is stable for 6 weeks, then monthly for 3 months. • Thereafter, at least every 12 weeks. • Monitor more frequently in people at higher risk of toxicity. • If dose is increased, monitor every 2 weeks until dose is stable for 6 weeks, then revert to previous schedule.
FBC: full blood count; GFR: glomerular filtration rate; LFTs: liver function tests; ALT: alanine aminotransferase; AST: aspartate transaminase	

Table 2. Primary care monitoring requirements for people on methotrexate

Monitoring	Frequency
FBC Renal function: creatinine/calculated GFR LFTs: ALT and/or AST and albumin	• Every 2 weeks until dose is stable for 6 weeks, then monthly for 3 months*. • Thereafter, at least every 12 weeks. • Monitor more frequently in people at higher risk of toxicity. • If the dose is increased, monitor every 2 weeks until the dose is stable for 6 weeks, then revert to the previous schedule.

FBC: full blood count; GFR: glomerular filtration rate; LFTs: liver function tests; ALT: alanine aminotransferase; AST: aspartate transaminase

Table 3. Primary care monitoring requirements for people on mycophenolate mofetil.

Laboratory monitoring	Frequency
FBC Renal function: creatinine/calculated GFR LFTs: ALT and/or AST and albumin	• Every 2 weeks until dose is stable for 6 weeks, then monthly for 3 months. • Thereafter, at least every 12 weeks. • Monitor more frequently in people at higher risk of toxicity. • If the dose is increased, monitor every 2 weeks until the dose is stable for 6 weeks, then revert to previous schedule.
FBC: full blood count; GFR: glomerular filtration rate; LFTs: liver function tests; ALT: alanine aminotransferase; AST: aspartate transaminase	

Table 4. Monitoring requirements for people taking biologics.

Monitoring	Frequency
FBC U&E, including creatinine LFTs: ALT and/or AST and albumin.	• At 2/52 for 6 weeks • Monthly for 3months • Then every 2-3 months (and/or as clinically indicated).
Signs of infection, such as chicken pox	• Before each injection/infusion.
Hepatitis B (surface antigen and core antibody)	• If clinically indicated, for example in people with raised ALT and/or AST, or ongoing (annually) in people who are at increased risk of infection.
Hepatitis C (IgG)	• If clinically indicated, for example in people with raised ALT and/or AST, or ongoing (annually) in people who are at increased risk of infection.
HIV	• If clinically indicated, for example if there are symptoms of seroconversion, or ongoing (annually) in people who are at increased risk of infection.
Autoantibodies	• If symptoms or signs suggest development of autoimmune phenomena, for example raised ALT and/or AST.
Tuberculosis (interferon-gamma release assay and chest X-ray)	• If clinically indicated, for example in people with symptoms or signs of tuberculosis, new exposure to tuberculosis, or residence in high incidence setting.
Urinalysis	• If clinically indicated.
Skin examination for non-melanoma skin cancer for patients at increased risk	• As indicated by risk at baseline and in the context of immunosuppression.

Appendix 1Competency recording for Uveitis nurse immunosuppressant clinic: Competency checklist - knowledge
Department ……

Name ……..…….

	Competency	Competency Checklist	Assessor Signature
1	Demonstrate familiarity with and understanding of the principles of the Trust Framework for Enhancing the Scope for Clinical Practice	**States key aspects of Trust Framework for Enhancing the Scope for Clinical Practice:-** • Competence to be assessed via Trust ratified competencies. • Competency development must be appropriate and safe. • Vicarious liability. • On-going competency-Trust requirements • Evidenced based practice.	
2	Demonstrate familiarity with Trust Infection Control Policy	**Under observation and where appropriate can state and demonstrate:** • Correct use of Personal Protective Equipment. • Safe handling of sharps. • Safe handling of clinical waste and spillage. • Decontamination of equipment. • Decontamination of environment. **Under observation and where appropriate can state and demonstrate:** • The importance of correct hand hygiene.	
3	Adopts and employs appropriate strategies to provide a safe environment for the ophthalmic patient.	**Under observation and where appropriate can state and demonstrate:** Works safely and effectively Monitors the welfare,health and safety of patients, self and others.	

	Competency	Competency Checklist	Assessor Signature
4	Demonstrate familiarity with Trust policy and Profession specific guidelines on records and record keeping	**State and discuss:** • The key points in the Trust for Records and Record keeping. • The importance of accurate documentation. • Individual accountability and confidentiality. **Under observation:** • Can document the appropriate information accurately and according to Trust Policy in the notes.	
5	Works effectively and efficiently with members of MDT when caring for the uveitis patients.	**State and discuss** Communicates effectively to provide best quality care from the most appropriate professional. Demonstrate knowledge of the nature of alternative roles within the care team.	
6	Demonstrate knowledge of uveitis conditions seen in nurse clinic	**State and discuss:-** • Uveitis condition • Treatments protocols • Risk and benefits • For consent to be valid, the patient must: o Be competent to take the particular decision; o Have received sufficient information to take it; o Not be acting under duress. • Patient's agreement to the intervention and the discussions which led up to that agreement. • Process to follow for complications.	

	Competency	Competency Checklist	Assessor Signature
7	Uphold the Nursing & Midwifery Council: The Code Professional Standards of practice and behaviour for nurses (2015) or similar professional standards	**State and discuss key aspects of the NMC or similar Code:-** • Exists to safeguard the health and wellbeing of the public. • Sets the standards of education, training and conduct that Nurses and Midwives need to deliver high quality healthcare consistently throughout their careers. • Ensures that Nurses and Midwives keep their skills and knowledge up to date and uphold the standards of their professional code. • Ensures that nurses and Midwives are safe to practise by setting rules for their practice and supervision. • Fair processes to investigate allegations made against Nurses and Midwives who may not have followed the code.	
8	Demonstrate knowledge and application of the ophthalmic anatomy and physiology, pathophysiology and pharmacology in practice through patient education.	**State & discuss:** • Appropriate patients for uveitis nurse led clinic • The anatomy of the eye • Areas of operation to avoid. • Awareness of cultural influnces on care requirements.	
9	Is able to identify appropriate equipment and drugs and understands the process for undertaking any procedures on the slit lamp	**State & discuss:** • Describes the equipment used and demonstrates understanding of its use. • Indications for procedures • Knowledge of risk/benefits to procedure	

Record of Final Supervised Practice

I……..(10th assessor) hereby confirms that……..(name of staff member)is competent to practice in the uveitis nurse clinics……...

Date…….
Signed and Printed…….

I……(Staff member) hereby confirm that I have completed 10 workplace supervised practices and now feel competent to run the uveitis nurse clinic, acknowledging limitations in clinical experience where appropriate.

Date…….
Signed and Printed……

A copy of the competency record must be kept by the individual staff member for their own professional records and a copy must be given to their line manager for their professional file.
Advice must be sought from line manager if competencies not achieved after 10 supervised practices.

Competencies checklist for patients Anti-TNF patients

Element of competence to be achieved	Date of achieved	Practitioner signature	Supervisor signature
Discuss the rationale for the use of subcutaneous biologic therapy in rheumatic conditions			
Discuss potential issues related to treatment including: • screening of patients • possible side effects or adverse events • drug interactions • contra-indications to therapy Discuss the circumstances when subcutaneous biologic therapy should not be administered.			
Describe interventions to alleviate symptoms.			
Discuss the process for assessing the patient's suitability for biologic therapy. For example, medical history, concomitant medications, allergies, level of disease activity, dexterity and attitude to treatment			
Demonstrate the ability to check the validity of the current prescription. This includes expiry date, dose, route by which the drug is to be administered and the checking of the patient identification			
Demonstrate the ability to teach a patient/carer how to administer subcutaneous biologic therapy			
Demonstrate the ability to assess a patient's/carer's suitability for home administration of subcutaneous biologic therapy			
Describe local health and safety guidelines and risk assessment required for providing a subcutaneous biologic therapy service in hospital and in the patient's home. With particular relevance to: • storage, handling and hygiene prep (hand washing/clean working area) • safe use and disposal of equipment			
Demonstrate the ability to discuss the information/ educational needs of the patient/carer in relation to home dministration of subcutaneous biologic therapy.			
Demonstrate the ability to provide the patient/carer with information about the treatment in order that they are able to give informed consent (written/verbal – in line with local guidelines)			
Demonstrate adherence to information governance policy and procedures, in relation to record sharing and confidentiality.			

Element of competence to be achieved	Date of achieved	Practitioner signature	Supervisor sign
Describe sites on the body that would be appropriate for subcutaneous injection			
Demonstrate the ability to maintain concise and accurate patient documentation and audit			
Demonstrate the ability to maintain concise and accurate patient documentation and audit			

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:			**Job Title:**
Reviewed by:			
Approved by:			**Date Approved:**
REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
DISTRIBUTION RECORD:			
Date	**Name**	**Dept**	**Received**

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