MS Nurse Clinic Template Letters

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BACKGROUND: Coming into the role of an MS Nurse without prior experience in running clinics can be daunting. Most nurses either come into the role directly from the ward or other specialities. Multiple Sclerosis is a complex disease that requires specialist care from all health care professionals often coordinated by MS nurses.

AIM OF THE POSTER: To share developed clinic template letters to help new and existing MS Nurses and perhaps other health care professionals. The template letters will help structure clinic appointments and promote patient centred care.

WHY THIS WORK IS IMPORTANT: Patient centred care is the foundation of any specialist care, especially in a complex disease such as Multiple Sclerosis. The template letters can also be used as an auditing tool against any clinical data activity and national guidelines that will further enhance patient care.

WHAT WAS DONE?: Created a template used during clinical consultations with MS patients during follow-up, newly diagnosed, relapse and pre- assessment clinics. The template has evolved in the last 2 years to accommodate the changing landscape of MS patient care.

MS NURSE FOLLOW- UP CLINIC CONSULTATION

Diagnosis- *I normally ask them when they were diagnosed and what/when their 1st symptom was*	
Main Discussion *how they have been since last review*	
Any relapses since last review/ Any progression of symptoms	
Treatment: *DMT, compliance, side effects*	
Other Medications *including OTC& herbal supplements*	
Ongoing MS Symptoms: *How are they managing these; discuss suggestions and support including potential medication or therapy*	
Mobility- *indoor, outdoor, balance, aids*	
Past Medical History/ Comorbidities *I also ask about family history of MS, EBV infection*	
General Health- *I ask about smoking and discuss its relationship to disease progression, alcohol intake, NOP staff measure the height & weight for me then I calculate their BMI, I ask about up to date smear test, mammogram or prostate check if applicable* *I encourage self- breast examination in female patients*	
Diet & Exercise/ Activities - *I discuss the importance of these and low salt, limiting animal fat diet & Brain Health* *Offer local MS Society exercise groups*	
Social/economic/support system- *employment (hours if still manageable), hobbies, support system*	
Bloods-	
Observations-	
Care Plan: *Next review, action plan*	

MS NURSE LED NEWLY DIAGNOSED CLINIC TEMPLATE:

Diagnosis	
History of Symptoms- *I would compare this timeline with the what the Consultant has written*	
Information about MS- *I normally ask what they have read so far and go from there. " De-bunk any wrong information"* *Use power point presentation if needed/ available*	
Self Management- *Symptom Diary, Brain Health When to seek help; relapse vs. exacerbations*	
Sources of Information of Support- *Reputable websites: MS Trust & MS Society, Online community platforms: Shift MS, Local charities: MS Society CAB, Access to Work, Employment rights*	
Discuss Treatment Proposed *(if appropriate) Use leaflets and MS Decisions*	
Past Medical History/ Comorbidities	
Current Medications & Allergies	
Legal Requirement following Diagnosis	**DVLA**
Role of MS Nurse- *Discuss what they can expect from your service, access, contact details, time frame Working together and shared responsibilities*	
Care Plan- *Next review, frequency of review*	
Bloods-	
Observations-	
Care Plan: *Next review, action plan*	

MS NURSE LED PRE-ASSESSMENT CLINIC TEMPLATE:

Diagnosis including EDSS	
Treatment Proposed- *Document patient involvement in the decision and include if this was an MDT decision as well*	
Patient Treatment Goal-	
- Mode of Action- In very simple terms, effectiveness compared to other treatments. Quote data from clinical trials if appropriate	
- Side effects (short term and long term)- *What to expect and when to seek help* *- Common vs Uncommon side effects, quote how many patients you have seen this against*	
- Monitoring Requirements *Schedule and how patients will incorporate this in their life*	
- Precautions including pregnancy - *Vaccinations, Contraception and appropriate pre-treatment*	
Current Medications & Allergies	
Investigations- *Bloods, chest xray, MRI, cervical smear, OCT, ECG, etc*	
Baseline observations including height and weight *- BP, Heart rate*	
Care Plan- *Proposed date to help organise child care and work commitments* *I encourage patients to see their GPs re: the proposed treatment and discuss how can Primary care can support them as well.*	

MS NURSE LED RELAPSE TRIAGE FORM:

Telephone Contact Date:	**Clinic Review Date:**
Patient Details	
Presenting Complaint	
Time Frame *(When, sudden, gradual, fluctuating ?)*	
Pre symptom history: *Infection, stress, sleep, change/s in life/family/ work dynamics*	
How do you feel now?	
Previous Relapse History	
Drug History including DMT and steroid use in the past	
Social History- *Family support, absence from work*	
Care Plan: *Clinic review* - *Steroids* - *Consultant review* - *CNRT referral/ Rapid response*	Neuro Exam: Romberg: Tandem Gait: Walking on heels & toes: Drift: Finger /Nose test: Finger & Hand skill: Visual field: Eye movement: Face: Reflexes/Plantars:
	Care Plan: - Steroids - Consultant review - CNRT referral

SUMMARY & KEY POINTS:

1. Content and length: must be succinct as possible and try and fit relevant information on 1–2 pages of A4 paper.
2. Grammar and English: always read your letter and edit appropriately, using a spellchecker.
3. Medical jargon: if a letter is addressed to the patient, ensure that it is pitched at their level of understanding.
4. Care plan: essential part of any nursing care; make sure you have a care plan either at the end or the beginning of the letter. I write mine at the end (which encourages consultants to read the entire letter!).
5. Tasks: underline or write in bold any task that needs action by the patient, the GP, or by other clinicians.
6. Contact details: ensure that you have your contact details included in the letter.
7. Medico-legal document: clinic letters are all legal patient documents. Always check the content is factual and true to the consultation. Use 'as stated' or 'patient verbalised' to directly quote a patient statement. Any opinions gathered from other clinicians must also be written down.
8. Remember that the consultation is the patient's time and the templates are to be used for guidance. Always go through the patient's list of concerns first which should always be encouraged.

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Ayer, M. Multiple Sclerosis nurse-led consultations: Evolution of clinic template letters. British Journal of Neurosciences Nursing . February/ March 2018, Vol 14 (1)