Identify people living with COPD who would benefit from Palliative care in East Ayrshire

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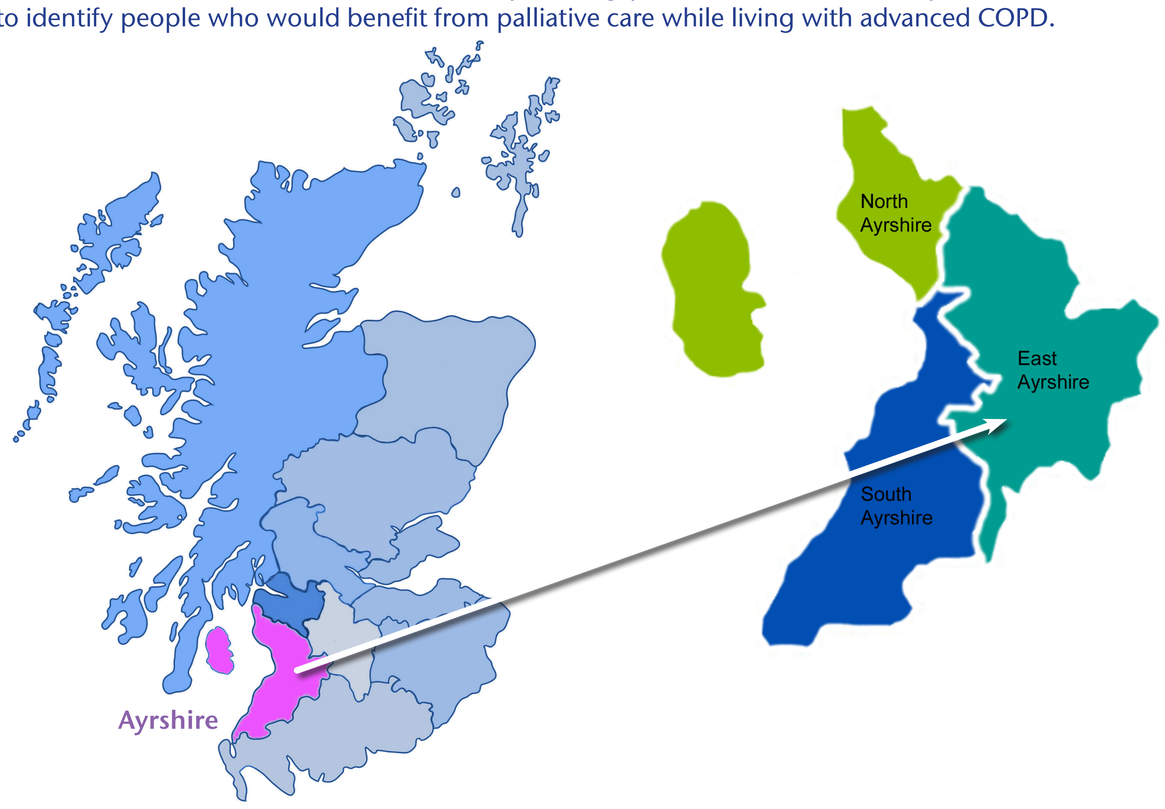
NHS Ayrshire & Arran has the highest proportion of people living with Chronic Obstructive Pulmonary Disease (COPD) in Scotland; the highest number of unscheduled care admissions relating to COPD, and the highest readmission rate at 28 days of 30%. Additionally, 40% of all medical admissions, planned and unplanned, are for respiratory conditions, with length of stay amongst the highest in Scotland. Aim - to work with one community nursing/practice team from January 2018 for 6 months, to identify people who would benefit from palliative care while living with advanced COPD.



The project team included the local district nurse and team leader, practice nurse/ ANP, community and hospital specialist respiratory nurses, practice manager, senior (HSCP) manager, Associate Improvement Advisor (AIA) East Ayrshire test site and the out of hours coordinator. The hospital charge nurse for the respiratory ward was included in all correspondence but was unable to attend.

It was decided that the best way to search for patients living with COPD in this practice was through an electronic search of the read codes. The practice uses EMIS (an electronic patient record system) and each registered patient is given an electronic code that best describes their illness. Alongside this Ayrshire & Arran have a Patient Information System that extracts data from other data systems and provide reports for the practice. It was decided that EMIS was the most useful search tool to apply refined searches on groups.

Practice nurse shown how to identify people with COPD who may also be in the last year of life /palliative using the SPCT (Supportive and Palliative Care Indicator Tool) https://www.spict.org.uk/ Palliative care identification tools comparator developed https://ihub.scot/improvement-programmes/living-well-in-communities/palliative-and-end-of-life-care/palliative-and-end-of-life-care-identification-tools-comparator/	• The Practice nurse reviewed patients able to attend the COPD clinic. She would request help/advice from respiratory nurse specialists/ Consultant /GP when appropriate. • During mapping session discussed -how would they know when someone with COPD needed palliative care? • Communication between project team revealed district nurses had additional knowledge and skills & already reviewed patients with COPD. • Engagement by phone/ email with nurse specialists when timely advice was needed. • Practice Nurse accepted the role of key co-ordinator & agreed to initiate Anticipatory Care Planning conversations. • Practice nurse join practice palliative care monthly meetings & propose patients with COPD for palliative care register.	• Searched EMIS using read codes for people with COPD (practice coding for diseases are different to hospital codes). • Needed Practice nurse knowledge to refine the list from EMIS search. • PDSA x 5 to refine search criteria. • Requested a treatment plan with discharged patients to prevent further admissions • Respiratory bundle/ future care conversations had while in hospital to be shared with community team sooner. • Frequent /regular communication needed between Practice nurse & community and respiratory nurses, • Useful good quality information needed on the practice's Key Information Summary (KIS) for out of hours' teams and staff in emergency departments.

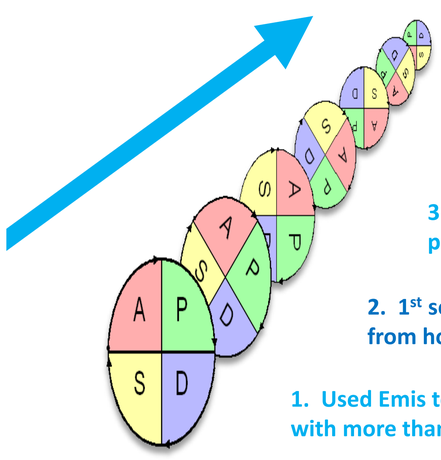
How are people with COPD identified as Palliative?

The Project team nurses use a range to decide this, here are their responses:

- COPD Assessment tool & Quality of Life tools
- Take a Medical history e.g. cardiovascular disease, progressive respiratory failure
- Results from Spirometry tests
- MRC (Medical Research Council) dyspnoea scale 3 or more
- Medications e.g. opioids for breathlessness / steroids
- Ability to function and undertake Activities of Daily Living
- Frequency of exacerbations and hospital admissions.

Often the patients with COPD in this practice are not identified early as being 'Palliative' until it is more obvious.

Practice Manager & Practice Nurse refined searches of people on already on the COPD register to identify people truly palliative. The SPICT was used to help confirm the person would benefit from palliative care:



5. 4th search criteria + people with type 2 respiratory failure
4. 3rd search criteria + people with corpulmonale & type 1 respiratory failure
3. 2nd search criteria + people with 12 or more prescriptions for Short acting beta antagonists
2. 1st search criteria + using oxygen / include smokers + discharges from hospital & emergency admissions in the last year
1. Used Emis to search COPD register (200 people) for those with more than 40 contacts with primary care team in a year

Impact

As a result of the monthly/ 2 monthly EMIS searches the Practice nurse identified new people that were discussed with the GPs for inclusion on the palliative care register. This enabled anticipatory care planning and cardiopulmonary resuscitation discussions with patients. The regular searches have triggered awareness with the practice team to assess people with COPD for palliative care. Therefore the numbers of people identified have steadily increased. The Practice nurse attends the monthly practice palliative meetings to propose new patients with COPD for discussion and liaises more frequently other professionals to share knowledge and support the care of people living with COPD.

Month	EMIS Search criteria & GP / Pr Nurse knowledge of COPD patients	Needing added to the practice palliative care register
Aug 2018	14 patients	1 (already known)
Sept 2018	15	3
Dec 2018	15	7
Jan	15	7
Feb	14	10

People who use the service and their carers:

The people identified by the search will be introduced to anticipatory care planning and the term palliative care through sensitive discussions initially with their practice nurse/ GP. Their condition and care will be monitored, evaluated and co-ordinated by the practice nurse, liaising closely with their GP, respiratory specialists and the community nursing team.

Staff delivering services: Practice nurse identified search criteria for EMIS ; Practice staff needs clear criteria and time to do the search; The practice nurse needs time to check the list of patients and identify anyone new added by the search.

Next Steps

Recommendation is to share the learning from this work with primary care leads and practice nurses working in Ayrshire & Arran and the Health and Social Care Partnerships to help improve the identification of people living with COPD who would benefit from palliative care.