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Further information

Send contributions for the next issue by [date] to the Editor:

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Letter from the Chair

This year has been extremely busy, but productive. Our conference in September was excellent – as you will see from the summaries starting on page seven. As the conference was oversubscribed again, we are looking at venue in Manchester for next year and will let you have more details as soon as we have them.

At the conference, the five winners of this year's RCN Ophthalmic Nursing Forum/Novartis Awards were announced and they are going to the American Academy meeting. Novartis have been kind enough to sponsor next year's award as well and I would encourage you to apply (see page two).

Our website is live now at www.rcn.org.uk/ophthalmic and becoming an excellent resource, as Stephen Craig explains elsewhere on this page.

The RCN has been reviewing forums and branches this year along with Congress voting rights. I am pleased to announce that despite the 78 or so forums being rationalised to just 42, the Ophthalmic Forum remains.

In addition to organising the conference and Novartis awards, members of the committee (along with the wider forum membership) have contributed to the NICE review of Lucentis and glaucoma this year as well as working on the UK National Vision Strategy and with Vision 2020. I thank them for their enthusiasm and expertise – it makes chairing the forum so much easier for me.

Our work plan for next year will involve reviewing the RCN dignity guidance and linking this specifically to visually impaired people. We will also look at the forum's competences and link educational requirements to educational programmes, work being undertaken as a result of a presentation at conference. *The nature scope and value of ophthalmic nursing* (third edition) will be published shortly and we will put it on the web and circulate it as widely as we can.

Best wishes for the festive season and 2009.

Yvonne Needham

STEPHEN CRAIG gives us a virtual tour.

Check out the Ophthalmic Nurses Forum's new online community

WWW.RCN.ORG.UK/OPHTHALMIC

The RCN has asked us to help build and manage a special web-based "community", where ophthalmic practitioners can come together to highlight practice issues, news and events, and requests for help. This is a dynamic community which will continue

to develop, but already it is populated with some useful information and links which you may want to access.

The community also allows regional

CONTINUED ON PAGE EIGHT

IMPROVING CARE FOR OPHTHALMIC PATIENTS

Novartis has generously agreed continued sponsorship for this award. This year's winners will be going either to Australia for the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) and the Australian Ophthalmic Nurses Association (AONA) meeting – or to the American Academy of Ophthalmologists and American Society of Registered Nurses conference, both in November 2009.

We may not think that our ideas and innovations are anything out of the ordinary, not particularly new or clever, and so there's no reason to talk about them. Often though, they are – and we should!

Small improvements make big differences to patients, especially if everyone does them. So think of what you've done to improve the patient's experience ... enter it for the award ... and perhaps you'll be on a flight to Australia or America next year (you don't need to present your paper there, just enjoy the conference).

Applying for the award (of which there are three, given on an individual or joint basis) involves you in writing about a development in nursing practice which has benefits for patients and patient care. The £2,000 award will be used to finance your visit in 2009 and your RCN conference place in 2010.

Your submission may be about any aspect of nursing and service provision, and one of the awards is specifically for submissions which reflect improvements in patient care in the field of AMD.

The RCN Ophthalmic Nursing Forum will ensure your work gets the recognition it deserves. You'll also need to be prepared to present your initiative at our conference in 2010 and have it published in *Eyelines*.

Janet Marsden

Announcing: The 2009 RCN and Novartis Educational Award

Here's how to enter!

The award is designed to encourage entry from all nurses who work in ophthalmology. It rewards nurses who have developed specific projects which have made a practical difference to patients' lives.

To enter you need to be:

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

- the holder of a valid passport.

If successful, you must:

- be able to secure study leave to travel for the conference
- present your initiative at the RCN Ophthalmic Nursing Forum Conference in 2010
- have your submission printed in the forum newsletter.

Timetable

Closing date for entries is **31 March 2009**. The winner will be chosen by mid-May and will attend the conference in November.

How to enter

Tell us about your initiative in less than 1,000 words, using the **STAR** approach.

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 any other ideas 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?

Then all you need to do is email your entry to: j.marsden@mmu.ac.uk, including:

- your name
- position
- RCN membership number
- workplace (including telephone number)
- the name and contact details of a referee who can substantiate your work.

Entries will be judged anonymously by a panel of ophthalmic professionals.

If you want to discuss ideas for your submission, do get in touch with Janet or with any other member of the forum steering committee:

- Helen Davies helen.davies@cd-tr.wales.nhs.uk
- Yvonne Needham y.needham@hull.ac.uk
- Mary Stott mary.stott@rwh-tr.nhs.uk
- Sandy Taylor sandytaylor123@btinternet.com
- Stephen Craig stephen.craig@northumbria.ac.uk
- Jenny Nosek jennynosek@aol.com

“Novartis Ophthalmics recognises the pivotal role of nurses in ensuring that patients receive the optimal care available to them. As such we are proud to be associated with the Ophthalmic Nursing Forum Award which recognises nurses for going beyond their everyday duties and developing services that lead to improving patient care.”

DR JOHN PROBERT,
NOVARTIS OPHTHALMICS

Here and on the following four pages we present the award-winning submissions for this year's awards.

Winners of the 2008 RCN/Novartis Ophthalmic Nursing Awards

From EILEEN SCOTT at the Western Eye/Hillingdon Hospitals, London.

Setting up an AMD service

Situation

In northwest London (with a population of approximately 1.8 million people) it is estimated that there will be up to 1,350 new cases of wet age-related macular degeneration (AMD) per year. The introduction of anti-VEGF therapy has revolutionised the treatment of neovascular AMD although photodynamic therapy (PDT) still has a part to play in treatment.

Previously limited PDT services in London meant that patients either had to travel long distances for treatment or remained indefinitely on waiting lists. Since 2005, the Western Eye and the Hillingdon Hospital, sponsored by the RNIB, have joined forces to provide London with more convenient and rapid access treatment centres.

A challenging nurse specialist post was also created to facilitate and advance the project. Currently the nurse specialist operates a cross-site service, with time spent on both sites.

Task

A strategic plan was established to facilitate future developments. I looked at best practice by visiting two London hospitals where the service was operational. In addition I attended several in-house training sessions for optometrists, general practitioners, ophthalmologists and nursing staff.

It became very clear that these patients should be referred on an **urgent**, as opposed to a routine, basis. Visual function may then be stabilised. A representative from Novartis sponsored practical help for setting up the project. The retinal specialist developed a patient care pathway.

I developed:

- nursing guidelines for the administration of PDT
- clinical practice for the preparation and infusion of the drug
- a competency statement to demonstrate

proficiency in both PDT and intravitreal procedures

- a philosophy of care.

Clinicians, service managers and co-ordinators held meetings with the commissioners to discuss the needs and benefits of the service. As providers of care, we offered a rapid "one stop service". As a result patients' expectations and communication needs were facilitated.

Our AMD co-ordinators were appointed and were responsible for obtaining funding. Meetings with all the staff involved were arranged.

Action

One of the greatest challenges was setting up a conducive environment. At the Western Eye a dedicated treatment area was commissioned. It was great fun, shaping and changing the ambience of the area.

At the Hillingdon Hospital some provision was already in place, but the area was small. Recently the unit has been refurbished, creating a larger, more conducive treatment area.

The clerical co-ordinators on both sites set up the number of patients per clinic. The profile included emergency slots. Outpatient nursing staff were involved and staffing levels considered.

As the numbers increased a second nurse specialist was employed to meet patient needs and this means that more prescribed time is given to counselling and listening to anxious patients. Clinic efficiency has also improved.

We work closely with the AMD Society. A volunteer has been recruited to the Western Eye Hospital, making a real impact on the patient's journey. We are currently awaiting a volunteer placement at the Hillingdon Hospital.

The following teaching methods are used:

- patient information leaflets developed
- CDs/DVDs/cassettes for staff and patients

- AMD counsellor on psychological effects of blindness
- ongoing informal teaching by the medical staff and nurse specialists
- link tutor from Thames Valley University (London)
- resource file with articles compiled for both sites
- Novartis study days
- ongoing teaching for opticians and other health care professionals in the community.

Results

Setting up the AMD service has been challenging and rewarding, and has given the team an opportunity to develop centres of excellence. The acid test of any service must surely be the opinion of the patient and patients seem overwhelmingly satisfied with the new service.

Clear and concise pathways are in place. Patient information has been developed. A dedicated environment is available. A clear commitment to the "named nurse" concept is operational. Care is less fragmented as patients feel more secure knowing who their carer is. The professional therapeutic use of self with prescribed time for counselling anxious patients is ongoing.

Practice development has been met and staff have empowered patients. Consequently, staff have more insight into the significant impact of AMD and quality of life. An opportunity to facilitate sustainable improvement in care and leadership skills is ongoing.

The key to setting up the "one stop service" is based on a team approach. We are all working in collaboration to optimise care and raise awareness of AMD, within both the hospital and the community. Finally, the implications of the success of our current AMD clinics will be the setting up of a new service at the Mount Vernon Hospital (Middlesex) and an expansion of our department at the Western Eye Hospital.

From LESLEY MALCOLM and AMANDA TATHAM at Ninewells Hospital, Dundee.

Establishing an IVT/clean room for patients with wet macular degeneration

Situation

The development of anti-VEGF treatment for age related macular degeneration (AMD) has had a huge impact on ophthalmology departments throughout the UK, and national media coverage increases the public's awareness and highlights the inequality of availability of treatment.

- In January 2007 following Scottish Medicines Consortium (SMC) guidance, the Scottish Executive advised that an anti-VEGF service must be available throughout Scotland for AMD patients and provision of this must not impact on the current services.
- Guidance provided by the Royal College of Ophthalmologists advocates the use of a "clean room" or theatre to provide this intravitreal treatment (IVT).

Task

Create a plan for the patient pathway and care provision

Initiate an IVT service using existing theatre resources and sessions:

- Commence treating patients who meet criteria within SMC guidance while beginning to explore all options for service provision.

Create a business plan detailing all aspects including anticipated expenditure:

- Include Macular Consultant, Clinical Lead, Theatre SCN, Senior Pharmacist and Business Manager.
- Consider the anticipated number of patients, number of outpatient visits and preferred treatment journeys.
- Collate experience and advice relating to theatre/IVT resources, infection control issues, various potential clean room sites and ventilation advice.
- Anticipate drug costs over a two-to-three year projection, initially with Pegaptanib, but transferring to Ranibizumab following SMC recommendation.

In preparing an option appraisal for the business plan, the location of a clean room was considered on five sites with regard to:

- geographical location within Tayside, ensuring access for all patients across this large area (Tayside covers almost 10 per cent of Scotland's land area and has a population of approximately 389,000.)
- ability to provide appropriate ventilation and associated suitability for purpose
- purchase costs of supporting equipment
- current use and availability of room.

The decision to site the clean room in Ninewells Hospital Ophthalmic Department was based on:

- room formerly unused
- minimal structural renovation required
- appropriate ventilation provision available via ducting from theatre
- proximity to ward allowing IVT clinic to be accommodated
- occasional equipment available in ward and theatre
- local provision of a wide range of ophthalmic backup services.

The plan was therefore established and the resulting business case was supported by local management and approved by local executive teams and NHS Tayside Board:

- Development of AMD anti-VEGF service to be progressed immediately, including staffing, drugs and development of local clean room.

Action

Creating the clean room

Co-ordinate physical development of clean room:

- Create action plan to include all building disciplines involved.
- Apply order of works and timescales for each discipline.
- Define and communicate anticipated completion date and anticipated date of use for clean room.
- Allow for two weeks of slippage time.

Create plan for internal facilities and furniture:

- Visit existing IVT service in Liverpool to share knowledge and experience, and gain advice.

- Locate and plan purchase of furniture and facilities to suit the needs of the service.
- Involve Infection Control staff.

Plan for consumable costs:

- While commencing IVT in theatre sessions, disposable, cost effective consumables were sourced and trialled.

Develop and create all supporting documentations:

- Create patient pathway in conjunction with Quality Improvement Scotland (QIS) Pathways.
- Local Treatment Protocol.
- Prepare computer database for prospective audit.
- Patient information pack.
- Documentation for course of IVT.

Adopt a proactive approach to problems:

- Ventilation ducting from theatre to the clean room delayed by one month on the discovery of asbestos; outside contractors recruited to remove asbestos prior to completion of ducting.
- Poor communication between hospital based trades led to creation of a strict plan to allow for logical flow of building requirements, with emphasis on timescales to recoup lost time. Senior manager enlisted to support.
- Infection control led to initial air-sampling test failing owing to inappropriate ceiling light vents. Light vents were upgraded and air-sampling certification completed.

Results

- Local protocol approved by Drugs and Therapeutics Committee.
- Clean room commenced weekly IVT sessions on 1 August 2007 (provision of safe, efficient, fit for purpose, patient focused service).
- Between August 2007 and February 2008, 282 injections have been given to 111 patients, with zero incidents of infection.
- Verbalised patient feedback via consultants supports efficient, friendly treatment service



From LINDA LEWIS at HM Stanley Hospital in St Asaph.

An alternative approach to shared care glaucoma clinics

Situation

Nurse-led shared care glaucoma clinics are held on the unit twice weekly. Patients attend with stable primary open angle glaucoma and are seen by the team of nurse practitioners. At this clinic following slit lamp examination, intraocular pressure check and discussion regarding use of eye drops, the patients have their pupils dilated and disc photographs are taken. These are then looked at, at a later date, by designated medical staff and the optic disc is assessed.

Following a departmental clinical governance meeting, discussion highlighted the following issues relating to the present clinic:

- Not all disc photographs are gradable for reasons such as lens opacities/poor media.
- Not all patients are suitable for photography – for example, because of inability to position patient by the fundus camera.
- Patients driving to clinic cannot be dilated for disc photos.
- Patients with reduced vision – for example, owing to known developing lens opacities – could not be listed at the clinic visit.

- From August 2007, removing IVT from theatre and reinstating theatre sessions has enabled 30 more cataract operations to be carried out per month.

Future

- Analyse audit data and improve current service as necessary.
- Gain awareness of the future of AMD treatments and work proactively to achieve.
- Project the use of the service in the near and distant future.
- Debate and consider IVT service as a nurse-led service.
- Debate and develop use of the clean room for other ophthalmic services, such as biopsy clinic in relation to new government targets.
- Strive for a high quality, flexible approach to use of the clean room facility to provide appropriate care for ophthalmic patients.

- Feedback on disc photos cannot be given to patients at that clinic visit by the nurse practitioner.

These issues impacted on the ophthalmic service and quality of care provided to patients attending the unit, with patients requiring extra return visits either to nurse-led SCGC for photos at a later date (taking up appointment slots for those already waiting) or back to the main doctor clinic where optic discs could be examined by the medical staff directly by the slit lamp. Hence the general feeling was that there was room for improvement.

Task

It seemed realistic to address these issues by developing an alternative approach to the existing SCGC, using newly acquired advanced nurse practitioner glaucoma skills in the interests of the patient to improve patient services and quality of care.

Having recently undertaken two MSc glaucoma modules in the assessment, interventions and treatment of glaucoma, a way forward seemed to be to work alongside a doctor in clinic seeing patients with stable glaucoma.

Action

A consultant colleague agreed for me to carry out a pilot over a six week period, working alongside her on one session per week. This would involve seeing stable glaucoma patients as previously I would directly assess their optic discs using non contact lenses, also carrying out pachymetry and consulting with her following examination.

Liaison with practitioner colleagues, the senior nurse and the outpatients sister took place to ensure support for the idea and resources for the pilot

A protocol was then drawn up highlighting which patients should be seen and what should be carried out on the clinic visit.

The pilot proved to be successful – minor issues were encountered which were easily resolved and other issues were solved by

flexibility and thinking out of the box.

Result

A retrospective audit over a 10 week period identified that out of 50 booked patients, 39 of whom attended, 52 per cent were seen by me with 48 per cent needing referral to the consultant. Reasons for referral proved variable – for example, inadequately controlled intraocular pressures, compliance problems, lens opacities, lid lesions and floaters.

The NHS Modernisation Agency's *10 high impact changes* (2004) highlights the need for service improvement and delivery as a continuous process. Ensuring the patient is seen at the right time in the right place by the right person and values optimising staff roles against skills and competences to enhance patient care.

Advantages of this alternative approach at HM Stanley Hospital are:

- Consultant is accessible to discuss problem patients/ prevent extra review appointment.
- If the patient has driven to clinic the optic disc may be examined on undilated pupils, preventing re-booking for disc photos at a later date.
- Diagrammatic disc drawings with cup disc ratio are recorded for future reference as disc photos are not always gradable.
- More time to discuss compliance issues with patients.
- Immediate feedback to patient following disc assessment.
- More time for medical staff to review the more complicated cases.
- Uses advanced skills and competencies of nursing staff.

Future recommendations are to continue with this alternative approach while teaching other members of the practitioner team advanced practice skills in glaucoma, including disc assessment using non contact lenses and pachymetry, enabling them to participate in these sessions. Further sessions will be developed in other consultant clinics with the possibility of assisting in peripheral clinics run by the unit.

From DEBORAH THORPE of the Wolverhampton Eye Infirmary.

Heading to come

Situation

As a trained ophthalmic nurse working in a busy outpatients department, one of my roles is to provide care for patients attending our nurse-led glaucoma clinic (NLGC).

This clinic provides a fast track service for new referrals direct from opticians, as well as other ophthalmologists, who are found to have raised intraocular pressure (IOP) or suspected glaucoma, and to co-manage with our medical colleagues those patients requiring further monitoring.

In the clinic my role, alongside my team of colleagues, is to provide a full glaucoma screening to all who attend the service and, importantly, provide support and education in understanding to help them comply with their treatment plan.

Following a clinical audit last year it was highlighted that information that may have been discussed was not recorded in the case notes. This led me to look at the information that nurses in the glaucoma clinic were documenting on our patients, such as lifestyle issues that could possibly have great impact on the patient.

Following a small audit carried out on notes of those patients attending the NLGC in November 2007, it was found that despite some issues around mobility, lifestyle and activities of daily living being documented, there was a marked variance in the level of detail on patients' lifestyles and any problems encountered as a result of their ocular condition.

The audit also showed that a small proportion of patients were advised regarding issues such as safety, alcohol and diabetes. Driving appeared missed. These are all significant issues that should be discussed, documented and elaborated upon.

I felt that we required a qualitative nurse-led glaucoma assessment tool to provide a more in-depth look at the patient's holistic status regarding their glaucoma and lifestyle,

and it would ensure key aspects of these wouldn't be missed among all the complex physiological measurements such as fields and pachymetry that are carried out.

Task

Before I could embark on developing a tool or making any changes to practice, I needed the support from my Nurse Manger and other colleagues. I wanted them to feel valued and to provide them with information on how changing practice would benefit everyone, but most of all our patients.

It was important to me that staff were involved and motivated at the outset. In some cases it this process could possibly recognise that knowledge and skills would have to be built upon and possibly additional support would be required for certain staff involved. I was delighted to discover that fellow colleagues supported my evidence. They were overwhelmed at the thought a NLGC assessment tool could reduce the amount of writing in clinics and yet provide a consistent high standard of care for our patients

Action

Consultation with colleagues identified the needs of a NLGC assessment tool. The aim was to provide a tool that would consistently capture all the necessary information we required from patients in a simple manner. This information could then be used to provide an individual holistic model of education and support to both the patient and their carers.

Literature shows that active management of hard-to-reach patients pays off in terms of good outcomes. Patients also greatly benefit from being involved in the services provided. They need time for their comments – importantly, time for a more comprehensive assessment if necessary.

The tool was developed through a number of short pilots. The current tool, which is undergoing a six month pilot, consists

of a number of tick box questions that capture both functional and emotional information. It is inserted into the patient notes during the initial interview and is available for the medical staff to see when the patient re-attends. It is designed to be updated, if required, at each visit because as the patient's situation or disease changes, naturally their holistic health needs may also need evaluating.

Results

Initial informal feedback has been positive. Both staff and patients have voiced that it has been good to discuss issues other than "putting in drops". It has been demonstrated that the NLGC assessment tool has supported other information we gathered on initial and subsequent interviews, and has increased our awareness of the need to continually develop the service we provide. It is so easy in this current target-driven NHS to focus only on efficiency over quality!

It is proposed that in six months after full implementation of the assessment tool, both a patient and staff detailed audit will take place to evaluate and assess the effectiveness of the service provided, with patient and staff thoughts and opinions considered. The result of this audit will be made available to staff and patients. It is hoped that this tool will be adapted to use with other chronic ophthalmic conditions, both by medical and nursing staff.

On a personal level I hope all staff will be motivated to continue this type of patient-centred development in our NLGC. Undertaking this project has certainly developed my confidence and determination to support patients at all stages in their care and to provide an expert nurse-led service that improves their lives.

We had another great conference in London this year and here are some very brief highlights. More comprehensive abstracts are available on the website at www.rcn.org.uk/ophthamic

Conference title – date missing

The essence of good care: great leadership

Isabelle Hamilton-Bower

Moorfields Eye Hospital Foundation NHS Trust, London

If there is a correlation between good leadership, good patient care and organisational sustainability (that is, recruitment and retention of staff, provision of adequate services, meeting of governmental targets) then there must be a need for good leadership in ophthalmology-knowledgeable, articulate and passionate ophthalmic nurses.

Training to ensure a sustainable workforce for the future is key. There is a case for prioritisation of leadership training and education as a central theme in both pre-registration education as well as a key requirement for post-registration continuing professional development.

The UK Vision Strategy

Lesley-Anne Alexander

Chief Executive, RNIB

This groundbreaking UK-wide initiative brings together for the first time people with sight loss, users of eye care services, eye health and social care professionals, and statutory and voluntary organisations – to provide a unified framework for action on all issues relating to vision.

The delivery of the UK Vision Strategy requires a united eye health and sight loss sector, speaking with one voice to strongly influence the future direction and prioritisation of eye health and sight loss.

Understanding the experience of ambulatory retinal surgery

Christine McCloud

Flinders Eye Centre, Australia

The provision of interventional care to people with retinal pathology in Australia has recently seen almost all surgery moved to the ambulatory setting in response to fiscal pressures and decreased beds. While an acute model of care has proven successful for the care of patients who require cataract surgery, the needs of patients who have experienced retinal pathology are significantly more complex.

Research revealed the inadequacies of the Acute Model of Care to meet the needs of the participants of this study and resulted in negative experiences of surgery. These complex needs were

identified from the voices of the participants. Unmet needs led to experiences of pain, nausea, psychological angst and fear of blindness.

The identification of the needs of the participants led to the development of a Chronic Ocular Model of Care.

Endothelial transplantation – DSAEK explained

Sue Bond

Royal Eye Infirmary, Plymouth

Penetrating keratoplasty (PK) has been performed for many years and while very successful, complications do occur. Because the wound is 360°, the eye is not as strong as normal and is at risk of rupture or wound dehiscence months or even years later.

DSAEK (Descemet's stripping automated endothelial keratoplasty) is a new technique, originally developed and practised in the USA, where just the endothelial cells and posterior stroma are replaced. This is carried out through a small incision, requiring only one or two sutures and leaving the eye intact and therefore safer.

Eye courses for clinical practice – a way forward?

Mandy Macfarlane and Dorothy Field

Royal Bournemouth Hospital/ Bournemouth University

The demise of the ENB brought problems which remain unsolved in terms of the teaching and learning of specialist nursing practice. The loss of a nationally recognised course is felt acutely in many ophthalmic units.

It is our view that the foundational blocks comprising thorough knowledge of ophthalmic anatomy and physiology, ophthalmic pharmacology and conditions are being missed. These requirements are well expressed in RCN Ophthalmic Competency Level 1 which has clear links with the NHS *Agenda for Change*.

Despite the falling numbers of nurses working in ophthalmology and increasing numbers of the remnant being required to work at higher levels, there is no equivalent rise in the percentage of those gaining post-graduate qualifications in ophthalmic nursing. Nurses may be being exploited, and patients and the NHS are not getting the quality working force needed.

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Setting up a support group for glaucoma patients

Helen Doe

Head of Sightline and Patient Support, International Glaucoma Association

The reason for encouraging hospital ophthalmic staff to set up and run patient support groups is to educate the patients about their glaucoma / ocular hypertension and therefore the importance of complying with treatment. From having this knowledge, patients are then better informed in making decisions about their treatment.

Factors affecting the adoption of cornea donation as a standard part of quality care at the end of life

Jane Fisher and Claire Smith

Royal Devon and Exeter Foundation Trust/Bristol Eye Hospital

There is a shortage of cornea material for transplantation in the UK. We represent one of eight national centres created to promote cornea procurement. The response of nursing teams to donation requesting has been variable, and suggests that many potential donors are being lost. This study seeks to use focus groups to explore why comparable teams have very different donation requesting patterns and donation rates.

It is hoped that impacts of the study will include facilitating ward teams, leading to more availability of corneas for grafting.

Improving your vision

Gail Stephenson

Head of Directorate of Orthoptics and Vision Science, University of Liverpool

Visual function is a very broad term to describe a wide range of specific functions. "Keep your eye on the ball" is a typical war cry of football coaches and fans, but do elite players have higher levels of visual function or do they use their visual system in a different way to non-football playing individuals? The first research paper in the area of sport and vision was published in 1926. Over a 12 year period data have been collected from an elite group of footballers. From this work the key visual functions of this group have been identified and also information regarding the development of visual functions.

Ocular oncology and the role of the Macmillan nurse

Rhona Jacques

Royal Hallamshire Hospital, Sheffield

This presentation describes the tumours most commonly diagnosed at the National Ocular Oncology Centres and explains the treatment options available to the patient. The treatment options are surgical excision of tumour, laser treatments, ruthenium plaque radiotherapy, proton beam irradiation, stereotactic radio surgery, removal of the eye or exenteration.

It includes a description of the impact of eye cancer on the patient and explains the importance of supportive care to meet the complex needs of both the patient and their family, based on current evidence in the literature and recommendations from the NICE *Guidelines on improving supportive and palliative care for adults with cancer* (2004).

Did you know you can read this newsletter online?

This and other forum newsletters are available on the RCN website even before they are mailed out to members.

So if you would like to be one of the first to read the next issue log on to **MyRCN** at www.rcn.org.uk/myrcn, or call RCN Direct on **0845 772 6100**, to register your email address and opt in to our email services. You'll then be sent an email with a link through to the newsletter each time it is published.

Help us reduce our carbon footprint and save some trees!

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ophthalmic centres to publicise study days, short courses and conferences as well as contribute helpful articles which may not appear in the more obvious journals.

The Internet is a wonderful place, but it's not well regulated and information can sometimes be less than valid. We hope in a short time that our community webpages will become the first call for ophthalmic practitioners to seek information, share information and *use* information to influence ophthalmic health throughout the UK and beyond.

Guidance on what we can publish is on the front page of the community, with links to both the Community Editor (that's me) and the *Eyelines* Editor, Janet Marsden. So by all means have a look, ask some questions, share information, contribute resources – and watch the community grow!



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For details of forthcoming **RCN EVENTS** go to www.rcn.org.uk/events

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies