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## Ophthalmic Nursing Competence Framework: What's it all about?

The RCN A&E Association developed the concept of a Faculty of Emergency Nursing over a number of years. This stemmed from issues around practice, variability of education, value of practitioners in emergency care settings and awareness that career structures and grading lacked coherence.

From the start, our steering committee saw the A&E model as a way forward for ophthalmic nursing. As a Cinderella specialty, particularly in general settings, our work is not always valued. Skill levels and expertise are not recognised and many ophthalmic nurses are under-graded for the incredibly skilled, expanded roles they undertake. Education around the UK is patchy to nonexistent and – worse – often where a course exists, managers are reluctant to second nurses because of the value they put on ophthalmic skills and expertise.

We hope to achieve a model for career development with explicit levels of practice, developmental themes with core competencies and specialist competencies for each level of practice, aiming to provide a consistent approach to the standards of ophthalmic nursing practice. This will fit well with implications of *Agenda for change*.

### Where are we now?

The A&E Association has successfully piloted the faculty concept and A&E nurses around the UK are putting portfolios together to show their level of competence.

Meanwhile, our committee has rewritten *The nature, scope and value of ophthalmic nursing* to provide a framework for practice as well as an audit tool. With this basis for moving forward, we have now almost completed the development core competencies, using the model developed by the Faculty of Emergency Nursing Pilot Project.

### How does it work?

The levels of expertise used to develop the core competencies go from V (newly-qualified or new to the specialty) to Z (consultant nurse). Between V and W, the nurse develops an appreciation of all areas ophthalmic practice, followed by increasing experience in the different clinical areas. At level Y the nurse is classed as a clinical expert.

Clinical groupings have unique skills and knowledge attached to them, building on the core competencies and associated with different patient groups or areas of practice covering the broad clinical range of ophthalmic nursing.

### What next?

We need to start developing UK-wide competencies in specialist ophthalmic areas. After much debate, these were identified as: • inpatient care; • outpatient care; • perioperative care; • children and adolescents; • adult and elderly; • day care; • accident and emergency; • primary care; • low vision.

We hope to start identifying nurses interested in these areas to help draft and refine specialist competencies. There's plenty of work for everyone so just give your details and area of expertise to a committee member. We *will* be in touch!

This is an exciting development and a great opportunity to put ophthalmic nursing even more firmly at the forefront of developments. It will be incredibly useful in supporting the correct placement of specialist nurses in *Agenda for change's* single pay spine, enabling education purchasers and providers to move to a UK-wide standard.

Thanks to **JANET MARSDEN** for this report.

Send contributions for the next  
issue by 15 January 2003 to the  
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# Letter from the Editor

The conference in Bournemouth in June was our biggest and best attended yet. Thanks to all who came and a huge *thank you* to all our speakers who made the conference so interesting and varied. We look forward to seeing you all again next year in Birmingham.

The committee has also been working hard on the ophthalmic competencies and that work will continue. We asked for volunteers at the conference and hope to have some of you along to our November working weekend to help take this forward.

I'm always looking for articles to fill our newsletter and would like to thank the contributors to this edition. I still need more so if you have anything shout about, complain about, laugh about or simply share, drop me a line. The next issue will be out in the spring so get those articles, letters, questions, cartoons or whatever to me by 15 January at the latest!

**Joan Mathison.**

*This was a second submission on behalf of the RCN and the Ophthalmic Nursing Forum, forwarded to the National Institute for Clinical Excellence in August.*

## HEALTH TECHNOLOGY APPL Photodynamic therapy macular degeneration

**T**he RCN Ophthalmic Nursing Forum would like to make the committee aware of their wholehearted support for the submission in evidence by Novartis. Issues from the final FAD raised many areas of concern and we would like to bring those to the attention of the committee.

Treatable “wet” AMD progresses much more quickly than the more usual “dry” form. They affect patients of similar age but “wet” is devastating in its speed of effect on the central vision.

Patients who have this form are often in their 50s and likely to be still working, contributing to the wealth of the community and supporting dependents. Any loss of vision will result in profound and speedy loss of fine vision details and colour. Reading and driving will be affected. This in turn will lead to loss of capacity for normal work, reliance on support from social services in terms of practical support, but also reliance on benefits and other family support.

In terms of “joined up thinking”, the loss to society of the normal contribution of the patient and the practical and financial support needed for perhaps 30-plus years should also be considered as the cost of *not* treating – and factored against treatment costs. The resulting loss of quality is a massive argument for treatment, not the gain in quality from treatment. Work on QALYs (Quality Adjusted Life Years ) tends not to go far enough in considering loss of QALYs because of lack of treatment.

The notion that little benefit accrues from treating individuals with visual acuity less worse than 6/36 again does not take into account the preservation of vision and therefore quality of life, and concentrates rather on **improvement** in quality when the best that can be hoped for is that vision and therefore quality of life **remains the same**.

The consequence of not treating is that vision and therefore quality of life is drastically reduced. The explanation to the patient who has 6/60 vision in one eye and hand movements or perception of light in the other eye that their remaining vision is not worth saving is very hard to justify.

The notion of only treating the better eye of the two affected, a conclusion reached in the previous FAD, is perverse and morally and ethically unsound. The aim of all national and international organisations concerned with vision is to prevent blindness and the notion that avoidable blindness should be allowed and, indeed, encouraged on the grounds of cost effectiveness is appalling.

The appraisal suggested that only one functioning eye is required for

# PRAISAL: y for age-related

normal life. This is patently untrue and there is enough literature available which describes this and the consequences of it. The patient experience of losing vision in the first eye leads to feelings of loss, grief and altered body image and may well be enhanced by the fact that the patient knows this could be treated, but must wait for both eyes to be affected. It is also clear that where there is only one functioning eye, trauma tends to occur in this eye due to fixation. Should any concurrent pathology occur in the remaining eye, unavoidable loss of vision may occur. This, combined with avoidable loss of vision in the other eye, leads again to avoidable, bilateral loss of vision with all its consequences.

Avoidable blindness appears to have been the previous NICE recommendation of the necessity to undertake cataract extractions on both eyes and indeed to undertake procedures such as glaucoma surgery or retinal detachment surgery where one functioning eye remains.

Further, where two body parts of any sort exist, the obvious conclusion might be that the patient only needs one to survive. So in procedures such as treating vessel disease, where it is expected that a patient will have bilateral disease, do we treat the good leg when it starts to cause problems and forget the poor one (loss of a leg because of lack of treatment – the patient still has one)? This is obviously ludicrous, contrary to ethical and moral norms and clinical governance principles. It would likely be challenged in the courts (harm by omission leaves clinicians just as culpable in negligence than harm by commission). We would hope that this recommendation is considered within the deliberations of the Appraisal Committee.

The restrictions placed on treatment in the original FAD showed little regard for the needs of this patient group and the principles of care stated above. We would urge a re-evaluation of all possible evidence, taking account of the patient's needs and joined up thinking around health and social care.

## RCN OPHTHALMIC NURSING CONFERENCE

28-30 June 2002 – Bournemouth

**W**e have never had so many delegates, such a wide range of topics or so many very professional talks given – a great success! Friday afternoon was devoted to the Faculty concept and competencies. Rob Crouch, ???title to be confirmed???, gave a talk about the A&E Association model, then I spoke about the ophthalmic competencies and the work so far. Chris Cox, RCN Assistant Director of Legal Affairs, gave a thought-provoking talk on competence and the law, after which we split into groups to discuss the competencies and explain where we want to go from here. We also asked nurses to come forward to help with the work still to be done on ophthalmic nursing competencies.

### Day Two

On Saturday the numbers swelled and there were so many talks that we also ran some concurrent sessions. Margaret Wheatcroft, Director of Nursing for Bournemouth, chaired the morning session and RCN President Roswyn Hakesley-Brown gave the keynote speech. Brad Kirkwood, a Corneal Nurse Practitioner, explained his role in the surgical correction of refractive errors.

A visual impairment symposium highlighted the plight of many patients who, having reached the end of useful treatment, are unfortunately left with little vision but still require our input to their support and well-being. I was pleased to hear so many speakers talk about this area of ophthalmic care as it is often not seen as valuable by management.

Concurrent sessions included one about the experiences of a British team taking ophthalmic operating skills to South America and a talk from Nasrallah Khalilia, a nurse practitioner from Jerusalem, about client health education at St John Eye Hospital in Jerusalem. Others covered nurse-led clinics, cost effectiveness of glaucoma treatment, the teacher as researcher and private care for NHS patients.

### The finale

Sunday continued with topics varying from chlamydia to corneal retrieval, benefits of Lutien and more. The conference ended with an entertaining look into the future by Bill McDermott and Les McQueen. Thank you to all our speakers and also to the RCN conference team who worked so hard to keep everything running smoothly.

**Joan Mathison, your Roving Reporter!**

The most recent audits have focused on our trabeculectomy surgical outcomes and a review of the astigmatism data in our yearly cataract summary.

## AUDIT: Trabeculectomy surgery

This audit looked specifically at patients undergoing trabeculectomy surgery, either as a single intervention or combined with cataract surgery. The final results show that the precedence of post-operative complications is lower than those published by the RCO (Edmunds *et al*, 2002), but comparable to our previous audit results.

Also, assessments of visual fields post surgery are erratic (as some patients are re-listed for the “second eye” at the three week post-operative visit and remain in the “cataract pathway”), so it is impossible to assess or quantify the attainment of stable visual fields post surgery (RCO **secondary** outcome).

**Actions:** Following this audit we will be able to demonstrate that patients undergoing surgery at this Directorate can expect few post-operative complications, although to ensure a **quality patient outcome** of surgery, the post-operative integrated care pathway needs to be addressed to see that visual field testing is standardised to be more closely monitored.

### AUDIT: Post-operative astigmatism

This audit compared pre-operative and post-operative astigmatism to investigate the degree induced by cataract surgery. By comparing the patients’ prescription pre-operatively to their post-operative auto-refraction, it was then possible to assess results as “good”, “indifferent” or “poor”.

Following poor initial audit results, the clinical director was able to make a case for the use of foldable lenses and “smaller incision” surgery to reduce the levels of induced astigmatism. The latest audit data (six months) following this clinical change is very encouraging, with an upturn in “good” results up by 22 percent and, of course, the trend in “indifferent” and “poor” results down by the same margin (see table).

These two small examples may seem very clinical in nature, not involving traditional nursing issues, but they demonstrate that by improving the standards of care pathways and surgical outcomes, we as nurses can make real improvements in quality of patient care.

### References

Edmunds, B.; Thompson, J.R.; Salmon, J.F. and Wormald, R.P. (2002) The National Survey of Trabeculectomy. III. Early and late complications, Royal College of Ophthalmologists, London, *UK Eye*, 16 (3) pp. 297-303.

## Clinical governance in ophthalmology: a nursing issue

It could be argued that ophthalmic nursing is one of the most challenging working environments, with quality of care and treatment developments requiring continuing practice modification through theoretical and practical education.

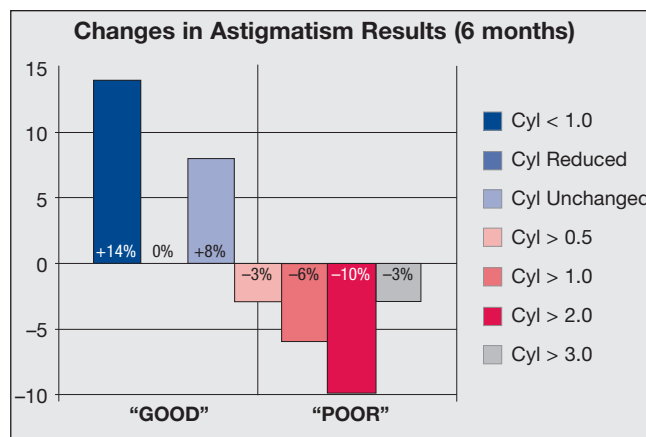
In October 2000, having five years’ experience in ophthalmology, I was “asked” by my clinical manager to be the Directorate’s clinical governance facilitator. This was on a part-time basis to fit in around clinical duties, initially without timescale or framework for reference.

To begin with, the main focus was on our monthly cataract audit, examining visual outcomes and patient satisfaction with surgical experience. This is primarily an exercise in monitoring outcomes in relation to national data, and also publishing specific data in our patient literature, addressing informed consent issues.

Since undertaking clinical governance, we have also studied the use of clinical pathways in the directorate, audited trabeculectomy, strabismus, biometry and astigmatism outcomes, expanded the cataract audit to encompass the recommendations of the Royal College of Ophthalmologists guidelines and collated critical incidents to look at trends in health and safety and risk management issues.

Audits, studies and critical incidents are presented at regular forums, which include the whole multidisciplinary team – consultants, doctors, nurses, orthoptists, secretaries and administration staff. Issues can be discussed and action decided. This process has brought to the fore many issues which, after discussion and recommendations, have led to many modifications in practice.

Kenneth Dawes



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