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Community COPD Services Available In Barnsley

Sue Hazeldine – Community Matron Service (SWYPFT)

Pat Burkinshaw – Community COPD Specialist Nursing Service (SWYPFT)

Sharon Dunning – Respiratory Hub (BHNFT)

Jill Young – Pulmonary Rehabilitation Service (SWYPFT)

Paul Hughes / Helen Marson – Care Navigation / Telehealth Service (SWYPFT)

Introduction

- Service Overview
  - *Community Matron Service*
  - *COPD Specialist Nursing Service*
  - *COPD Respiratory Hub*
  - *Pulmonary Rehabilitation*
  - *Care Navigation / Telehealth Service*

- SWYPFT Comm. Nursing Operating Framework

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Comm. Nursing Operating Framework

High **Patient is unstable/ high complexity/ complex deterioration**	Symptoms or needs are unstable or of high complexity. Some unexpected episodes of a deterioration in health with the need to change the care plan. Regular reviews with worsening family distress and or social burden. Condition management and support needed.	• Case management will often involve the community matrons or specialist nurses. • Involve clinical contacts face-to-face or non-face-to-face with community matron or specialist nurse. • Assess and instigate social network support. • Key worker adopts role of care co-ordinator across all agencies involved. • Consider telehealth vital sign monitoring to monitor worsening of symptoms to identify the requirement to undertake face-to-face intervention. • Consider care navigation/health coaching to influence positive health-related behaviour change and initiate where appropriate. • Promote and support self-management and ongoing education. ***Step down to AMBER as condition determines***
Medium **Patient has fluctuating stability/ some complexity/ expected deterioration**	Some complexity of symptoms or needs which are mostly met by current care plan at a maintenance level. Occasional exacerbations may require additional management and support.	• Ongoing management undertaken by staff nurse in long-term conditions or district nurse involving face-to-face and non-face-to-face contact. • Consider telehealth vital sign intervention for initial six months duration. • Consider care navigation/health coaching services to promote self-management particularly to support medication concordance/requirement to influence positive behaviour change/provide additional disease-related education. • Promote and support self-management and ongoing education. ***Step up to RED if condition becomes unstable/high complexity*** ***Step down to GREEN when condition stabilises/low complexity***
Low **Patient is stable/ low complexity**	Symptoms controlled or needs met by current care plan. Discrete short term interventions and support may be needed.	• Annual review performed by a district nurse. • Ongoing monitoring provided by Telehealth services. • Promote model of self-management, referring all newly referred/diagnosed patients to receive care navigation/ health coaching services as appropriate. • Refer and utilise other services that are available eg. cardiac and pulmonary rehabilitation. ***Step up to AMBER / RED as condition determines***

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CASE 1

Case 1

- *75 year old lady*
- *Known COPD*
- *Smoker*
- *Phoned in for home visit reported difficulty with breathing.*
- *Consider practitioner goals*
- *What are patients goals?*
- *Who would you refer her to ?*

Case 1

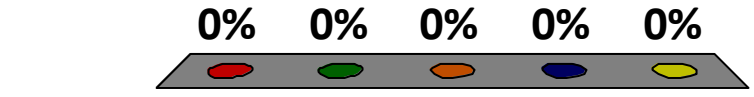
A. Community Matron

B. COPD Specialist Nurses

C. COPD Respiratory Hub

D. Pulmonary Rehabilitation

E. Care Navigation/TeleHealth



Community Matron

COPD Specialist Nurses

COPD Respiratory Hub

Pulmonary Rehabilitation

Care Navigation/TeleHealth

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Barnsley Community Matron Service

Case 1

- *Integrated working (between Community Specialist Nursing Services).*
- *Partnership Working between community and hospital based services.*
- *Encourage improved self-management of condition.*

Community Matron Service

- Referral Criteria
  - *Diagnosed with two or more unstable/poorly controlled long term conditions.*
  - *Had two or more unplanned and preventable admissions or A&E visits in the last six months or significantly increased contact with their GP or unscheduled care services or a high user of social services.*

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Community Matron Service

- Information Required at Referral

  - *GP Summary Print Out*

- Contact Information

  - Telephonic referrals via the Communications Service
  Tel. 01226 436095 or Fax 01226 785690

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Case 2

Case 2

- *72 year old 'Doris' calls out GP twice in 3 days*
- *COPD exacerbation*
- *commences antibiotics.*
- *Doris refuses admission to hospital*
- *GP has growing concern with regards to her urgent needs and deteriorating COPD.* ?

Case 2

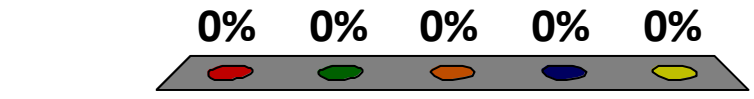
A. Community Matron

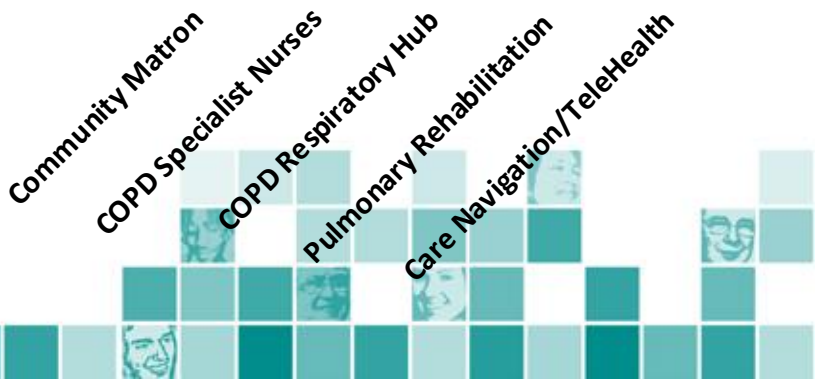
B. COPD Specialist Nurses

C. COPD Respiratory Hub

D. Pulmonary Rehabilitation

E. Care Navigation/TeleHealth





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Barnsley Community COPD Specialist Nursing Service

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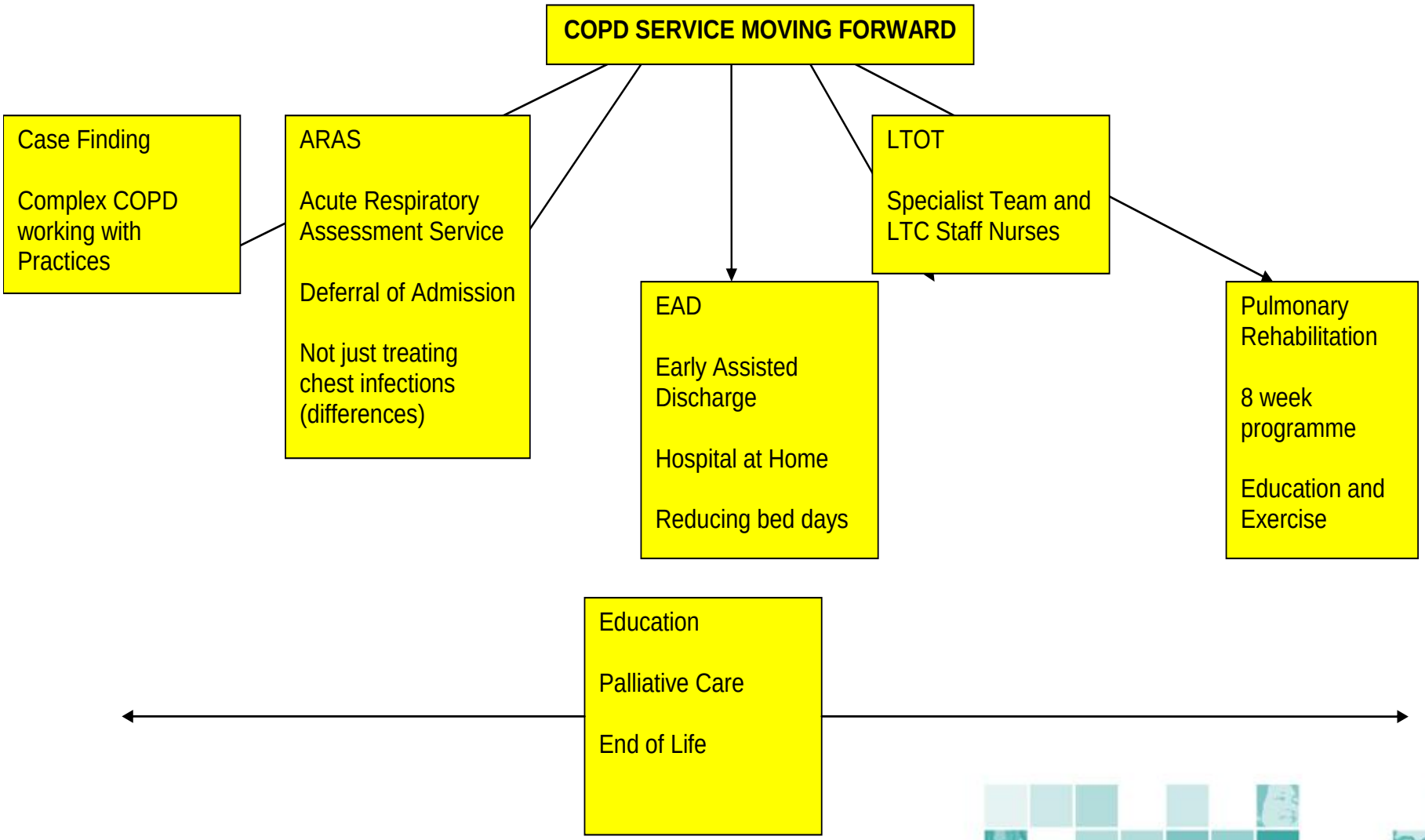
Barnsley Community COPD Specialist Nursing Service - Information Required at Referral

- D1
- Patient Summary
- Recent Spirometry
- Clinic Letters

- Contact number- 01226 209889


COPD SERVICE MOVING FORWARD
Case Finding
Complex COPD working with Practices
ARAS
Acute Respiratory Assessment Service
Deferral of Admission
Not just treating chest infections (differences)
EAD
Early Assisted Discharge
Hospital at Home
Reducing bed days
LTOT
Specialist Team and LTC Staff Nurses
Pulmonary Rehabilitation
8 week programme
Education and Exercise
Education
Palliative Care
End of Life

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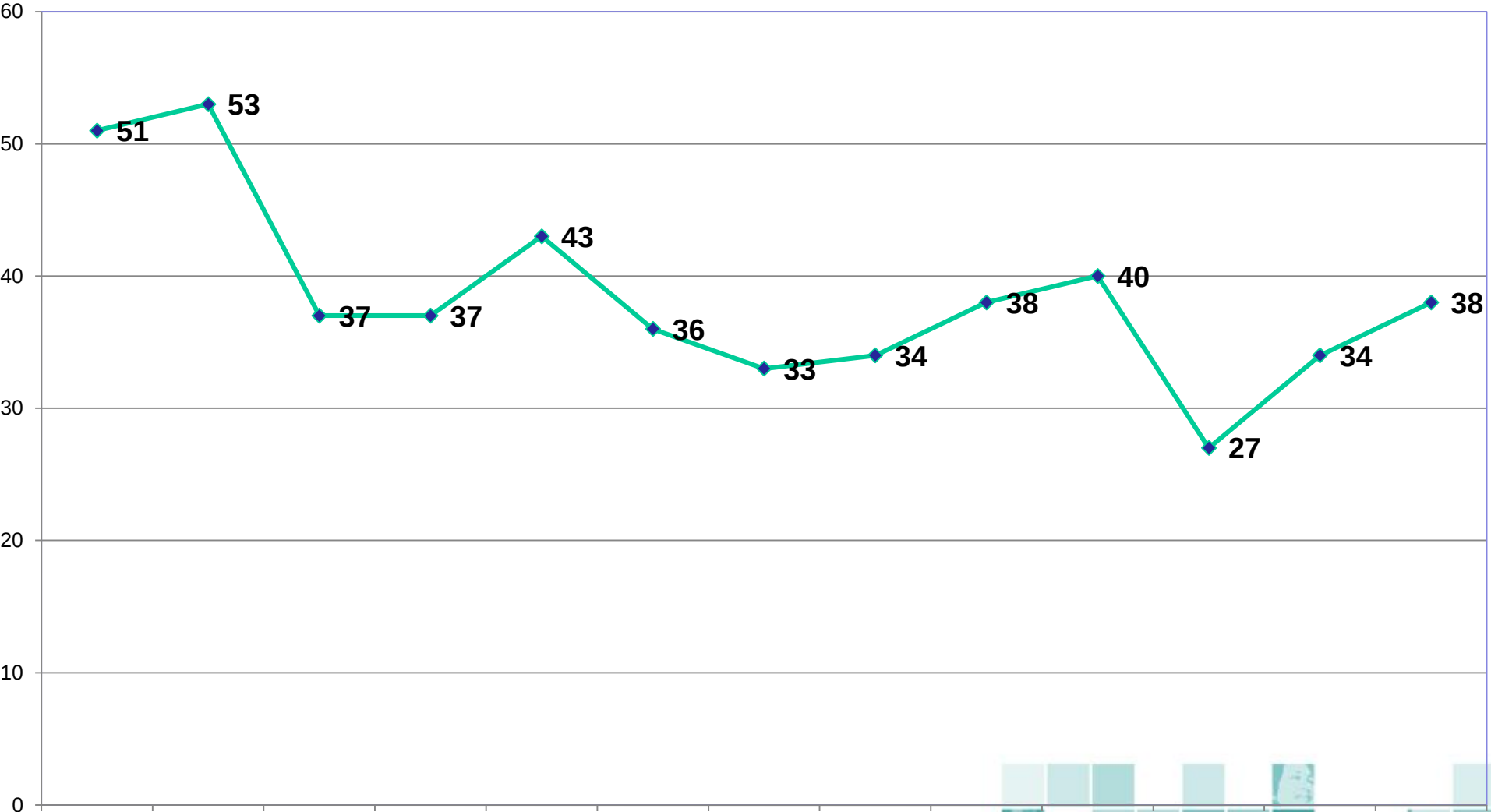
Community COPD Referrals
January 2014 - January 2015



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Case 3

Case 3

- **Female aged 62yrs.**
- **PC – Increase S.O.B, anxious, green sputum (but very difficult to cough up) poor appetite, wheeze, chest tightness.**
- **PMH – Severe COPD on LTOT, arthritis, depression, OA, eczema, asthma. Recent hospital admission following pneumonia in Jan 2015.**

- **Social – ex smoker, lives with husband, stair lift, no pets.**
- **FH – fibrosis and emphysema**
- **Treatments- salbutamol, carbocisteine, doxycycline, fostair, lorazepam, sprivia, and co-codamol.**
- **Sputum result – moderate pseudomonas species**

Case 3

- Observations –
- BP 134/83,
- RR 20,
- HR115,
- Temp 37.5,
- sats 92%
- on LTOT.
- NEWS 5. ?

Case 3

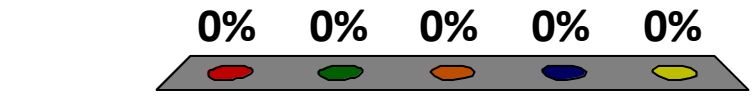
A. Community Matron

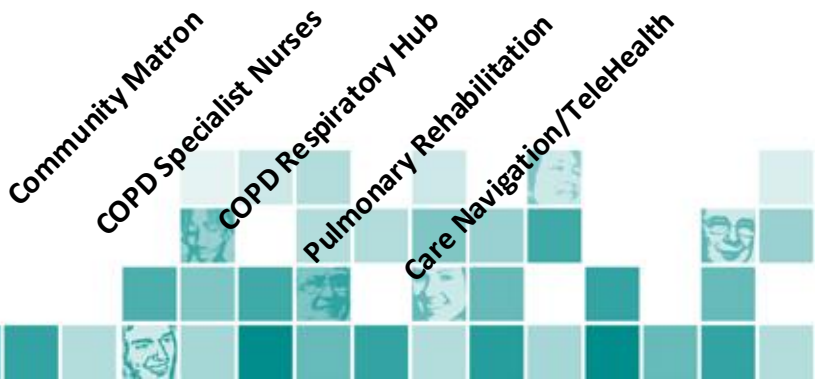
B. COPD Specialist Nurses

C. COPD Respiratory Hub

D. Pulmonary Rehabilitation

E. Care Navigation/TeleHealth





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Barnsley Respiratory Hub

Case 3 - Outcome

SEEN IN RESPIRATORY HUB BY CONSULTANT

- **CHEST – On examination generalized decreased AE with exp rhonchi.**
- **CHEST X-RAY – Bi-basal haziness, No consolidation.**
- **BLOODS – WCC 12, Neutrophils 7& CRP 35**
- **IMP- Treated for mild exacerbation of underlying severe COPD with pseudomonas.**

Case 3 - Outcome

- **Discharged with steroids, ciprofloxacin 3/52 (orally), saline nebuliser, and ensure drinks.**
- **Continue with own Doxycycline.**
- **Follow up in chest clinic with consultant.**
- **Sputum C&S 6/52 after finishing ciprofloxacin.**
- **COPD bundle and home visit.**

- **Referral Criteria**

- *Must have a confirmed diagnosis:-*
  - *COPD*
  - *Asthma*
  - *Pulmonary fibrosis*
  - *LRTI*
  - *Bronchiectasis*
  - *Pleural Effusion*
- *Must have 02 levels >88 on room air*
- *Requires diagnostics i.e. Chest X-Ray etc.*

Respiratory Hub (BHNFT)

- **Information Required at Referral**

  - *Patients details / NHS number*
  - *Current diagnosis / treatments*
  - *PMH*
  - *Clinical observations*
  - *Patients mobility*
  - *Social*
  - *Transport in*
  - *Patient well enough to sit safely unsupervised*

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Respiratory Care Hub

- SHARON DUNNING
  01226 434344
  07792587635
- Based on Ward 18. Mon-Fri (09.00-17.00hrs)
- Last referral is 15.00hrs.

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Case 4

Case 4

- 69 year old male.
- Referral from practice nurse.
- COPD - FEV1/FVC ratio: 41%.
- MRC (Medical Research Council Dyspnoea scale): 3.

Case 4

- Medical History: MI - 1992, CABG - 1995,
- OA knees & hips, panic attacks.
- Ex smoker – 25 pack year history - quit 4 years ago.
- Lives with wife.
- ?

Case 4

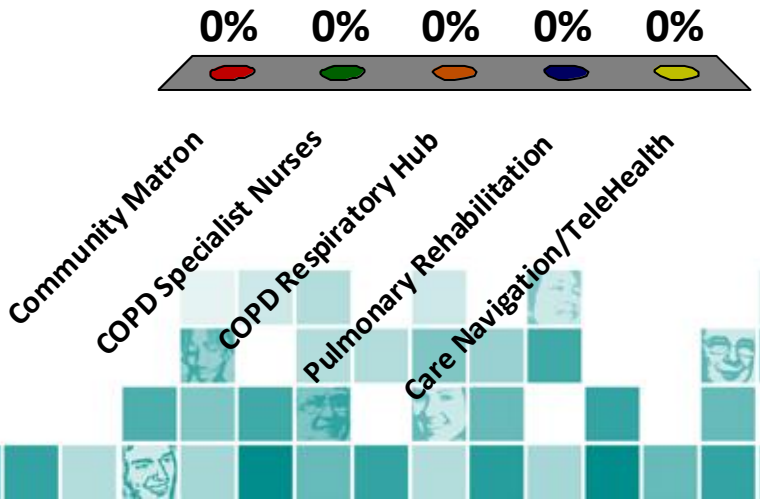
A. Community Matron

B. COPD Specialist Nurses

C. COPD Respiratory Hub

D. Pulmonary Rehabilitation

E. Care Navigation/TeleHealth



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Barnsley Pulmonary Rehabilitation Service

Case 4– Outcome

Referred to Pulmonary rehab → Care Navigation

8 weeks 2 x 2 hour/week

	Pre programme	Post programme
6 MWT	300 m	390 m
O_2 sats (rest)	93%	97%
Lowest O_2 sats (walk)	84%	88%
CRD QoL		
Dyspnoea 5/35	10	23
Fatigue 4/28	7	23
Emotional Function 7/49	15	47
Mastery	8	28
GAD - 7	9	0
PHQ - 9	3	0

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Pulmonary Rehabilitation Service

- A Programme of exercise and education for people with a chronic lung condition such as COPD, Bronchiectasis or Pulmonary Fibrosis.

NICE guidelines [CG101] Published date: June 2010

1.2.8.2 - Pulmonary rehabilitation should be offered to all patients who consider themselves functionally disabled by COPD (usually MRC grade 3 and above, there has been a shift towards addressing COPD earlier in the natural history of the disease and debate has ensued as to whether pulmonary rehabilitation may be of benefit to those with MRC dyspnoea grade 2).

Pulmonary rehabilitation is not suitable for patients who are unable to walk, have unstable angina or who have had a recent myocardial infarction.

Make available to all appropriate people <u>including those recently hospitalised for an acute exacerbation</u>

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

Individualised multicomponent/multidisciplinary interventions to suit patient's needs

NICE 2010

- **Referral to service**
- COPD
- or other chronic lung condition eg. Bronchiectasis/Idiopathic Pulmonary Fibrosis.
- Optimised medical treatment
- Are motivated and willing to attend (even if currently smoking or on LTOT).

- **Patients are unsuitable** if:
- Have unstable cardiovascular disease (e.g. Unstable angina, recent MI)

- Severe cognitive impairment

- Relevant infectious disease

Pulmonary Rehabilitation Service

- Full assessment
- - checking inhaler technique
- patient's knowledge of their condition.
- Exercise assessment - given an individualised exercise programme.

- Attend for 8 weeks (2 x 2 hours a week)

- 1 hour exercise,1 hour education.

- Programme held at Dorothy Hyman Sports Centre, Cudworth, Barnsley S72 8LH

- Dial-a-ride service available – door to door (cost to patient, set amount)

- No 32 bus stops outside
- Held on an afternoon (most patients prefer pm)
- Dedicated gym, no public

- **Members of staff**

Multi disciplinary team -
Respiratory Specialist Nurse, Physiotherapist, Staff Nurse and Exercise Instructors

Education sessions also include -
Mental Health Access Team, Dieitian, Stop Smoking Service, Continence Service, Community COPD Team, Care Navigation / Telehealth Service.

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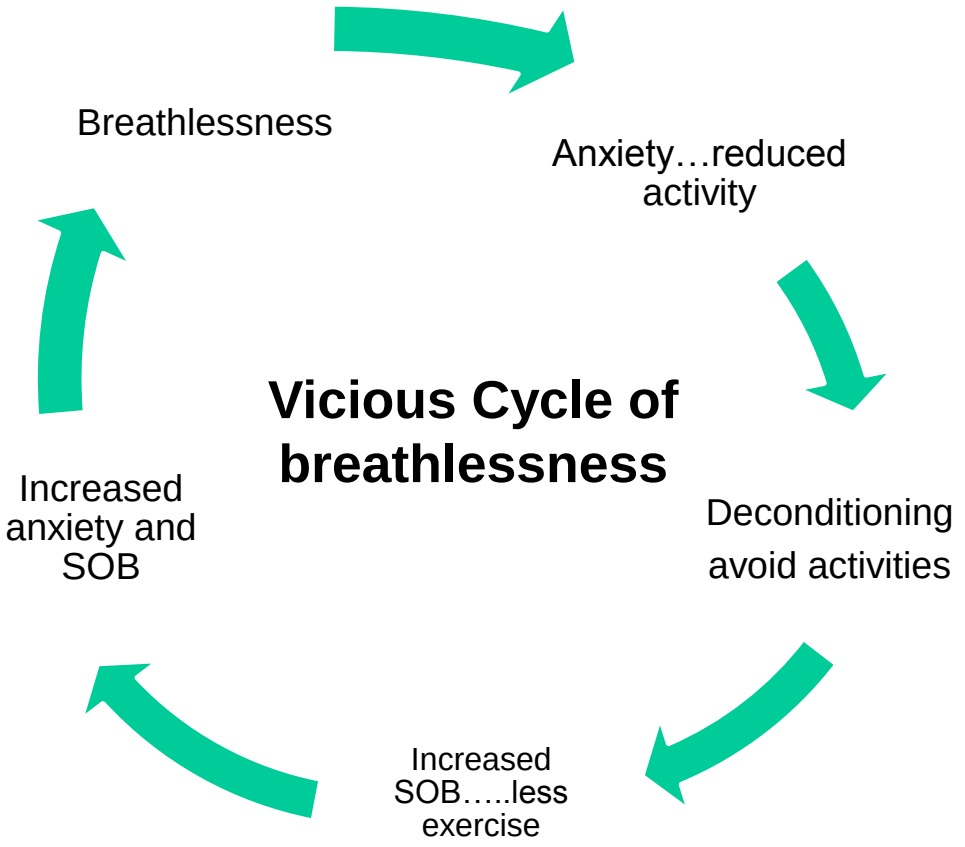
Pulmonary Rehabilitation Education

	Date	Title	Summary of talk	Speaker
1.	Mon 2nd Mar	Welcome to Pulmonary Rehabilitation. Smoking Cessation.	How smoking can damage your lungs & benefits of quitting.	Rehab Team & Stop Smoking Service
2.	Wed 4th Mar	What is COPD? Oxygen Therapy.	How COPD is treated. When is oxygen used & why. If you need long term oxygen	James Woodhouse Staff Nurse
3.	Mon 9th Mar	Goal setting. Travelling with COPD	Setting your goals for exercise before starting the programme. Advice on travelling with oxygen	Lee Anne Jenkins Physiotherapist
4.	Wed 11th Mar	Breathing control & chest clearance. Why exercise?	Advice & techniques to help you control breathing and help clear sputum from your chest	Lee Anne Jenkins Physiotherapist
5.	Mon 16th Mar	Medications	Which medications & inhalers are commonly used to treat COPD. How they interact/side effects.	James Woodhouse
6.	Wed 18th Mar	Inhaler devices	Demonstration on how to use the different inhaler devices. Have your technique checked	Jill Young & James Woodhouse
7.	Mon 23rd Mar	COPD exacerbations. Self management plan	What is an exacerbation? How can a self-management plan help?	Community COPD Team
8.	Wed 25th Mar	Osteoporosis. Falls management	What is osteoporosis? Why are some people with COPD diagnosed with it? What to do if you fall.	Jill Young
9.	Mon 30th Mar	Eating well.	Advice on healthy eating. How to gain, reduce or maintain weight. Why it is important for people with COPD	Dietitian
10.	Wed 1st Apr	. Energy conservation	Hints & tips on how to conserve your energy when you are unwell or having a flare up/exacerbation.	Occupational Therapist
11.	Wed 8th Apr	Tele Health Sleep services. Sex & breathlessness	What is Tele health & how you can refer yourself to the service. What is Obstructive Sleep apnoea? What is Non Invasive Ventilation? Advice on breathlessness during sex	Tele Health & Jill Young
12.	Mon 13th Apr	How to manage continence problems.	Advice provided by continence team on improving continence.	Gill Smith Specialist Nurse
13.	Wed 15th Apr	Keeping your mind active	Highlights the importance of keeping your mind active.	Lee Anne Jenkins
14.	Mon 20th Apr	How to live with chronic airways	Where to go for benefits advice. Discuss end stage COPD & end of life issues	James Woodhouse
15.	Wed 22nd Apr	Stress reduction & relaxation. Anxiety management	Techniques given to help relax and reduce stress. Help with managing anxiety. rehab	Mental Heath Access Team
16.	**Mon 27th Apr**	**Breathe Easy Support Group Follow on exercise programmes**	**When & where the support group meet. Advice on continuing to exercise after finishing pulmonary**	Breathe Easy Group & Rehab Team

Aims of Pulmonary Rehabilitation

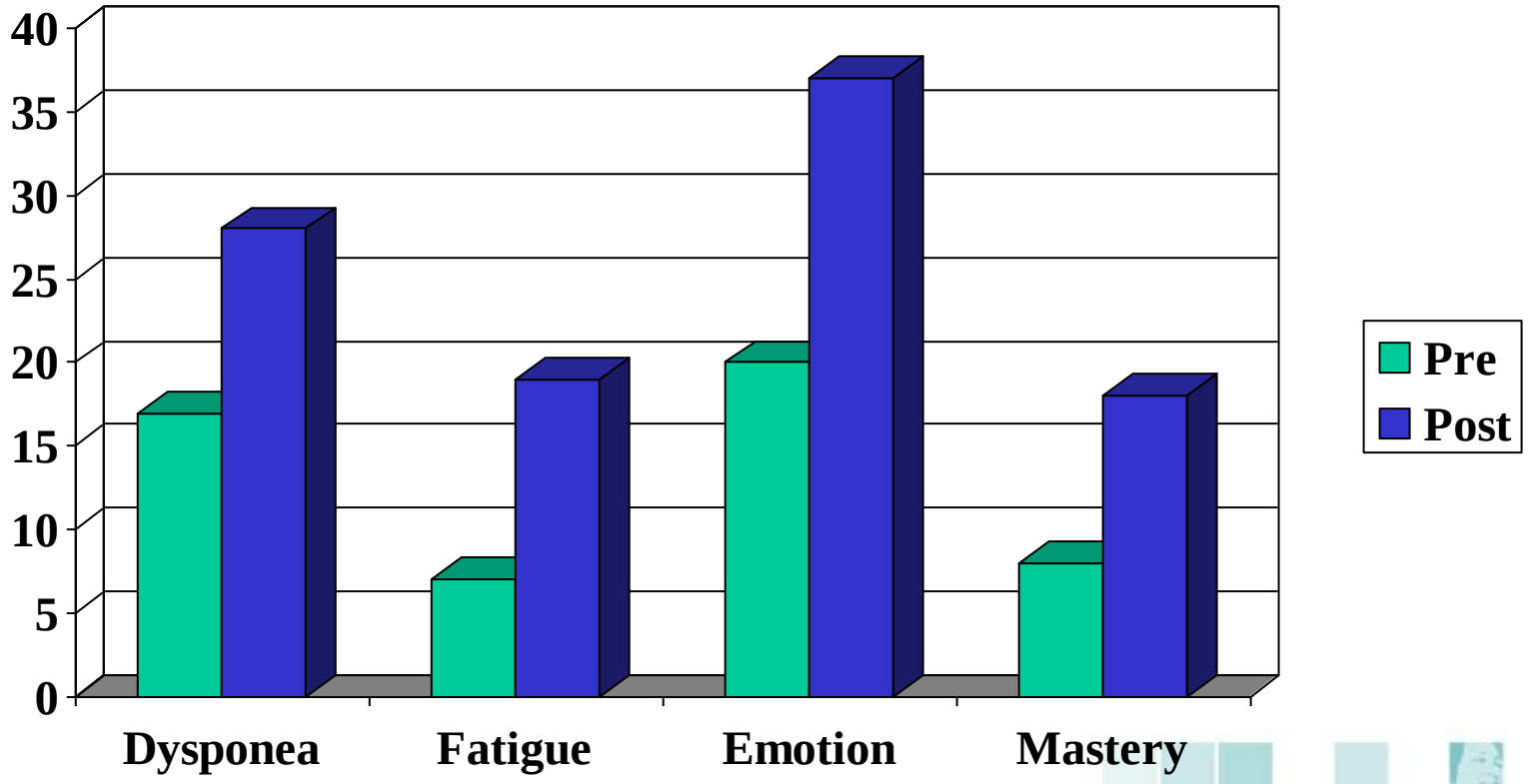
- Break the 'vicious cycle' by

- Improving exercise tolerance
- Regaining a degree of activity and independence
- Improve QoL



Case Study – 78 year old Male (COPD)

Chronic Respiratory Disease Questionnaire - results



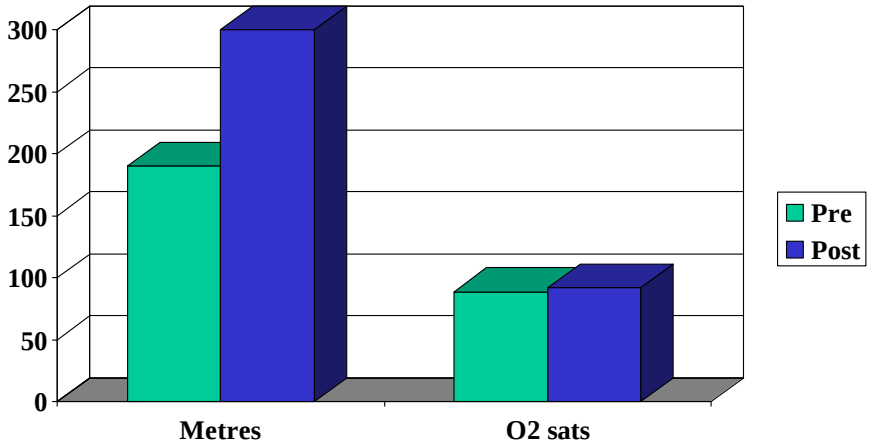
Case Study

Increased walk test by 100 m

Recovery time reduced by 40 seconds.

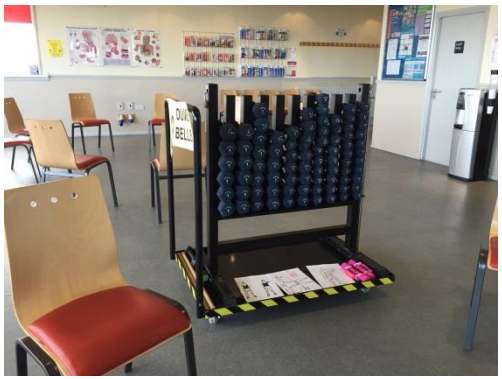
O2 saturations: Room air
Pre: 94% (at rest) - ⇓89% (walking)
Post: 97% (at rest) - ⇓92% (walking)

6 Minute walk test



Case Study

- Previous exercise tolerance: 10 minutes walk with rests 2-3 times per week.
- Goal set at beginning of programme: To walk thirty minutes three times per week.
- By end of programme: Mr M enjoying one hour walks regularly, minimal rests.



Long Term Exercise

- Must continue to exercise to maintain benefits
- Patients own choice as what they continue to do
- Theraband and home based exercise given as a minimum

If you don't use it you lose it!

- Can be referred back to PR after 12 months

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"A pulmonary rehabilitation programme should be presented by the referrer as a fundamental treatment for COPD rather than an optional extra."

BTS guidelines 2013

Referral form from a Health professional to:

Cardiac/Pulmonary Rehabilitation
Dorothy Hyman Sports Centre, Cudworth,
Barnsley S72 8LH

Tel: 01226 719780
Fax: 01226 719789

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Case 5

Case 5

- 46 year old man.
- Recently diagnosed with COPD.
- Smoker.
- BMI = 38
- Requires additional advice and support.

Case 5

- Does not currently access any additional services.
- Patient low in mood due to recent diagnosis.
- Works part time (unable to attend regular appointments).
- Has not yet experienced a COPD exacerbation.

Case 5

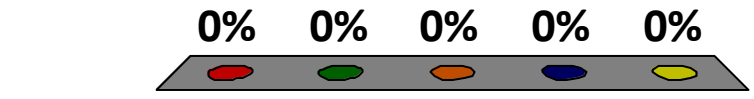
A. Community Matron

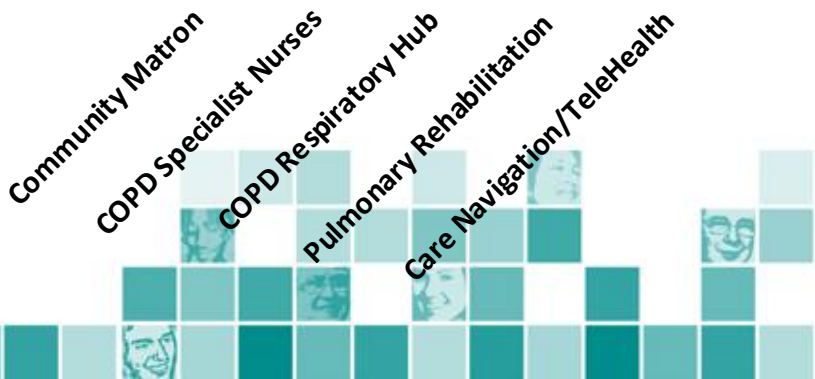
B. COPD Specialist Nurses

C. COPD Respiratory Hub

D. Pulmonary Rehabilitation

E. Care Navigation/TeleHealth





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Barnsley Care Navigation / Telehealth Service

Case 5 - Outcome

Service would ensure the following:-

- Recently diagnosed with COPD – patient has all relevant advice, support / education.

Case 5 - Outcome

Service would ensure the following:-

- Smoker – Enquire whether patient would like to stop, ask if he tried to stop previously and enquire regarding potential referral to Smoke Stop Service.

Case 5 - Outcome

Service would ensure the following:-

- BMI = 38 – what does he want to do about this? Has he thought about any weight loss regime?

Case 5 - Outcome

Service would ensure the following:-

- Does not currently access any additional services – Sign post to relevant services.

- Works Part Time (unable to attend regular appointments). – able to book telephonic appointments around work. Attempt to motivate the patient to achieve positive behaviour change.

Case 5 - Outcome

Service would ensure the following:-

- Attempt to motivate the patient to achieve positive behaviour change.

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What does the Care Navigation / Telehealth Service Provide?

Information

Signpost

Advocate

Empower/ build skills/achieve behaviour change

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Care Navigation / Telehealth Service

Elements of Service provided by the Care Navigation / Telehealth Service

Interchangeable and mutually supportive

Care Navigation

Post Crisis Support

Health Coaching

Telemonitoring

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Care Navigation / Health Coaching Services

Staff Nurse – LTC assesses patient's self mgt. resilience through assessment to identify the appropriate pathway to follow

Patient does not identify areas to change → **Care Navigation (sign posting / info & advice)**

6 calls

12 weeks

Patient does identify areas to change → **Health Coaching (positive behaviour change)**

6 calls

5 months

Telehealth Vital Sign Monitoring

- Remote vital signs monitoring for patients with LTC's (Heart Failure, COPD, Diabetes).
- 220 Telehealth units currently deployed throughout Barnsley.
- Initially H.I.U. patients being targeted. GP's / Specialist Nursing Services referring patients into service.
- Escalation to Specialist Nursing Services following parameter alerts being triggered.

Post Crisis Support

- 24hr Post Acute Discharge Contact.
- A series of 1 to 3 calls to Patient.
- Identification of Unmet Needs / Sign Posting / Advice.
- Ability for Patients to Progress onto Care Navigation / Health Coaching Pathways.

Outcomes Achieved

The outcomes listed below are based on patient service utilisation 6 months prior and post access to the SWYPFT Care Navigation / Telehealth Service in Bassetlaw for 2013 / 2014.

- **Primary Care attendances:**
  - Reduction 46.5% (Coaching)
  - Reduction 14.6% (Telehealth)

- **A & E attendances:**
  - Reduction 31% (Coaching)
  - Reduction 35% (Telehealth)

- **Emergency admissions:**
  - Reduction 46% (Coaching)
  - Reduction 27% (Telehealth)

Care Navigation / Health Coaching Referral Criteria

Those diagnosed with a Long Term Condition who are:

- **Over 18 years.**
- **Registered with GP within the CCG region.**
- **Need more information about their condition in order to become more self managing.**

Why Refer?

Patient needs:

- More information about local services, self help programmes, financial services, social services etc, to meet their individual needs.
- help / support in accessing services (advocacy).
- regular telephonic support to comply with advice/treatment.
- help with motivation and confidence.
- help to change behaviour.

Telehealth Monitoring Referral Criteria

Those diagnosed as having severe COPD, Heart Failure or Diabetes who meet one or more of the following criteria:

- Those identified as having 2 or more secondary care admissions in the last 12 months with a primary diagnosis of Heart Failure, COPD or Diabetes.
- Those that have had 2 or more exacerbations of their LTC within the last 12 months that resulted in primary / secondary care intervention.
- Those identified as having a history of inappropriate use of emergency ambulance services.
- Those who are deemed non-compliant with prescribed treatment or those that require monitoring re: medication changes.

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Care Navigation / Telehealth Service Referral Process

- Completion of electronic referral via email to the following secure email address stating reason for referral:

  carenavigators@nhs.net

  A member of the team will acknowledge the receipt of the referral by responding to your email.

- Alternatively call the Freephone number **0800 612 1976**.

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Service Contact Details / Hours of Operation

- Based at Mount Vernon Hospital
- Tel. 0800 612 1976
- Email: carenavigators@nhs.net
- Website: www.takecontrolbarnsley.co.uk
- Service operational: 7 days per week.
- 9.00 a.m. to 5.00 p.m. Monday to Friday
  8:30 a.m. to 4:30 p.m.
  Saturday / Sunday / Bank Holidays

Thank you for your time

Any questions?