NLC in Rheumatology: service set-up, practical issues, quality assurance and auditing

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Presenter Disclosure Information:
Conflicts of interest/
Tricia Cornell is Rheumatology Consultant Nurse for Abbvie and has an honorary contract with Poole Hospital NHS Foundation Trust
Session aims

* Evidence for NLC
* Example of service set up – practical issues
* Quality assurance and audit
* Discussion
Why nurse-led care?

RA causes diverse problems for patients – nurse-led clinics can:

* Provide holistic management
* Interact with multidisciplinary team
* Empower patients
* Significant improvements in pain, morning stiffness, psychological status, knowledge and satisfaction when compare to consultant-led cohort
* Better symptom control
* Enhanced patient self-care

References:
RCN survey 2008 – specialist nurses highly trained, cost-effective but under threat!

* 11% spec nurses downgraded
* 23% have been told they could face redundancy
* 45% have been asked to work outside their specialist role to cover staff shortages
* 47% have been asked to justify their posts

Clinical Nurse Specialists – adding value to care

- Report launched at RCN congress 2010
- Pandora – software based work load tool
  - Recorded complex activity of rheumatology nurse specialists (RNS)
  - National project 1 year duration
  - Recorded work as series of events
  - 8 dimensions
  - Narrative

Clinical Nurse Specialists – adding value to care

- Cost savings
  - Outpatient work done by RNS is worth £72,128 per nurse WTE
  - Saves £175,168 per nurse WTE freeing up Consultant appointments
  - Telephone consultations also save £72,588 pa per nurse WTE reducing number of GP appointments

Royal College of Nursing - London
What should nurse-led clinics provide?

* Typically
  * Drug and disease monitoring
  * Drug administration
  * Counselling
  * Education and social care
Advanced nurse led care

Typically:

* Physical examination – musculoskeletal exam
* Disease and drug monitoring using validated assessment tools
* Following clinical assessment – action plans for pt’s
* Intra-articular/intra-muscular/sub-cutaneous injections
* Independently prescribe Disease Modifying Anti-Rheumatic Drugs/NSAID/steroids/biologics
* Request x-rays, blood tests, investigations
* Refer to Orthopaedic/Renal/etc
Examples of nurse led clinics

* General rheumatology monitoring
  * Monitoring drug therapy and/or disease activity for RA, OA, PMR, Osteoporosis
* Annual review
  * RA patients in remission
* Connective Tissue Disease
* Sero neg arthropathy
* Biologic clinic
* Telephone clinics
* Ax SpA clinics
* Early RA clinic
Where do I begin?

Consider:

- Needs of the patients
- Needs of the department
- Identify issues that inform decisions
  - Commissioning needs, NICE guidelines
- Decide on type of clinic
- Create a plan
- Think about your leadership skills
- Understand administrative requirements
- Have a clear view of the MDT and nurse clinic

Preparing the proposal – developing a framework for practice

- Review current practice
- Preparation work
  - Identify best practice
  - Demographics etc
- Background data
  - Change in workload
  - Costings
- Collating data
  - Gather evidence
  - Is there general support?

Preparing the proposal - developing a framework for practice

* Prepare the draft document
  * Be aware of who will read document and adjust accordingly
  * Prepare the document again!
* Consult widely
* Review the consultation comments
* Re-write the final proposal and submit
* Start the clinics
* Reflect and analyse
* Audit and review

Service set up - Practical issues

* Time for clinic
  * Day, time, how many slots needed?
* Funding
  * clinician time
  * Notes
  * Admin time
* Room space
* Which nurse?
* Training?
Setting up a new Nurse-led clinic – an example
Implementing early arthritis monthly review clinics (EAC)

- 2008-9 Reviewed current service
  - All pt’s reviewed 3-4 monthly by Rheumatology Practitioners (RP’s)
  - No spare appointments for monthly review
  - No money
- Team meeting
  - How to implement
  - The Plan
  - Pathway of care – treat to target
Implementing EAC – The Plan

- Stable IA patients
  - Protocol for reducing clinic appointments to annual
- Instigated annual review in 2010
  - 2 clinics per month RP’s
- Instigated monthly review clinics in March 2010
  - Commenced with weekly clinics for RP and SpR
  - Increased in July 2010 to 2 extra clinics per month - RP
  - Protocol for monthly review and treatment pathway
  - Protocol for RA patients over 2 year duration
Protocol for Annual Review Clinic

1000 + patients with RA

* Stable or no escalation of DMARDs in the previous year
* Patient compliant with DMARD blood monitoring regime
* No evidence of active systemic involvement (inflammatory eye disease, vasculitis etc)
* Stable inflammatory markers for at least 6 months
* No more than one SOS appointment or IM depomedrone injection in the last year
* Patient and/or carer/partner able to recognise a flare of arthritis and seek appropriate help
Poole Pathway for RA over 2 year duration

Definite RA (seropositive or seronegative)

**DAS28<2.6**
- Stable disease – annual review

**DAS28 2.6 – 3.1**
- Stable disease – annual review
- Active disease – raised inflammatory markers, swollen joints/us synovitis
- Increase review to 6-8 weekly until under control. Target to be decided with patient

**Das28 3.11 – 4.1**
- Stable disease – annual review
- Active disease with raised inflammatory markers, swollen joints, synovitis, US - increase review to 6-8 weekly until under control.
- Target to be decided with patient

**DAS28 4.11 – 5.1**
- Stable disease – annual review
- Active disease with raised inflammatory markers, swollen joints, synovitis, US - increase review to 6-8 weekly until under control.
- Target to be decided with patient.

**Das28 >5.1**
- Stable disease – annual review
- Active disease with raised inflammatory markers, swollen joints, synovitis, US - increase review to 6-8 weekly until under control.
- Target to be decided with patients
Poole Hospital DMARD Protocol for Early Rheumatoid Arthritis

Definite RA (seropositive or seronegative)

Symptoms < 6/12

MTX 15mg weekly or SSZ titrated to 40mg/kg OD/BD*
120mg IM depomedrone

Symptoms > 6/12

MTX 15mg weekly
HCQ 200mg OD*
120mg IM depomedrone

Months 1 and 2
DAS > 2.4
120mg IM depomedrone or up to 3 IA injections *

DAS > 2.4
Tritrate MTX 5mg monthly to 30mg (PO or subcut) and consider adding SSZ
Or add MTX 15mg weekly if on SSZ
Depomedrone 120mg IM
DAS < 2.4
Reduce follow-up to 3 monthly with SOS access

DAS > 2.4
Add SSZ 40mg kg and HCQ 200mg (if not on)
Or titrate MTX if not on maximum dose Or consider changing to S/C MTX
Depomedrone 120mg IM
DAS < 2.4
Reduce follow-up to 3 monthly with SOS access

DAS > 5.1 on max tolerated triple therapy (or CI), including had trial of S/C MTX consider anti-TNF or enrolment in a clinical trial
DAS 2.4-5.1 on max tolerated triple therapy consider switching to:-
leflunomide, leflunomide and MTX, cyclosporin and MTX etc or enrolment in a clinical trial
Consider on-going monthly review until DAS < 2.4
DAS < 2.4
Reduce follow-up to 3 -4 monthly with SOS access
DAS < 2.4 for 6/12 consider slowly decreasing DMARDs

*In patients with very active disease consider introducing combination therapy early +/- the use of IV or PO glucocorticoids.

Protocol reviewed February 2011
Poole EAC
What does it look like?

10 clinics per month

* 30 minute appointment per patient
* 55 patient appointments per month
* 6 Rheumatology Practitioner clinics + 4 SpR clinics
* Rheumatology Practitioners
  * Independent Prescribers
  * BSc/MSc Nurse Practitioners
Clinical Governance/Audit
Clinical Governance/Audit

“...a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.”¹

Audit EAC

- Audit against NICE CG79
  - Audit tool available on www.nice.org
- Contact Trust audit department
  - Complete audit form proposal
- Decide on standards
- Collect data and analyse
- Reflect on results
- Publish – abstracts
- Adapt practice

The problem: Patients not having DAS28 recorded on first appt

- Rheumatologists given disease activity VAS to use
- Rheumatologists to use a DAS calculator and record DAS28
- Request patients to have blood test prior to appointment
- Standardise DAS28 and train SpR in DAS28
Summary and take home message

- Communicate – with the team, manager, audit, anyone and everyone!
- Time
- Plan – ‘failing to plan is planning to fail’
- Implement
- Evaluate
- Audit
“Be the change you want to see in the world”

- Gandhi
Discussion and questions

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