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Further information

Send contributions for the next issue by 18 September 2006 to the editor:

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Letter from the Editor: Joan Mathison

Happy reading and good luck in the coming year

Newsletter time again! How quickly it comes around. I hope you all had a good Christmas and that you are maintaining all those New Year resolutions. Our RCN Conference organiser won the lottery, so 2006 is a great year for her, and I hope it proves successful for the rest of you.

For the past three years, the Pfizer/RCN Ophthalmic Nursing Award has allowed the forum to enable ophthalmic nurses to travel to international conferences in New Zealand and America. We would like to sincerely thank Pfizer for their collaboration with us and for their generous sponsorship. For a chance to attend the International Ophthalmic Conference in Las Vegas, please go to page seven.

There has been a brisk and continuous exchange of emails in the last couple of months over the RCN's Professional Development Framework issue. The issue has recently been debated at Congress, so hopefully we will know where we stand on this soon – when as we receive further news, we will certainly let you know.

I hope we will see many of you at the RCN Ophthalmic Nursing Forum Conference in the autumn – please watch out for the flyer in future editions of the newsletter. We have plenty of articles to cram in this time, including details of a fascinating journey to Jerusalem, so I hope you enjoy them, and please keep your articles coming.

One hundred years of corneal transplants

On 7 December 1905, Dr Eduard Zirm, the Chief of Medicine at a hospital in Olomouc, in Moravia (now part of the Czech Republic), performed the world's first successful cornea transplant. **YVONNE NEEDHAM** reports on the impact.

This milestone marked the start of one-hundred years of sight-saving operations and the birth of the transplant age. In fact, the method used by Dr Zirm is still the basis for cornea transplantation today, and corneal transplantation restores sight to more than 2,200 people in the UK every year.

A nationwide survey marking one-hundred years since the world's first successful cornea transplant has revealed that an astonishing 84 per cent of UK residents see their eyesight as the most precious of their five senses. Eyesight is valued ahead of hearing, which came second, with 5 per cent of votes. Smell, taste and touch all received 2 per cent of the votes (GfK NOP poll of 1,001 people). Chris Rudge, Managing Director of UK Transplant said: "Yet again this survey shows just how important sight is for so many of us. Thanks to the generosity of donors and their families, last year, 2,375

blind and partially-sighted people were given an opportunity to see again through a cornea transplant. However, even more people could be helped if it were not for a shortage of donors. I urge everyone to take the time to consider becoming a donor – you could be making a huge difference to people's lives."

Anyone can join the NHS Organ Donor Register by telephoning: 0845 6060 400 or by visiting www.uktransplant.org.uk. UK Transplant will send out information and posters for display. If every eye unit was to display the poster and information, we could increase the number of available corneas for transplantation across the UK.

**84 per cent
of UK residents see
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Do once and share – the glaucoma project

The Do Once and Share Programme (DOAS) is a national programme designed to provide clinical input into the design, development and implementation of the Connecting for Health Programme (CfH) for IT in the NHS. It is composed of about 50 clinical topics that include glaucoma, cataract and diabetic eye disease.

The Glaucoma DOAS Project started on 14 November 2005. This phase of the project had a duration of six months. It is a distinctly multi-disciplinary venture, ensuring that all health care professionals involved in eye health care are represented, and that the views of patients are reflected within it. This clinical care pathway and core dataset will inform the development of the NHS Care Record, its presentation to the user through the Common User Interface and ultimately, its use in practice.

The purpose of the DOAS programme as a whole is to ensure that the needs of clinical specialties are taken into account, whilst providing a care record that focuses on the needs of the patient, who may have more than one disease, and involvement with more than one specialty.

The Glaucoma DOAS Action Team will be working with a multi-disciplinary National Steering Group (whose members include ophthalmologists, optometrists, nurse practitioners, GPs, voluntary organisations and patients), to ensure that the clinical care pathway and its dataset are fit-for-purpose, feasible and practicable.

The proposed benefits are :

- to provide national consistency in glaucoma care that is based on best current guidance, and which is robust and transferable so that localisation within health communities may be feasible.
- to make the production of data the by-product of clinical care rather than an activity in its own right
- promotion of clinical standards by providing a common core dataset of clinically meaningful information.

Stakeholder engagement

Glaucoma management has been evolving rapidly in recent years and several models exist, emphasising co-management between professional groups and between primary and secondary care. This is an important opportunity for clinicians to engage in, and inform the Connecting for Health Programme, and take full advantage of IT and emerging technology to improve patient care and health services. To succeed it will be essential not only to have professional body approval and engagement of health care professionals involved in glaucoma management, but to also have engagement of patients to reflect their perspectives and needs for health care and information. Ophthalmology has done well in getting three out of fifty of these projects and this is a real opportunity to keep it in the mainstream of future IT developments for the NHS.

We would welcome any of your contributions and thoughts on this project, but particularly on :

- areas where you feel good practice exists already in glaucoma care
- local guidelines and protocols for glaucoma management
- what sort of clinical information is shared within the clinical team and across primary and secondary care
- how this information is shared, for example, via existing electronic or IT based systems
- sharing your experience of how glaucoma is managed in your locality.

Your input and contributions into this process are essential and greatly valued. Please get in touch and let the Glaucoma DOAS Action Team know through the website: www.doasglaucoma.org

RCN publishes Core Career and Competency Framework

The RCN has produced new guidelines that help nurses to identify and plan their career development and at the same time link it to their specialist area of work. The Core Career and Competence Framework shows how the NHS Knowledge and Skills Framework (KSF) applies to different career stages in nursing. The guidelines will also help nurses to meet the expected levels for

career progression within the remit of *Agenda for Change (AfC)*, and to identify the knowledge and skills that need to be applied specifically to practice areas.

Commenting on the Framework, Lyn Garbarino, the RCN's Senior Fellow, Competence Development, RCN/Skills for Health, said: "This is a useful tool that can serve multiple purposes. It is mapped to

the KSF and Skills for Health (SfH) competences to assist any nurse to achieve competence at their career level and can also be linked to the many specialist frameworks that already exist on the RCN and SfH websites."

You can access the Core Career and Competence Framework in our resources section: www.rcn.org.uk/resources/corecompetences

Opticare” survey prizewinner and results

Sue Kelly, winner of the survey’s prize draw, has been a glaucoma clinic nurse in High Wycombe General for the last five years.

Like most eye clinic nurses, Sue has a large case load to deal with and finds that compliance issues don’t always get the attention that they deserve. The degree to which clinic nurses address compliance issues is partly determined by the importance that the doctors give to it, and how firm they are to patients about the importance of taking their medication when directed. If a doctor is not firm, she said: “Some patients simply don’t take their drops, saying ‘Why do I need them? I have no symptoms’ Others are not clear why they are taking drops – no one has explained it to them or they forget and some just get annoyed, frustrated or embarrassed about a nurse reminding them to take medication.”



Alison Wilson, Managing Director of Cameron Graham Limited, presents prizewinner Sue Kelly with a copy of Janet Marsden’s newly published book *Ophthalmic Care*.

The full results of the survey on eye drop compliance can be viewed at: www.opticare.org.uk, with some responses featured, below.

If you would like to receive a patient support pack from Opticare, please telephone: 01484 667822, or

email: info@cameron-graham.co.uk. If you did not get an opportunity to complete the survey but would like to do so, please visit www.opticare.org.uk and take the opportunity to complete it online.

Eye Drop Compliance Survey – the results

What percentage of patients do you estimate as being non-compliant or non-concordant with their eye drop medication?

	None	1–10%	11–20%	21–50%	>50%
Response	0%	48.4%	22.6%	19.4%	9.7%

In your opinion, patient non-compliance or non-concordance associated with eye drop instilling is due to what reason?

Response	Never	Seldom	Frequently	Always
Lack of confidence in self-administration	3%	23%	74%	0%
Physical difficulties in self-administering	0%	13%	71%	16%
Forgetting to take drops	0%	35%	61%	3%
Poor application technique	0%	26%	58%	16%
Issues with drug side effects	16%	58%	26%	0%
Other reasons	77%	10%	13%	0%

What other reasons contribute significantly to patient non-compliance?

Of the other reasons stated, patients not understanding the purpose of their drops was the most common (56 per cent respondents).

Patients admit to having problems instilling their eye drops

	Never	Seldom	Sometimes	Usually	Always
Response	0%	3.3%	80%	13.3%	3.3%

If patients have difficulty self-administering eye drops, what action do you take?

90 per cent respondents would teach patients good technique, 80 per cent would suggest they use an eye drop dispenser, 63 per cent would advise a carer to administer them, 53 per cent would provide a leaflet on good technique, 43 per cent would pass it over to a community nurse to help and only 6.7 per cent would refer the patient to a clinical ophthalmologist.

A call to ‘research active’ ophthalmic nurses

As promised at the Forum Conference 2005, a group of people with a mutual interest in ophthalmic nursing research have met together for the first time, where it was agreed that:

- we should meet formally as part of the 2006 Forum Conference
- we should try to find out which other ophthalmic nurses are research active
- we should circulate details about ourselves and our project / interests.

If interested, please provide the requested information below, on a

separate sheet of paper, and return to Heather Waterman, Professor of Nursing and Ophthalmology, c/o School of Nursing, Midwifery and Social Work, Coupland 3, University of Manchester, Oxford Road, Manchester, M13 9PL, telephone: 0161 275 5021. By returning this information, you agree to your details being circulated. We look forward to your responses and to finding out what is really going in ophthalmology!

Please provide the following details:

- name

- qualifications (academic and professional)
- contact details (place of work, email, telephone)
- project title (duplicate page if more than one project)
- project design (duplicate page if more than one project)
- source of funding of project (duplicate page if more than one project)
- length of project (in months) (duplicate page if more than one project).

Herpes simplex keratitis/dend

By Julie Tillotson BSc, RGN, OND, Advanced Nurse Practitioner, Ophthalmology, Bournemouth

Herpes simplex virus (HSV) is a DNA virus that infects only humans. Infection is common; up to 90 per cent of the population are seropositive for HSV-1 antibodies, although most infections are subclinical (Kanski, 2003). Herpes simplex keratitis or dendritic ulcers occur due to secondary herpes simplex virus disease or as a recurrence. The primary infection occurs usually in childhood (HSV-1). HSV type 2 is mainly a genital infection occurring at 16 to 30 years of age, but can rarely be transmitted to the eye through infected genital secretions, either venereally or at birth (Kanski, 2003). Infection is transferred by contact and by the presence of the virus in the bloodstream, occurring during the primary infection, which induces the production of antibodies that persist throughout life.

Manifestation

Primary infection manifests as herpetic lip lesions, ulcers in mouth, flu-like symptoms and swollen regional lymph nodes. In immune-deficient patients, the symptoms can be severe and the patient can become quite ill. Primary infection of the eye is less common but can present as unilateral follicular conjunctivitis, lid oedema with vesicular eruptions or ulcerative blepharitis. The patient may also have swollen pre-auricular lymph glands. Fifty per cent of patients with HSV conjunctivitis develop keratitis after 7 to 14 days – this may be punctate, dendritic,

sub-epithelial or, rarely, stromal (Fechner and Teichmann, 1998).

Infection of the eye is usually ‘back door’, spread to the ophthalmic nerve via trigeminal ganglion from an orofacial site. It is often difficult to isolate where primary HSV infection manifests as follicular conjunctivitis, as it is not common practice to swab every patient with conjunctivitis for viral studies. Indeed, swabbing rarely isolates the virus, in any case. For this reason, caution is advised when treating viral conjunctivitis with steroids, in case the cause is HSV.

After the primary infection, ocular or orofacial, the virus settles in the trigeminal neurons, and probably also in the cornea, in a state of latency. The virus maintains a ‘dynamic balance’ with continuous slow replication of a portion of the viral genome. Recurrence probably comes from neuronal reservoirs and non-neuronal cells such as cornea and skin. Antibodies seem to prevent recurrence of systemic disease but do not influence survival in cells. When balance between host and virus is disturbed, local recurrence develops. The factors that tend to influence recurrence are illness, stress, or anything that lowers the immune system. Bright sun and wind are also thought to be influential in causing recurrence.

Ten per cent of herpetic infections recur within one year, 50 per cent within ten years and more than 60 per cent within a twenty-year observation period (Fechner and Teichmann, 1998).

Signs and symptoms

The patient may complain of a red, painful or gritty eye. They may be photophobic and may complain of blurred vision and lacrimation. They may also have a common cold or other illness.

Diagnosis

An accurate diagnosis is made by detailed history taking and slit lamp examination of the eye. Examination with fluorescein shows either micro-dendrites, which appear star-shaped (keratitis), or a larger, more central ‘dendrite’-shaped ulcer. Corneal sensation is usually reduced and there may be some associated stromal infiltrate.

Treatment

Most HSV infections will heal spontaneously within two to three weeks. However, corneal infections may leave scarring, and treatment is aimed at reducing the duration of the infection and minimising corneal scarring. Secondary stromal involvement occurs in some frequency, whether the infection is treated or not. Fechner and Teichmann recommend debriding the viral ulcer carefully with a cotton bud to remove virus particles, but this is not commonly carried out in the UK. Treatment here is usually with antiviral ointment aciclovir (zovirax) five times a day for ten days. The ointment does not kill the virus but reduces replication by inhibiting nucleic acid synthesis. Aciclovir is 30 times more potent

Central dendritic ulcers

Central Dendritic Ulcers Ophthalmology Unit

against the HSV cell than the host cell and is broken down rapidly by the host cell, thereby causing less damage to the healthy cell (Rang et al., 2003). However, the antiviral ointment can still be quite toxic to the cornea, which can take some weeks to recover. In this situation, the addition of lubricants can be beneficial. Because aciclovir is quite toxic, its use should be limited to a firm diagnosis of HSV. If there is any doubt, it is safer to treat the patient with oc chloramphenicol or a lubricant and follow up the patient.

It is commonly accepted within complimentary medicine circles that taking high doses of vitamin C (one gram a day) can help reduce the duration of the virus (Brewer, 2002). However, it is difficult to find actual research to validate these claims. Certainly, having a healthy immune system appears to help prevent recurrence of the virus.

If there is corneal stromal involvement, then steroid eyedrops may be used in conjunction with aciclovir to reduce the incidence of stromal scarring. This is usually in the form of Predsol eyedrops. However, once steroids have been used, any future recurrences tend to need the combined treatment.

Patients should be warned that repeated recurrences of HSV can lead to further scarring and possible reduction in vision, depending on the location of the infection. Central dendritic ulcers are more likely to affect vision than peripheral scarring.

Article references are available from the editor.

Novartis/RCN Ophthalmic Nursing Award

This year, we would like to invite all RCN Ophthalmic Nursing Forum members to consider their work and what they do with and for patients. Novartis has agreed to collaborate with us in this award, which is based on innovation, service redesign and the enhancement of patient care.

Application for the award (of which there are three that may be given, on an individual or joint basis) involves you writing about a development in nursing practice that has benefits for patients and patient care. The £2,000 award encourages entry from all nurses who work in ophthalmology and will reward those who have developed specific projects that have made a practical difference to patients' lives. The money will be used to finance your visit to the American Society of Ophthalmic Registered Nurses (ASORN) conference in Las Vegas, 10–13 November, 2006.

Your submission may be about any aspect of nursing and service provision, but one of the awards is specifically for submissions that reflect improvements in patient care in the field of age-related macular degeneration.

Award winners will present their initiatives at the RCN Ophthalmic Nursing conference and have them published in *Eyelines*.

Each entrant must be:

- a registered nurse
- a member of the RCN Ophthalmic Nursing Forum
- the holder of a valid passport.

The closing date for entries is 14 August 2006. The winner will be chosen by early September and will attend the ASORN conference in November.

How to enter

Please state your initiative, in less than 1,000 words, writing your entry along the following lines, using the **STAR** approach, below.

S-Situation

What was the situation before you had the idea for patient care improvement? What problem needed solving? What issue did you need to address? What prompted your idea?

T-Task

What did you decide to do? How did you decide what to do? Who was involved in the decision-making process? Were there other ideas that were rejected? How did you get approval for your plan?

A-Action

What did you actually do? Who was involved in the project? What issues or challenges did you face in putting the plan into action? How did you deal with them?

R-Result

What was the outcome? How did you measure it? What do you plan to do next?

To enter, please include your contact and referee details (indicated below), separate to your attached entry, and send it to Bernie Cottam at RCN headquarters, at 20 Cavendish Square, London W1G 0RN. The work and form can also be emailed to: bernie.cottam@rcn.org.uk. Please type your entry, as it will make it easier for our judging panel to read.

Novartis/RCN Ophthalmic Nursing Award Application

Name:

Position:

RCN membership number:

Workplace telephone number:

Referee details:

Name:

Position:

Workplace telephone number:

MARY SHAW and JANET MARSDEN
report on their eventful March 2006
trip to St John's School of Nursing

Courage and

Twenty-four hours before we set off, the six o'clock news reported that a violent attack was being perpetrated against a prison in Jericho. Tanks had been mobilised by Israeli troops and prison walls were being bulldozed in an attempt to arrest prisoners. Not the sort of news you want to hear before travelling to Jerusalem, but after an email from Jackie Jaidy, Matron at the St John Ophthalmic Hospital, saying we should still come if we felt OK about it, we set off.

Touching down

We arrived safely into Ben Gurion airport on Thursday, 16 March, arriving about 5.30 in the morning at the hospital, where a room each was provided for the rest of that night in the private patient wing. We drifted off to sleep as the Muezzin at the local mosque began chanting prayers. Later, Jackie met us in her office and warmly welcomed us to Jerusalem.

St. John's has its own School of Nursing, headed by Ahmad Ma'ali. In 2004, the curriculum for Ophthalmic Nurse Training was developed in conjunction with Thames Valley University (TVU). The hospital is liaising with a local university to enable the Palestinian students to complete a degree. Delivered at Level 2 only, there are 10-12 students taken on annually on course contracts. Due to difficulties in moving freely around the city, accommodation is available on site, and students receive 'pocket money' for the duration of their training. Waleed El-Khateer, lecturer/practitioner, has just been given

‘We drifted off to sleep as the Muezzin at the local mosque began chanting prayers’

responsibility for quality. The hospital is working towards ISO 9001, which is a first for Palestine and they are rightly proud of their achievement.

The hospital serves a population of 2.3 million people on the West Bank and one million in Gaza. Eye problems range from being in a war zone, eye trauma from UXBs and bullets that children pick up and play with, to congenital problems (the consequences of consanguineous marriages), and diabetic eye disease is common. Eleven per cent of the population are diabetic compared with only 0.01 per cent in UK.

Orientation

The OPD sees 150 to 200 patients per day, a reduction on previous statistics, resulting from the travelling restrictions, placed on patients and relatives, by the Israeli authorities, which means they are all required to have a permit to travel in their own country.

Even for staff, travel is not easy – they spend long hours queuing at check-points. Sometimes they are not able

to get home. For those on the Gaza Strip, they can never get home – the separation wall being built by Israel is causing access problems and is likely to cause many more. Because of the situation, the hospital is setting up other outreach clinics in the north, in case Jerusalem gets cut off.

The staff include three orthoptists, an optometrist and a contact lens specialist – many of these people were nurses, having the ophthalmic qualification, who have done an extra course. These roles are essential, given the needs of the service. There is a self-funding private practice in the hospital, although there were not any private in-patients whilst we were there. There is a male ward and a ward for women and children. Children over 12 years of age go on the adult ward. There is usually a separate children's ward, but refurbishment at present means sharing.

The OPD is a busy place, seeing 40,000 patients annually. Patients are classified by ability to pay: insured, not insured or refugee. There is a nurse-led minor surgery clinic, emergency centre, main clinic, refraction and ocular prosthetics. Much like an OPD in the UK, except that nurses at St John's do nearly everything. The CSSD department is run by two women who pack cotton wool balls, make orange sticks as well as clean and pack instrument trays. They do use some disposables but have agreement to re-sterilise once, which saves them money. Senior nurses and matron, plus others,

inspiration in Jerusalem

communicate in person or via mobile phones – they find it quicker, cheaper and easier than paging.

A busy schedule begins

Saturday was the day of the conference, and attendance was down due to road blocks and permit issues. The presentations were very informative and professionally prepared. Sunday was spent with Jackie and Khalil, who showed us around many historic sites in Bethlehem, while on Monday we spent the day wandering around the Mount of Olives and down into the Old City.

Tuesday, we were off with an outreach team to the small village of Turmus Aiya. There were three nurses, a nurse practitioner and a doctor. This was the first clinic to be held there and the host hospital staff were excited at the prospect and made us welcome. The clinic set-up included assembling slit lamps and vision testing equipment, followed by breakfast shared on the surface of what was to be the nursing/ophthalmic history/administration activity desk. Sixty-seven patients were seen by the nurse practitioner and doctor before 1.30pm. Janet saw one or two eye casualty patients and removed foreign bodies whilst I did some general helping out, but even vision testing was difficult due to the language barrier, despite some patients speaking good English.

Children to the very elderly were amongst the patients seen, with a range of conditions, from allergies, refractive error and trichiasis to cataracts, conjunctivitis and diabetic

retinopathy. The circumstances under which patients were seen were less than ideal – there were two in the consulting room, and the clinic was noisy and full, because entire families tended to attend with the patient.

The village Mucktah (mayor) came round to greet us all. It was he who inspired the clinic session. The hospital was built with aid money – we were told that there are many of these small but perfectly formed hospitals around. Unfortunately, there is often little thought past the building, and issues of staffing and patients are not considered.

Nearing the end

Thursday, our last full day, was spent at Jericho's outreach clinic. En-route to the city, the oldest and lowest in the world, we did a detour up to the mountains of the Temptation of Christ, where we had a picnic breakfast with the clinic staff, amidst stunning views and an aquaduct where the water appeared to be flowing upwards! The rest of the journey was relatively uneventful, but the main road in was strewn with rocks and boulders, the remnants of a riot from the night before. We also passed the site of the prison incident, which was in the throes of being cleared up after the tank damage.

The clinic itself was set up on the first floor of a health clinic, which meant carrying all the equipment up a flight of stairs. Already teeming with patients and their relatives, it was decidedly noisy. The atmosphere was different to the others we attended,

possibly because this was a regular clinic. The doctor and the nurse practitioner worked side by side seeing patients.

There were no hand-washing facilities except outside the toilets and there was nothing to dry hands on. Luckily, there was some alcohol gel. The case load, as before, was undifferentiated, with patients' ages ranging from seven months to over 80 years old. Any patient needing diagnostic tests or an operation has to apply for a permit from the Israeli authorities, as does anyone accompanying them. They may be refused a permit if they or a relative is considered a security risk – this can mean some people may end up blind.

After the clinic we drove to the Dead Sea at El Gedi, which was a lovely end to the day. As we travelled home from our last outreach, we were left to contemplate on the day. The team had worked well and cooperated with one another. And whilst sometimes appearing brusque with patients, who did not seem to mind and were the same back, they genuinely cared for the patients' needs.

St John is a very special place and there's no doubt we'll be back. The staff are enthusiastic, committed and open to advice and I think we felt that we were able to give useful input in some areas while learning a lot in others.

At the airport, we had security check after security check – the staff, it seemed, could not understand why we were happy to do what we'd done without being paid for it!

Action for blind people – questionnaire

The Eye Care Patient Support Service Group is looking to complete a report outlining the need, value and benefits for service users and providers for an information, advice and support service based within hospital eye clinics.

The Group would like the report to reflect:

- the subjective views and experiences of individuals with sight loss, including both positive and negative reflections and outcomes. An example would be how an individual was empowered to remain independent by signposting from the information service that subsequently led to the timely access and intervention from support services
- the objective and quantitative benefits of providing an information service.

Examples would be an increase in clinic patient throughput, freeing up nurses and consultant time by providing non-medical information, the ability to identify at-risk patients, more efficient use of clinic time, and increased uptake of services in the community

- that this relates more to the benefits and spin-offs for the health service itself. However it is important to demonstrate and prove the value of an information and advice service, particularly to eye care

professionals. This would provide a pathway to develop joint working relationships and a motivation for the provision of an information and advice service within the hospital eye clinics, and ultimately, providing a gateway into the target-led health service

- any evidence or research that highlights the links between sight loss, and
- National Service Frameworks – elderly, falls, stroke
- government initiatives – smoking, alcohol, cancer, hypertension.

General questionnaire to map current hospital information services and locate services provided by rehabilitation officers (sensory/visual loss) social services and nursing staff

Please would you find the time to answer as many questions as you can. Strict confidentiality will be kept; we are initially trying to map where services are and the issues to successfully establishing a nation wide programme

Name: <input type="text"/> Job Title: <input type="text"/> Local Authority: <input type="text"/> Location: <input type="text"/> Team/Department: <input type="text"/> Address: <input type="text"/> <input type="text"/> <input type="text"/> Contact number: <input type="text"/> Email: <input type="text"/> <input type="text"/>	Service provided by? (name) <input type="radio"/> Social Services <input type="text"/> <input type="radio"/> NHS Trust <input type="text"/> <input type="radio"/> local PCT <input type="text"/> <input type="radio"/> RNIB <input type="text"/> <input type="radio"/> Action for Blind People <input type="text"/> <input type="radio"/> local voluntary society <input type="text"/> <input type="radio"/> other <input type="text"/> How is the service funded? <input type="text"/> Staffed by <input type="radio"/> nurse <input type="text"/> <input type="radio"/> rehabilitation officer <input type="text"/> <input type="radio"/> volunteer <input type="text"/> <input type="radio"/> ECLO <input type="text"/> <input type="radio"/> other <input type="text"/> Have they had any training and to what level? <input type="text"/> How many hours are allocated to the post? <input type="text"/> How many eye clinics are there per week? <input type="text"/> How often does the hospital information service operate? <input type="text"/>	How long has the service been established? <input type="text"/> Are you aware if consultants and eye care professionals refer their patients to the hospital information service? <input type="text"/> Is there a defined pathway of referral within the eye care management of patients? <input type="text"/> Are consultants aware of the benefits of an information service for patients? <input type="text"/> Quality level <input type="text"/> What is the provision? <input type="text"/> <input type="text"/> How would you describe the level of service? <input type="text"/> How relevant is the information offered? <input type="text"/> Would you describe the service to be provided on a formal/professional level? <input type="text"/> Any opportunities which could be used to provide and promote the service? <input type="text"/> Is there a low-vision clinic? <input type="text"/> Does it operate in conjunction with the eye clinics and hospital information service? <input type="text"/>
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About the hospital information service

The main hospital eye clinic:

 Local Health Authority:
 Local PCT:

 Do Social Services and PCT cover the same boundaries?
 Is a hospital information service provided?

With thanks for your time.

To return the form, or if you have any comments, research or evidence or could point the Group in the right direction, please contact Heather Billington, National Manager, Hospital Information, 35–37 Bold Street, Liverpool, L1 4DN or email: Heather.Billington@actionforblindpeople.org.uk



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