MS Nurse Education & Information Provision:

Information Needs	Delivery Method/Activity	Benefit
Diagnosis: From the first symptom onset Diagnosis acceptance Diagnosis understanding and acceptance Trusted information sources Carer support Psychosocial support	Participation in neurologist-led clinics (face to face) Coordination of Nurse-led clinics (face to face) Triage of calls to Neurology Phone Home Visits Collecting, entering and accessing data from MS registries and patient's electronic health record (EHR), used to enhance patient safety, evaluate care quality, health outcomes, inform good treatment decisions and support	Improved understanding of patient diagnosis and disease course, including Clinically Isolated Syndrome (CIS) diagnosis and support Availability to ask questions, when needed (especially via telephone) Improved self-advocacy and greater empowerment to make decisions related to their care Increased ability to cope with and manage their health in the context of their disease and its treatment Provision of information on research and clinical trial updates which meets their individual needs, is relevant to them and assists patients to meet their treatment goals Building patients' knowledge, understanding and preparedness for self-management Development and improved coordination and management of individualised treatment plans
Treatment Options Modifiable risk factors Non-modifiable risk factors Medical history, assessment and tests Treatment options and decisions	Participation in neurologist-led clinics (face to face) Coordination of nurse-led clinics (face to face) Triage of calls to Neurology Phone Home Visits Referrals to other departments	Increase patient health literacy Developing a collaborative therapeutic relationship with the patient Providing information and suggesting strategies to manage disease effectively Emphasize the importance of a brain healthy lifestyle Benefits of early diagnosis and treatment to modify disease course Establishing and managing treatment expectations Better understanding of treatment options, side effects and toxicities

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	Pathology, MRI and scheduling of other assessments and tests Patient education, coaching and follow-up Collecting, entering and accessing data from MS registries and patient's electronic health record (EHR), used to enhance patient safety, evaluating care quality, health outcomes, inform good treatment decisions and support	Distribution of evidence-based patient education materials (nurse-developed and distributed) that enhance patient adherence and self-care capacity Importance of monitoring, regular clinical evaluations and risks management protocols: to achieve goal of minimising disease activity whilst optimising safety Individualised treatment through shared decision-making Increased treatment efficacy, adherence and compliance Access to psychosocial support: depression and other psychological disorders Treatment initiation, treatment administration, monitoring the development of treatment-related adverse events and support during treatment changes
Adapt and plan Pseudo relapse and relapse management Symptom management Comorbidities and medication management Professional support network and referrals Monitoring and risk management Referral DMT and Pregnancy preparation, DMT and breastfeeding information & support GP liaison	Liaise and negotiate specialist protocols with Emergency Department (ED) and Ambulatory Care Collecting, entering and accessing data from MS registries and patient's electronic health record (EHR), used to enhance patient safety, evaluating care quality, health outcomes, inform good treatment decisions and support Adopt standardised data management, track clinical and subclinical events	Health assessment: Rapid identification of treatment failure and assistance with patient education and shared decision making around switching medications and treatments Monitoring treatment outcomes, relapses, identification of potential neurological progression and increase patient understanding of MRI activity Identification, responding to and reporting of adverse events Recognition of cognitive impairment, liaison of appropriate assessment and information provision support Triage facility and support resulting in reduced psychological distress and stress Promotion of recovery and improved function during and following completion of treatment of relapse ED avoidance, decrease in admissions, reduced readmissions and days in hospital Coordinating appropriate treatment/response

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Discharge planning support	Populate and use national and international MS registries and databases Participation in Neurologist-led clinics (face-to-face) Coordination of Nurse-led clinics (face-to-face) Triage of calls to Neurology Phone triage and support	Improved symptom management and overall chronic health disease management, increased confidence in self-management strategies Referral, planning and coordination support, addressing barriers and access issues and structured follow up Improved Quality of Life patient outcomes
Progressive Disease management Medical evidence preparation and support for NDIS access Liaison and education with staff within residential disability and aged care providers Assistance with advance care planning	Collecting, entering and accessing data from MS registries and patient's electronic health record (EHR), used to enhance patient safety, evaluating care quality, health outcomes, inform good treatment decisions and support Preparation of medical reports and assessment documentation Participation in Neurologist-led clinics (face-to-face) Coordination of Nurse-led clinics (face-to-face) Triage of calls to Neurology Phone support	Providing evidence-based information, education and symptom management and rehabilitation support Nurse health assessment Improved clinical care and support whilst in other settings i.e. residential aged care or disability housing support. Liaison with multidisciplinary team: better symptom control, pain management, improvement in continuity and coordination of care, daily living assistance, access to assistive technology, proactive medical care and disease management Improved Quality of Life patient outcomes Service and support coordination to avoid carer burden Facilitating and promoting conversations about advanced-care planning that could lead to informed decision making on health care preferences, life prolonging treatments and proxy-decision makers and legal implications. Creation of advanced-care directives

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	Visits to residential settings to ensure treatment plans are understood and adhered to; to establish protocols that avoid unnecessary ED admissions	
End of Life/Palliative Care Support Communicating and coordinating the goals of treatment and care options: checking their understanding, understanding preferences and implications Quality of Life maintenance and support around symptom management, pain, emotional, social and cultural needs Coordination of comprehensive inter-professional care, consistency and communication Caregiver support	Face to face, phone support Liaison with ED, ICU and other departments during periods of hospital admissions Liaison with multi-disciplinary teams Referrals, coordination of support and care Triage of calls to Neurology Phone triage and support	Provision of patient centered end-of-life care during hospital admission Liaison with multidisciplinary team: better symptom control, pain management, improvement in continuity and coordination of care, daily living assistance, access to assistive technology, proactive medical care and disease management Reduce the need for unnecessary hospital admissions Ensuring access to palliative care whilst at home / hospice care / nursing home Service and support coordination to avoid carer burden

Information needs and Education: Capacity building within own hospital setting & external stakeholders

Audience	Delivery	Outcomes
Own hospital setting Ambulatory care Emergency Department Incontinence services Other allied health Pain specialists and providers Speech therapists Spasticity specialists Psychology and Neuropsychology **Stakeholders** GPs Neurological and other community nursing support Private neurologist and specialists Other in community allied health professionals National Disability Insurance Agency (NDIA) Aged Care Providers Disability Providers Employment support Other disability and aged care service providers	Information and education within various group settings such as in-house training, department or team meetings, peer support groups Telephone support and consultation MS-specific protocol and pathway development, negotiation, implementation and review Discharge coordination and support/Referral support	Awareness and recognition of early signs and symptoms Understanding the negative impact of delaying diagnosis and treatment Adoption of new diagnostic criteria Importance of prompt referral to specialist MS neurologists or specialist MS clinic to speed up diagnosis and treatment Establishment of MS specific protocols and pathways between departments Improved access to specialist MS care: making the diagnosis; monitoring procedures; support needs of newly diagnosed Alignment of prescription guidelines to latest diagnostic criteria to give people the opportunity to start treatment and receive support once diagnosis is confirmed Consultation with other providers in order to increase understanding of treatment plans and goals, aiming to achieve the best outcomes for patients Provision of specialist documentation, assessment and support for eligibility assessments for Disability Benefits, Carer Benefits, Aged Care and NDIA supports Provision of information and education to employers about how to increase flexible supports for employees with MS, where a referral to specialist MS employee supports is not available Liaison, information provision and support for other disability and aged care service providers to ensure treatment plans are understood, implemented and supported