RESPIRATORY MEDICINE 2020 – HIGH QUALITY, LOW CARBON

Design and implementation of a discharge care bundle for patients following an exacerbation of COPD

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What is a care bundle?

- Optimum clinical outcomes require methods of delivering care processes in a consistent manner to reduce unwarranted variation (Fisher 2003).
- A Care Bundle integrates elements of the latest evidence-based guidelines and provides a means for staff to measure compliance to key clinical procedures(DoH2007).
  - usually a distillation of 4-6 priority elements from several published guidelines/articles into a one-page form.
  - must be completed within a defined timescale.
  - all elements should be delivered to maximise patient benefit: compliance ='yes' if ALL elements are delivered OR = 'no' if ANY element is missed.
  - care bundles do not replace clinical judgement; exceptions should also be evidence based.

Why develop a care bundle for COPD?

- 5th Leading cause of death in the UK, number one reason for hospital admission and readmission, large economic burden to the NHS.
- 2008 RCP audit reveals variations in outcomes
- National Outcomes Strategy
- Improve patient experience

- Trusts to be fined for readmissions.....

How did we develop it?

- Used NICE, BTS & GOLD international Standards
- Systematic literature review
- Opinion from clinical stakeholders
  - Medical, nursing, physiotherapy, pharmacy
  - Kensington and Chelsea Breathe Easy Group
  - Patient representative input
  - Telephone survey post discharge

- Patient issues
  - Support post discharge
  - More pulmonary rehabilitation / exercise support
  - Unsure about medication
  - Appreciate support with inhalers
- Staff issues
  - Lack of confidence with inhalers
  - Poor understanding of pulmonary rehabilitation

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) DISCHARGE CARE BUNDLE

Summary – This care bundle is a group of evidence based items that should be delivered to all patients being discharged from the hospital following an Acute Exacerbation of Chronic Obstructive Pulmonary Disease (AECOPD). The care bundle aims to improve quality of care, patient experience and minimise the risk of re-hospitalisation. To ensure the bundle can apply to all we have prepared a combination of actions and documents to facilitate the discharge process.

Inform the COPD CNS of all COPD patients within 24 hours of arrival including patients discharged . Extension _____

PRIOR TO DISCHARGE

CARE BUNDLE STEPS
All required documents are included in package.

1. If patient is a smoker offer smoking cessation assistance
For community referral Fax _____
For clinic referral Fax _____
Completed ☐ Declined ☐ N/A ☐ Not Done ☐

2. Pulmonary rehabilitation -assessed for suitability
First point of contact, either by the CNS Nurses or Physiotherapist, who will assess and refer patient. Nurse to contact if not done prior to discharge (fax referral form)
Completed ☐ Declined ☐ N/A ☐ Not Done ☐

3. Written COPD patient information given including :
•British Lung Foundation Self Management Book
•Oxygen alert WALLET card
•Information about the Breathe Easy Group
Completed ☐ Not Done ☐

4. Satisfactory use of inhalers demonstrated and understood
Please assess during medication rounds. Observe the patients using the device(s) and document on electronic prescribing record adequate technique demonstrated. (Refer to pharmacist or CNS if extra support is needed).
Completed ☐ Not Done ☐

5. Outpatient follow up appointment made and given to patient
Patient should see respiratory medical specialist and COPD respiratory nursing specialist within 1 month of discharge. (Appointment should be scheduled and patient made aware of location, time and date).
Completed ☐ Not Done ☐

DAY OF DISCHARGE

Patient Sticker

GO TO

Patient COPD Safe Discharge Checklist

To be completed by nurse with the patient.

Note: Ensure phone Call scheduled for 48-72 hours post discharge. (6)

Nurse (Initials) ☐

Checklist Completed ☐

Date:___/___/___

Place the faxed referral form(s) in the plastic sleeve during the patients stay, at discharge place with the COPD Discharge Checklist in the 'Completed' COPD Care Bundle Box located;
_____: Nurses Station (Maroon coloured boxes)

Care bundle components are based on:
NICE COPD guidelines 2004 (1-5)
A Patient Experience Survey CLAHRC team April 2009 (6)
Systematic Literature Review supported by CLAHRC April 2009 (1-6)

British Lung Foundation (BLF) 08458 505020 www.lung.org
To find your local Breathe Easy Group 08458 505020
www.lunguk.org/supporting-you/breathe-easy
NHS Quit Line0800 0224332

Name: _____ Hospital Number: _____
Date: _____ DOB: _____

This plan is for people who are going home after coming to hospital with a 'flar ase)

Be es.

COPD safe discharge checklist

	Here
You sh steroi	
The nu appro	
The be you ha	
If you are a smoker you should have been offered assistance to quit.	
You should know what the plan for your follow up care is.	
You should have received written information explaining about COPD.	

IST

COPD SAFE DISCHARGE CHECK

Once you are home

1. Hopefully your condition will improve steadily. If you feel that you are getting worse or that your breathing is disturbing your sleep then get in touch with your GP or community COPD team promptly.
   GP number:_____

2. If you are on a course of antibiotics or steroids it is important to complete them even though you may feel better.

3. You should have a follow up appointment within a few weeks of going home to review your care.

4. Somebody from the hospital or the community team should be in touch in the first few days after you go home to see that you are getting on OK.
   Tick if you **do not** want to receive this phone call ☐

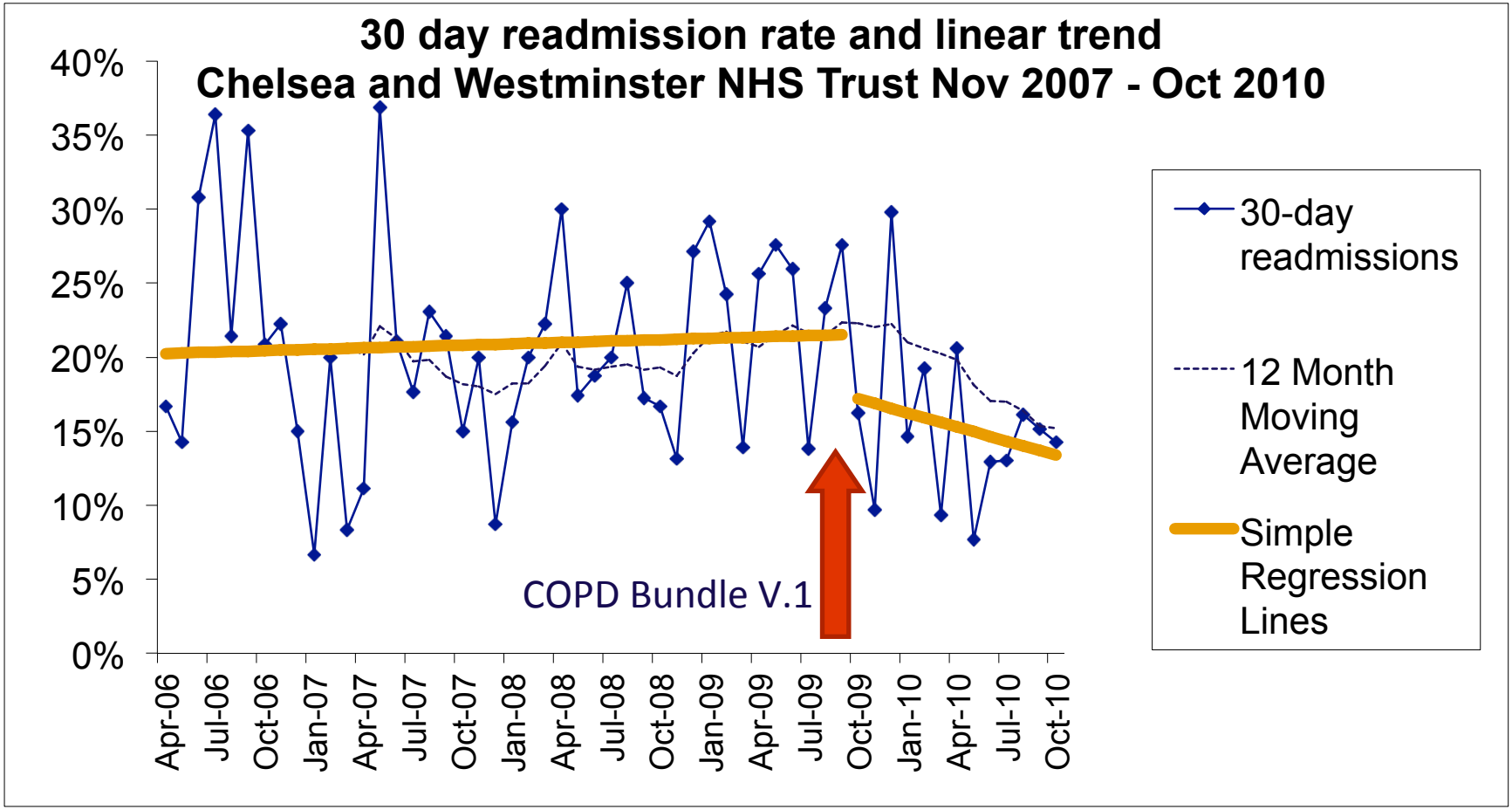
My phone number is: _____ **Preferred time to call:** _____

Health Professional (Print and Signature):

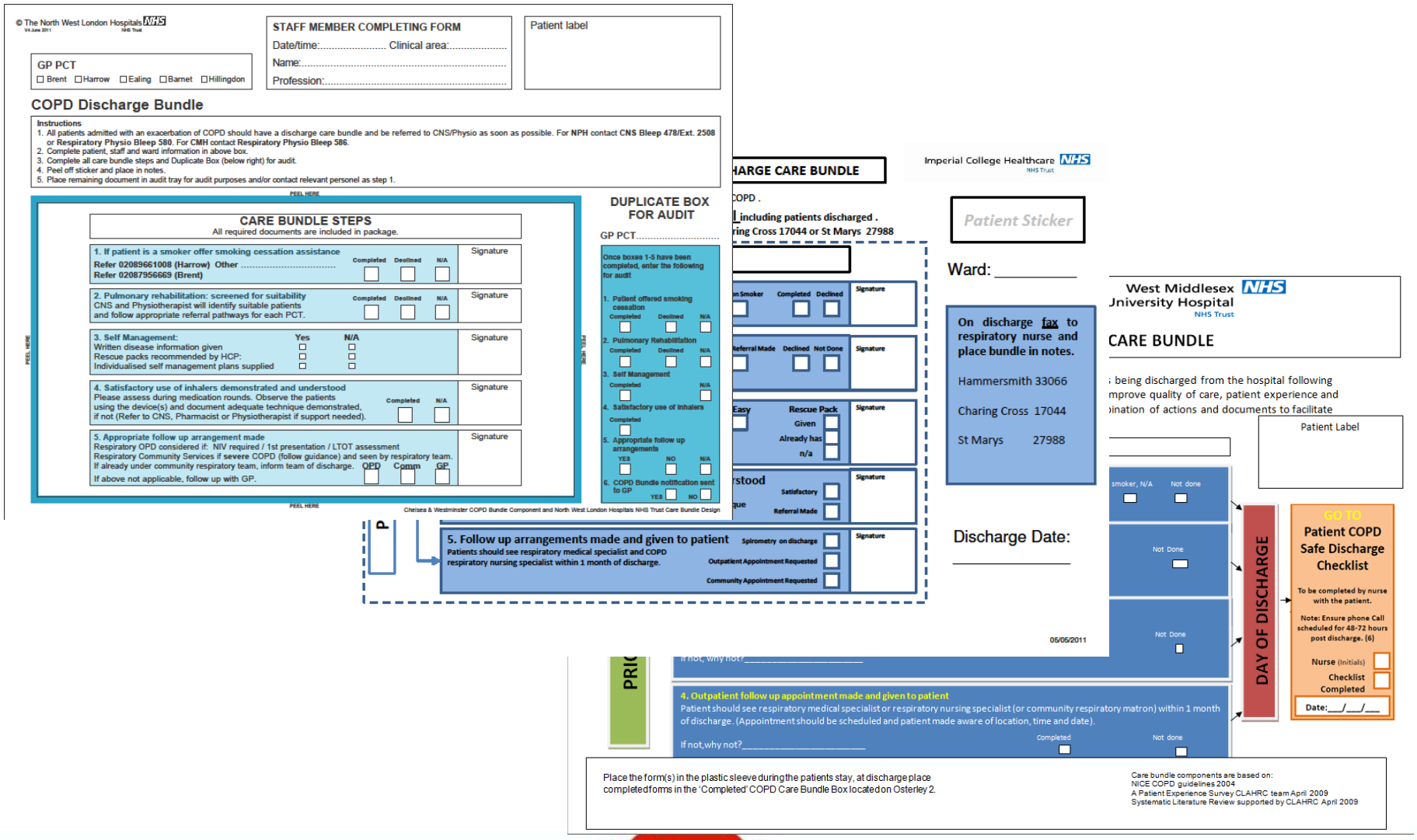
_____ _____

Patient Name: _____

Patient Signature: _____



Hopkinson Thorax 2012 (67) 90-2



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STAFF MEMBER COMPLETING FORM
Date/time:..... Clinical area:.....
Name:.....
Profession:.....

Patient label

GP PCT
☐ Brent ☐ Harrow ☐ Ealing ☐ Barnet ☐ Hillingdon

COPD Discharge Bundle

Instructions
1. All patients admitted with an exacerbation of COPD should have a discharge care bundle and be referred to CNS/Physio as soon as possible. For NPH contact CNS Bleep 478/Ext. 2508 or Respiratory Physio Bleep 580. For CMH contact Respiratory Physio Bleep 586.
2. Complete patient, staff and ward information in above box.
3. Complete all care bundle steps and Duplicate Box (below right) for audit.
4. Peel off sticker and place in notes.
5. Place remaining document in audit tray for audit purposes and/or contact relevant personel as step 1.

PEEL HERE

CARE BUNDLE STEPS
All required documents are included in package.

	Completed	Declined	N/A	Signature
1. If patient is a smoker offer smoking cessation assistance Refer 02089661008 (Harrow) Other ..... Refer 02087956669 (Brent)	☐	☐	☐	
2. Pulmonary rehabilitation: screened for suitability CNS and Physiotherapist will identify suitable patients and follow appropriate referral pathways for each PCT.	☐	☐	☐	

3. Self Management:	Yes	N/A	Signature
Written disease information given	☐	☐	
Rescue packs recommended by HCP:	☐	☐	
Individualised self management plans supplied	☐	☐	

	Completed	N/A	Signature
4. Satisfactory use of inhalers demonstrated and understood Please assess during medication rounds. Observe the patients using the device(s) and document adequate technique demonstrated, if not (Refer to CNS, Pharmacist or Physiotherapist if support needed).	☐	☐	

	OPD	Comm	GP	Signature
5. Appropriate follow up arrangement made Respiratory OPD considered if: NIV required / 1st presentation / LTOT assessment Respiratory Community Services if severe COPD (follow guidance) and seen by respiratory team. If already under community respiratory team, inform team of discharge. If above not applicable, follow up with GP.	☐	☐	☐	

PEEL HERE

DUPLICATE BOX FOR AUDIT
GP PCT.....

Once boxes 1-5 have been completed, enter the following for audit

1. Patient offered smoking cessation — Completed ☐ Declined ☐ N/A ☐
2. Pulmonary Rehabilitation — Completed ☐ Declined ☐ N/A ☐
3. Self Management — Completed ☐ N/A ☐
4. Satisfactory use of inhalers — Completed ☐
5. Appropriate follow up arrangements — YES ☐ NO ☐ N/A ☐
6. COPD Bundle notification sent to GP — YES ☐ NO ☐

PEEL HERE

Chelsea & Westminster COPD Bundle Component and North West London Hospitals NHS Trust Care Bundle Design

HARGE CARE BUNDLE

COPD .
including patients discharged .
ring Cross 17044 or St Marys 27988

Imperial College Healthcare NHS Trust

Patient Sticker

Ward: _____

On discharge fax to respiratory nurse and place bundle in notes.

Hammersmith 33066
Charing Cross 17044
St Marys 27988

West Middlesex University Hospital NHS Trust

CARE BUNDLE

being discharged from the hospital following improve quality of care, patient experience and ination of actions and documents to facilitate

Patient Label

Discharge Date: _____

n Smoker	Completed ☐	Declined ☐	Signature
Referral Made	Declined ☐	Not Done ☐	Signature
Easy	Rescue Pack Given ☐ Already has ☐ n/a ☐		Signature
rstood	Satisfactory ☐		Signature
gue	Referral Made ☐		

5. Follow up arrangements made and given to patient — Signature
Patients should see respiratory medical specialist and COPD respiratory nursing specialist within 1 month of discharge.
Spirometry on discharge ☐
Outpatient Appointment Requested ☐
Community Appointment Requested ☐

smoker, N/A ☐ Not done ☐

Not Done ☐

Not Done ☐

4. Outpatient follow up appointment made and given to patient
Patient should see respiratory medical specialist or respiratory nursing specialist (or community respiratory matron) within 1 month of discharge. (Appointment should be scheduled and patient made aware of location, time and date).
If not,why not?_____
Completed ☐ Not done ☐

DAY OF DISCHARGE

GO TO
Patient COPD Safe Discharge Checklist
To be completed by nurse with the patient.
Note: Ensure phone Call scheduled for 48-72 hours post discharge. (6)
Nurse (Initials) ☐
Checklist Completed ☐
Date:__/__/__

05/05/2011

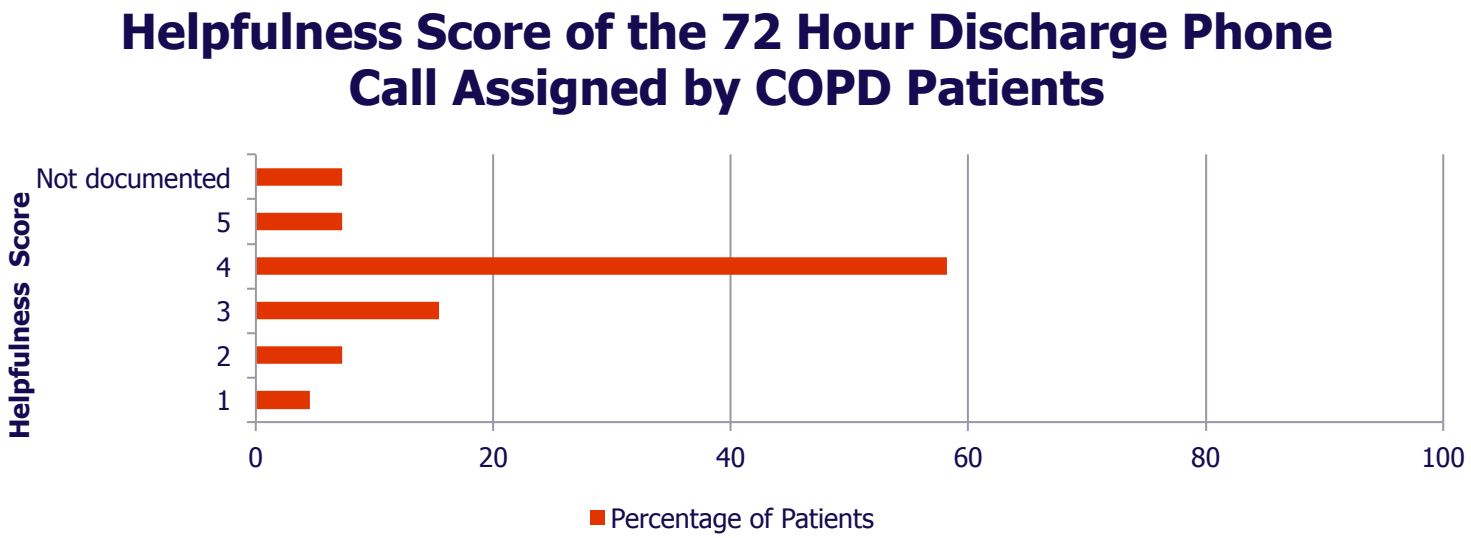
Place the form(s) in the plastic sleeve during the patients stay, at discharge place completed forms in the 'Completed' COPD Care Bundle Box located on Osterley 2.

Care bundle components are based on:
NICE COPD guidelines 2004
A Patient Experience Survey CLAHRC team April 2009
Systematic Literature Review supported by CLAHRC April 2009

NW London experience

In 18 months –

W Mid 186
NW London 389
ICNT 529

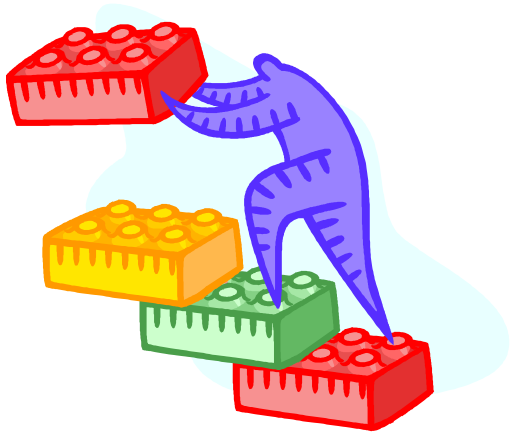


Shared challenges across sites

- Engagement of a multi-professional team
- Staff shortages/fast turnover
- Engagement of a patient representative
- Usage of improvement/CLAHRC methodology tools e.g. PDSA cycles, web reporting tool
- Patient coding
- Lack of downstream services such as Pulmonary rehabilitation

Shared facilitators

- Partnership with Patients
- Persistence in staff engagement/awareness
  - Induction
  - Teaching
- Pivotal Players
- Peer Reviews
- PDSA
- Providing the tools
- Performing champions
- Coding



Making a difference ....

- Awareness in patient groups
- Cost efficiency
- Quality increased
  - Pulmonary rehabilitation
  - Smoking cessation
  - Inhaler use
- Spread within NWL
- NHS London Respiratory CQUIN
- Interest beyond NWL to rest of UK and Europe.
- BTS developing admission/discharge bundles