Belfast Breathing Better: A COPD Collaborative

Anne Marie Marley
Respiratory Nurse Consultant
BHSCT
Stage 1a Primary Care
Primary prevention
Health promotion and education

Stage 1b General Practice
Accurate diagnosis
Spirometry screening of high risk patients in community and general practice
Accurate performance and interpretation of spirometry
COPD register
Stratification of disease severity: mild, moderate, severe
Referral pathways to specialist support for diagnostic difficulty

Stage 2 General Practice
Treatment and management of stable disease
Salford COPD treatment pathway/NICE guidelines to optimise treatment
Vaccination
POINTS templates to guide management
Specialist medication reviews by community pharmacist
Self management education and written individualised action plans
Anticipatory care
Knowledge and support for carers

Stage 3 Enhanced General Practice and community specialist services
Complex/severe disease
Case management by appropriate case manager (generalist ACM or Respiratory Nurse Specialist)
Telehealth/virtual ward
Community specialist service and clinics with MDT support (including physiotherapy, psychology, oxygen)
Non Invasive Ventilation
Planned hospital admission for those who need it

Stage 4 Specialist and generalist community, hospital and OOH services
Unscheduled care
Admission avoidance through intermediate care
Hospital admission
Supported discharge to reduce LOS via CAST/RNS or intermediate care
Pathways post admission follow up

Stage 5 Specialist and generalist community and hospital
End of life care
Gold Standards Framework
Prognostic indicators for primary and secondary care
Specialist support
Referral pathways
Treatment and management

COPD Integrated Care Pathway

Smoking cessation, health promotion and self care
Pulmonary Rehabilitation
Co-ordinated social care
Supportive and palliative care

Admission avoidance
Education and clinical support
Information and Clinical Audit

HSC Belfast Health and Social Care Trust
caring supporting improving together
Integrated COPD Service
“Exemplar for NI” (RQIA 2016)
Involving the Team and Others

- Patient Reference Group
- Chest Heart and Stroke NI
- Liaison with GP practices
- Both acute and community MD team input
- NIAS
- BOC
- Respicare
- Northern Exposure/PHA/Health Improvement
- Local Commissioning Group
- Marie Curie
- NI Hospice
- Community pharmacy
- ED/Acute Care at Home/BCH Direct

- Lots of communication!!
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Smoking cessation, health promotion and self care
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Focused Case Finding

1402 case reviews
212 pts screened

Cluster 1
Cluster 2
Cluster 3
Cluster 4
Cluster 5
Cluster 6
Cluster 7
Cluster 8

HWC Centres
Community COPD clinic
Home Oxygen Clinics
Pulmonary Rehabilitation
Hospital
Quit While You’re Ahead
Case Management

1196 Patients

- Frequently admitted-2+ admissions or with complex needs-admission avoidance
- Those commenced on LTOT/NIV
- Very severe disease or unable to cope
- Referrals from GP, Consultants, RNS, other staff
- Non attendees at clinic
- Regular attendees at A/E
- Provision of both supportive and palliative care
Control with Style
Clinical Psychology
Provide Pulmonary Rehabilitation

Make available to all appropriate people, including those recently hospitalised for an acute exacerbation.

Tailor multi-component, multidisciplinary interventions to individual patient’s needs.

Pulmonary rehabilitation
An individually tailored multidisciplinary programme of care to optimise patients’ physical and social performance and autonomy.

Hold at times that suit patients, and in buildings with good access.

Offer to all patients who consider themselves functionally disabled by COPD.

[new 2010]
Home Oxygen Service
Transportable concentrators
740 Belfast patients on Home Oxygen
836 new assessments/1286 reviews
Stage 1a
Primary Care

Stage 1b
General Practice

Stage 2 General Practice

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Stage 5 Specialist and generalist community and hospital

End of life care

COPD Integrated Care Pathway

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Chronic Obstructive Pulmonary Disease (COPD) Discharge Care Bundle

This care bundle is a group of evidence based interventions that should be delivered to all patients in preparation for discharge from hospital following an Acute Exacerbation of COPD. The COPD care bundle aims to improve quality of care, patient experience and reduce the risk of re-hospitalisation.

1. If patient is a smoker offer smoking cessation assistance
   - Completed
   - Declined
   - N/A
   - Has NRT been prescribed?
   - Yes
   - Declined
   - N/A

2. Pulmonary Rehabilitation - referral for assessment. (RNS / Respiratory Physio to complete assessment)
   - Completed
   - Declined
   - N/A

3. Written COPD patient information given including:
   - COPD Self Management Action Plan given to patient / by trained facilitator.
     - Yes
     - Updated
     - No
   - Information about the British Lung Foundation (BLF) or Chest Heart and Stroke NI + support groups
     - Yes
     - Declined

4. Satisfactory use of inhalers and nebulisers demonstrated and understood. (If for home use)
   - Completed

5. Oxygen alert card/mask given
   - Yes
   - N/A

6. Patient aware of telephone call within 2 working days of discharge.
   - Completed

7. I the patient (or carer) can confirm that all items on this checklist have been discussed, explained and understood.
COPD Bundle Outcomes (1008)

- 93% of COPD patients received education
- 61% referred to smoking cessation
- 125 referred to pulmonary rehab
- 758 patients (75%) received a self-management plan
- 90% had inhalers/meds reviewed
Nippy 3 Ventilator (120 patients)
Weekend Extended Service

• 120 palliative patients supported at home (rather than 7 days hospital stay)
• 66 patients had early discharge (132 bed days)
• 130 additional weekend exacerbations managed at home (910 bed days)
• Approx. 1882 bed days saved = 5 beds

• Better holistic care for patients
Impact for BHSCT COPD Admissions

• 5% reduction in overall COPD admissions

• 6% reduction in bed days

• Compared to an increase of 9% in other medical admissions
Other Initiatives

• NIAS COPD Pathway

• Warmth at Home Project

• CHS Self Management Programme

• Support Groups/Activities
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Belfast Health and Social Care Trust
Caring, supporting, improving together
Palliative Care Patients
324 with complex needs

Identify
- Identify the EOL patient
- Register/information system
- Patient pathway
- Key worker

Communicate
- Prognosis and treatment intent
- Personal
- Professional
- Information pathway

Assess
- Holistic assessment
- Carers’ assessment

Plan
- Advance care planning
- Equipment and transport
- Out of hours
- Care of the Dying Pathway (LCP)
- Bereavement

Treatment........................Support..........................Care

Raising awareness
Information monitoring
Training and education
Policies and guidelines
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