Nationwide audit of COPD care reveals many aspects of provision have improved, but the number of units with specialist nurses managing COPD caseloads has declined

An audit of care provided to patients with COPD

In this article...
- Discussion of the role of respiratory nurse specialists
- Key results of a national audit of COPD care
- Recommendations for further developments

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The National COPD audit is a five-year programme established to drive service and healthcare quality improvement for patients with COPD in England and Wales. It recently published two reports on the resources and organisation of COPD care in acute units in England and Wales, and on patients admitted to acute units with COPD exacerbations. This article discusses key findings of the audit and makes recommendations to help achieve further improvements.

An unplanned hospital admission with an acute exacerbation of chronic obstructive pulmonary disease (COPD) can be a frightening time for patients, many of whom experience already high levels of anxiety and depression (Giacomini et al, 2012). It is therefore crucial that the care patients receive in hospital should be compassionate, supportive and evidenced-based to ensure that:
- Their psychological needs are met;
- Their condition is managed as effectively as possible;
- They understand how to manage their condition to minimise their risk of future exacerbations and to slow disease progression as much as possible.

However, a recent national audit of COPD, which examined clinical care of patients experiencing an acute exacerbation, suggested that, while overall care has improved, further improvement is needed in a number of areas, such as smoking cessation advice and improved discharge planning (Stone et al, 2014).

Respiratory nurses have a fundamental role in navigating the journey along the care pathway of patients with COPD admitted to hospital, from liaising with emergency departments over safe, early and supportive discharge for those who do not need inpatient care through to supporting ward nurses in planning for patients’ discharge, and providing clinical advice and support at all stages in between.

Background
The National COPD Audit Programme recently published two reports from a national audit of 142 acute hospital trusts and six health boards (total 199 units) in England and Wales. The reports focus on:
- A national organisational audit that examined the resources and organisation of care in acute NHS units in England and Wales in 2014 (Stone et al, 2014);
- The audit of patients with COPD exacerbations admitted to acute units in England and Wales in 2014 (Stone et al, 2015).

There have been three previous audits since 1997 focusing on the delivery of COPD in secondary care services and building knowledge on the long-term care of patients, which can be found on the RCP website (Bit.ly/RCPaudits). These built momentum to enable contributing organisations to compare performance against national standards, assist in improvements in quality of care and identify change.

Audits make a significant contribution to guiding the role of respiratory nurses as they provide benchmarking to allow...
nurses to monitor the quality of their respiratory services. The organisational audit gives nurses a good indication of how their services compare with others.

The audit
The National COPD Audit Programme for England and Wales is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit Programme. It is led by the Royal College of Physicians, working in partnership with a number of key organisations including the British Thoracic Society, British Lung Foundation, Royal College of General Practitioners and the Primary Care Respiratory Society UK.

The leading partners in this national COPD secondary care audit were the Royal College of Physicians and British Thoracic Society, and there is nursing representation on the steering group of the National COPD Audit Programme (Bit.ly/RCPWhoCares).

Commissioned in 2013, the National COPD audit is a five-year programme to deliver a cohesive work programme and seek to drive service and healthcare quality improvement for patients with COPD in England and Wales (Box 1).

Discussions of findings
There has been a 22% rise in median emergency medical admissions since 2008, with COPD admissions rising by 13%. It is encouraging that there have been improvements in the organisation of admissions and resources, non-invasive ventilation (NIV) and the availability of early or supported discharge since 2008 (Stone, 2015). The report suggests that NIV services have improved notably; in 2008 74% of respiratory wards were providing this level of care, while the audit suggests this had increased to 81% of respiratory wards by 2014. Consequently, there has been a reduction in general wards using NIV, from 12% in 2008 to 7% in 2014. The organisation of NIV is an important quality measure as it forms part of the NICE quality standards (NICE, 2011). From my experience respiratory nurses and ward sisters/charge nurses have been instrumental in driving this improvement.

The audit revealed many other improvements, outlined in the report, but I wish to highlight the reduction in the number of patients with COPD being inapprorriately treated with high-flow oxygen at the time of admission. In their randomised controlled trial of high-flow oxygen with titrated oxygen treatment for patients with an acute exacerbation of COPD in the prehospital setting, Austin et al (2010) concluded that “titrated oxygen treatment significantly reduced mortality, hypercapnia, and respiratory acidosis compared with high-flow oxygen in acute exacerbations of COPD”.

There has been much work driven by the British Thoracic Society and oxygen guidelines to promote these messages, which I believe that respiratory nurses and the respiratory community have championed.

Both reports highlight recommendations for further improvement (Stone et al, 2015; 2014), and the wide variation in service provision for patients with COPD across England and Wales. They also call for improvements in clinical data, pointing out that many patients with COPD are still not under the care of a respiratory consultant and have not been seen by a member of the respiratory team; those in the care of a specialist respiratory team received better evidenced-based care.

The audit revealed that despite an increase in COPD admissions, the number of respiratory units with respiratory specialist nurses supporting a COPD case-load has decreased since 2008, from 80% to 71%. I believe this may be due to a number of factors such as de-investment in respiratory services, change in job roles to more “generalist” long-term condition nurses, and the effects of rebranding, job evaluations and respiratory roles being made more “generic” and suitable for nurses or physiotherapists. This is an area that the Association of Respiratory Nurse Specialists should explore further with its members.

Recommendations
Both audit reports make a number of recommendations that I urge all respiratory nurses to read and disseminate to key individuals at different levels within their organisations. Box 2 lists five key areas I believe respiratory nurses can influence or champion for further investment within their own organisations. NT

References

For more on this topic go online...
- Reducing admissions with patient group directions
- Bit.ly/NTCOPDAdmissions

BOX 1. COPD AUDIT WORK STREAMS
- Primary care: collection of audit data from general practice patient records
- Secondary care: audits of admissions to hospital with COPD exacerbation and outcomes at 30 and 90 days; organisational audits of the resourcing and organisation of COPD services in acute units admitting patients with COPD exacerbation
- Pulmonary rehabilitation: audits of service delivery, quality, organisation and resourcing of pulmonary rehabilitation services
- Patient-reported experience measures: one-year development work exploring the potential for/feasibility of PREMs to be incorporated into the programme in future

Source: Royal College Physicians, 2013

BOX 2. RECOMMENDATIONS
Respiratory nurses can champion the following:
- Improved availability of early/Supported discharges services for COPD within your organisation, and if not already available, seven-day services
- Formalised pathways to improve referral to early/Supported discharge teams and community pulmonary rehabilitation services if not integrated
- Improved access to specialist care ensuring that patients admitted with a COPD exacerbation see a respiratory specialist within 24 hours, seven days a week
- Improved recording and documentation of quality-assured spirometry
- Improve the co-ordination of care at discharge

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