COPD Rapid Response Help Line

Initiative Type

Service Improvement

Status

Deliver

Added

08 July 2020

Last updated

23 September 2021

URL

https://test.clinicalexcellence.qld.gov.au/improvement-exchange/copd-rapid-response-help-line

Summary

Currently a successful model enabling Chronic Obstructive Pulmonary Disease (COPD) exacerbation clients to remain in their home, where deemed safe. The successful partnership between the client, the COPD Rapid Response line and the Hospital in the Home has enabled this vulnerable population to remain in their homes and receive in reach care and support there. It is projected that there will be a reduction in bed days for those who require admission, less presentations to ED and improved

client satisfaction.

Key dates

May 2020

Implementation sites

Implemented in the Cairns Hospital under the Respiratory Nurse Navigation portfolio

Partnerships

Local community health and the Hospital in the Home team

Key Contacts

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Aim

Proactively optimise identified COPD patients' care in their home, continue to maximise their health and wellbeing throughout the COVID-19 pandemic and concurrent winter flu season and manage those exacerbations within the community, where appropriate through the provision of a self referral portal thereby improving health care accessibility.

Benefits

- Remote triage as a means of preserving inpatient capacity & limiting exposure
- Protect COPD vulnerable community- minimise COPD client's risk of exposure to COVID-19
- Improved patient experience through provision of virtual support to assist in the reduction of anxiety and acute exacerbation of symptoms
- Reduction in risk of COPD exacerbation requiring acute inpatient management (patients who could be managed at home) and associated resource pressures
- Reduce unnecessary COPD emergency presentations (patients who could be managed at home)
- Shortened length of stay secondary to early intervention in the community and earlier discharge possibilities secondary to increased access to COPD specific HITH beds.

Background

The Department of Health recommended a process to identify patients from within Hospital and Health Service (HHS) and Primary Healthcare Network (PHN) with the primary diagnosis of Chronic Obstructive Pulmonary Disease (COPD), and who have had a/multiple hospital admission/s over the previous 12-month period for this diagnosis. Department of Health requested Hospital and Health Service's respond to support these vulnerable members of the community by developing strategies that optimize the care of COPD patients within the COVID-19 pandemic and winter flu season.

Solutions Implemented

Cairns and Hinterland Hospital and Health Service identified strategies to assist in maintaining patients' usual levels of health and wellbeing and reducing risk of hospital presentations secondary to an exacerbation of COPD throughout the COVID-19 pandemic and winter flu season. The Respiratory Nurse Navigator was recommended by CHHHS executive as the nominated COPD coordinator locally. CHHHS strategy includes:

- COPD Rapid Response strategy to be included within Respiratory Nurse Navigation (NN) portfolio as the CHHHS COPD Coordinator. This will provide centralization of the model, it's mechanics and potential reporting.
- Addition of new:

- COPD Rapid Response Help Line [self referral] for triaging and exacerbation management.
- Extend the service to 7 days
- COPD Rapid Response monitoring Model- Included within Cairns Hospital in the Home portfolio via referral from Triage Service for medical governance.
- Partnership with Hospital in the Home.
- Mareeba Hospital [rural facility]inclusion.

Evaluation and Results

Formal reporting to be conducted in August [12 weeks after May commencement]. Anecdotally the line is being used by clients and there has been success in managing them at home during their exacerbation, direct admission to the respiratory ward and a reduction in bed days facilitated by early discharge under Hospital in the Home.

Lessons Learnt

COPD clients will engage! There is reduced health care accessibility for those who are challenged by transport, fatigue, oxygen dependence with the expectation that all health care needs to be delivered from within the hospital or be centre based. Chronic disease clients are very able to self manage once the correct support mechanisms are put in place. There is a certain level of mistrust around health care and health care facilities. Representation rates and bed days can be reduced for those with chronic disease. Client preference [in the main] is to be managed at home wherever appropriate.

References

State-wide Respiratory Network Australian Lung Foundation Metro South Health [COVID-19 screening tool] COPDX guidelines

Further Reading

Lung Foundation Australia COPD Action Plan Lung Foundation Australia: Writing an Action Plan