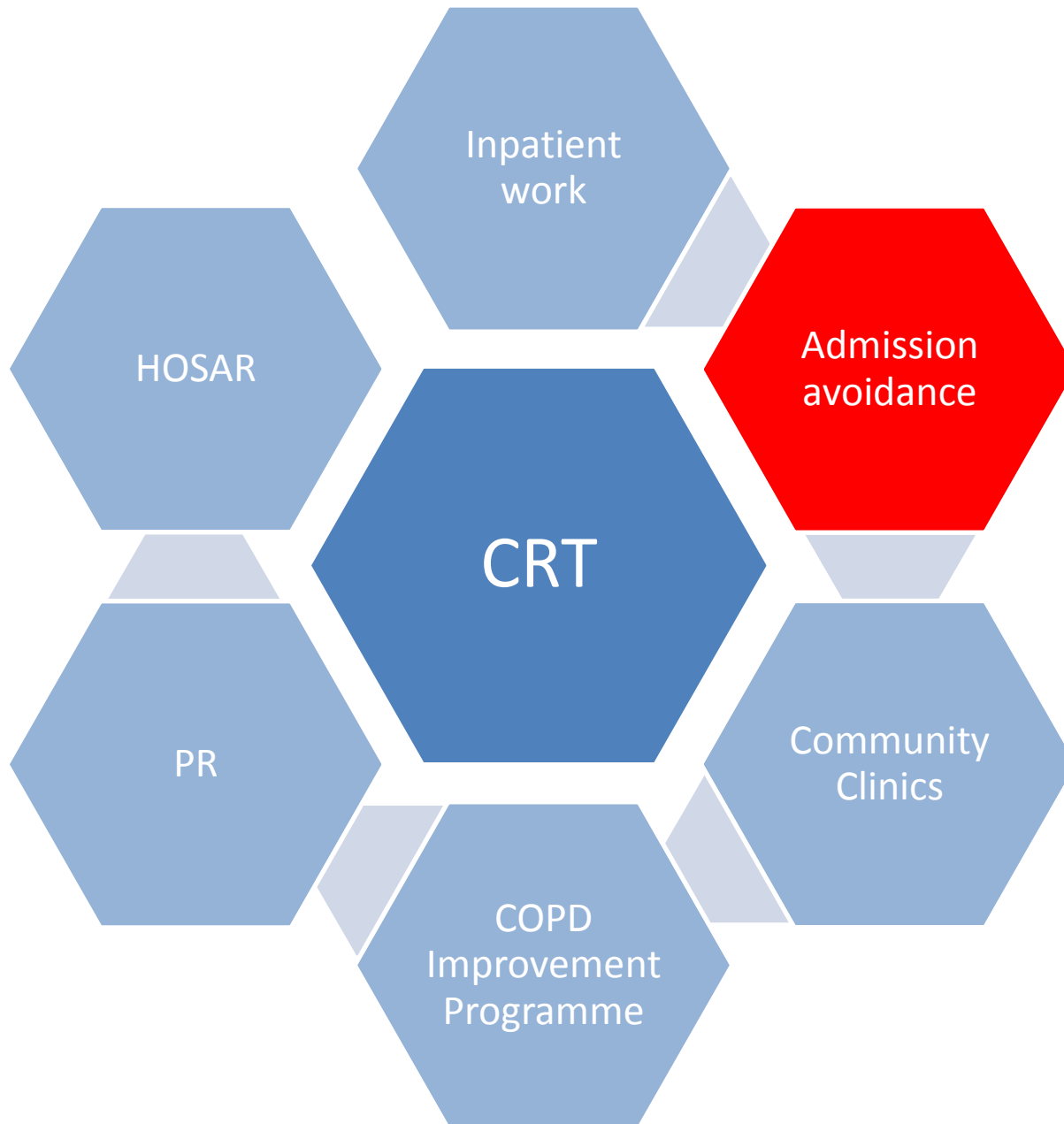


Croydon Respiratory Team

Leann Campbell
Specialist Respiratory Nurse
Team leader
Croydon Respiratory Team
March 2019



Admission Avoidance

COPD (HOT) clinic

- For patients with diagnosed COPD who are acutely unwell and at risk of admission from their COPD
- Self (if known to CRT) / HCP referral
- Pre-arranged appointments
- Can usually be seen same day (if referred before 11.30am – patient will need to make their own way in)
- CXR, bloods, sputum as necessary
- Can be reviewed by a respiratory medical physician if necessary

Acute community

- For housebound patients with diagnosed COPD who are unwell and at risk of admission from their COPD
- Self (if known to CRT) / HCP referral
- Pre-arranged appointments
- Can usually be seen same day (if referred before 11.30am)
- Basic observations and specialist clinical assessment
- Support via GP to prescribe urgent acute treatment after clinician assessment

SEE REFERRAL FORM FOR
INCLUSION/EXCLUSION CRITERIA



Factors to consider when deciding where to treat

- Taken from the BTS COPD guidelines

Factor	Treat at home	Treat in hospital
Able to cope at home	Yes	No
Breathlessness	Mild	Severe
General condition	Good	Poor/deteriorating
Level of activity	Good	Poor/confined to bed
Cyanosis	No	Yes
Worsening peripheral oedema	No	Yes
Level of consciousness	Normal	Impaired
Already receiving LTOT	No	Yes
Social circumstances	Good	Living alone/not coping
Acute confusion	No	Yes
Rapid rate of onset	No	Yes
Significant comorbidity	No	Yes
SaO ₂ < 90%	No	Yes (consider HOT clinic)
Changes on chest radiograph	No	Present (consider HOT clinic)

Inpatient work

COPD Discharge Bundle

- We aim to see all patients admitted due to an exacerbation of their COPD seen within 24 hours admission where applicable
- COPD management optimised
- Appropriate changes and onward referrals made
- Follow up call 48-72 hours post discharge
- Follow up face to face review with in 2/52 – this can be as soon as day 1 post discharge – dependant on clinical need e.g. Clinic/ home visit

Facilitated Discharge

- Aim to reduce length of stay
- Provide appropriate support to patients at home post discharge to prevent readmission and aid a faster recovery
- Liaise with other agencies for support as required.



Readmission Avoidance

- Aim to reduce readmissions within 30 days for COPD patients.
- Improved care for our patients in an appropriate location.

CRT offer:

- Review during admission and completion of a COPD Discharge Bundle
- Home visit/ Clinic review for every appropriate patient post discharge.
- Education for family members/carers
- Prompt review if deteriorating post discharge
- Telephone contact for every patient post discharge.
- Respiratory medication optimisation, self-management promotion and support advanced care planning of the COPD patient.
- CMC discussion
- Temporary Nebuliser Loan (NB we do not supply permanent machines)



Here for you

Recent developments

We have 2 new Generic Support Workers who are being trained to support patients at home who are frequent attenders to CUH. Often these admissions are due to anxiety, low mood and/or poor self management.

Their visits are minimally clinically focused. These are to help enable patients to manage their symptoms better, highlight external services that can add support, advice RE day to day breathlessness. The frequency of the visits will be dependent on the needs of the patient. Aim would be to reduce frequency to as their self management improves .

Review of inhaler techniques and suggesting adjuncts to support independent use eg Haleraids, spacers, turboaids.



MR X – CASE STUDY

- 46 male
- Ex smoker
- FEV 1 13%
- CAT 37, MRC 5, PHQ 6/6, GAD 6/6.
- Frequent exacerbations
- Eosinophilic on bloods
- Homogenous emphysema with left upper lobe fibrosis
- Fostair 100/6 mdi, Salbutamol 100mcg mdi, Slophyllin, Carbocistiene
- Nebulised Ipratropium and salbutamol QDS, Often taking further nebulised doses in the night.

Acute contacts Mr X Contacts pre pilot

- AE PRESENTATION 7/7/2018
- AE PRESENTATION 26/7/2018
- INPATIENT 12/8/2018 TO 15/08/2018
- HOME VISIT 16/8/2018
- AE PRESENTATION 18/8/2018
- INPATIENT 23/8/2018 TO 4/9/2018
- HOME VISIT 5/9/2018
- HOME VISIT 2/10/2018
- INPATIENT 14/10/2018 TO 18/10/2018
- HOME VISIT 20/10/2018
- HOME VISIT 28/11/2018
- HOME VISIT 1/12/2018
- INPATIENT 3/1/2019 TO 14/1/2019
- There has Not been any admissions or acute contacts since the pilot started 15/1/19.



Here for you

'MR X'

He was too anxious to leave his home at all after having a few exacerbations, frequent AE presentations, CRT Home visits, short hospital admissions and prolonged admission due to Influenza. He required a POC as he was unable to manage his ADL's

He missed a tertiary centre OPA.

Became very focussed on his oxygen levels and symptoms.

Poor sleep.

Became more deconditioned as was avoiding anything that made him feel breathless.

He became increasing socially isolated

Over using his SABA and rescue packs.



Here for you

Recent developments 'MR X' cont'd...

What CRT did.

CRT were heavily involved in his discharge planning on the ward.

Senior CRT practitioner reviews on ward to reduce anxiety RE discharge and rapid initial post discharge follow up at home.

GSW support and reinforcement of self management techniques

Referral to Red Cross for support and befriending.

Promoting use of IAPT service.

Supported Mr X with organising transport to RBH.

CRT liaison with GP re medication recommendations and highlighting active concerns.



Progression of Mr X

- Mr X was identified as someone who would greatly benefit from Pulmonary Rehabilitation and increase his suitability for any possible surgical interventions but his anxiety and symptoms prevented him.
- CRT and PR piloted a high intervention care plan which involved some home 'Prehab'.
- Assessed by a Senior PR Specialist Physio, exercise plan constructed and delivered by our service.
- Aim was to increase activity and recondition to enable him to attend the formal sessions in the community.
- GSW accompanied Mr X to start to venture out of his flat.
- Focus on promotion of self management and self empowerment.



Here for you

Mr X follow up

- Nil admissions since the plan commenced, Nil acute contacts.
- Patient attended his tertiary OPA
- Patient has rapidly increased his activity levels
- Is leaving his home to go for walks alone.
- Has started driving short distances alone to local shops.
- Is attending St Christophers' Breathlessness Intervention Service.
- Utilising adjuncts for breathlessness eg, fan, positioning, relaxation DVD rather than over using his SABA.
- Back on his LAMA and less reliant on nebulised drugs (bd salbutamol only).
- Mood improved.
- Nil acute treatment needed.
- Aim to start formal PR in the coming months
- GSW visits have reduced, phone support available
- Currently independent of ADL's



Here for you

Ongoing support if needed - Community Clinics

Respiratory Practitioner led

Twice monthly in each network pair :

- Croydon University Hospital
- Purley War Memorial Hospital
- New Addington – Parkway HC
 - Patients with first COPD admission
 - Patients who need on-going COPD management advice
 - Post discharge reviews

Consultant led

Held at Croydon University Hospital 2 times a month

- Patients who have had NIV during admission
- Complex patients with first COPD admission
- Patients with complex management needs



Here for you

Moving forward.

Improving communication between Primary and Secondary Care.

- CRT would like to become more involved with GP Huddles and Networks.
- Attend GP consultations with patients re CMC discussions or complex management.
- Working towards a smoother pathway for the hospital avoidance community CRT staff to speak with GP's RE urgent prescriptions to avoid an admission/readmission
- Working towards improved access for spirometry reports with the graphs and patient summaries.



Contact details / Referrals

Generic email address for ALL referrals:
ch-tr.crt@nhs.net

020 8401 3963 Direct to team
administrator.



Here for you

Many thanks

