Livewell Southwest

Community Respiratory Services Operational Policy

Version No. 2

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

Author: **Respiratory Services Manager**

Asset Number: **838**

Reader Information

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	v1:2 Community Respiratory Services Operational Policy. V.1.1
Author contact details	By post: Local Care Centre Mount Gould Hospital, 200 Mount Gould Road, Plymouth, Devon. PL4 7PY. Tel: 0845 155 8085, Fax: 01752 272522 (LCC Reception).

Document review history

Version no.	Type of change	Date	Originator of change	Description of change
0.1	New Policy	05.08.2013	Respiratory Services Manager	New policy to replace policies 54, 396, 432, 638 and 700
1	Ratified	September 2013	Policy Ratification Group	Minor amends.
1.1	Minor Changes	January 2015	Respiratory Services Manager	Minor changes to 11.6, 11.7, 11.8 11.9 for clarification.
2	Minor changes	July 2015	Respiratory Services Manager	Minor changes and changing e-PEX to SystmOne throughout.

Community Respiratory Services Operational Policy.

1. Introduction.

1.1 Respiratory medicine encompasses a diverse range of conditions affecting patients of all ages, often characterised by periods of well-being interspersed with exacerbations, usually becoming more disabling with time. They are one of the main causes of Hospital admissions. Locally, COPD alone accounts for over 11% of hospital admissions.

1.2 The Community Respiratory Service is an evolving service whose primary aim is to reduce morbidity of adult respiratory patients and to prevent repeated admissions to hospital. They do this by ensuring correct diagnosis, and ensuring that patients receive the appropriate therapy for their condition. They educate patients, and carers, on how to keep themselves as well as possible, to recognise impending exacerbations, and give them the confidence to manage their condition themselves, with an agreed action plan. They also support patients, and their families, at the terminal stage of their condition.

1.3 The Community Respiratory Team support the work of GP's and Practice nurses. They work in conjunction with PHT (Plymouth Hospital Trust) staff, including Consultants and Specialist Nurses, including providing an Oxygen Assessment Service at the Chest Clinic, Derriford Hospital. The Service also provides a Pulmonary Rehabilitation Service. In addition, they work with the British Lung Foundation in educating professionals and the public about respiratory conditions.

2. Purpose.

2.1 The purposes of these guidelines and protocols are to:

- Provide a standardised protocol for the team of Respiratory Specialist Nurses and Physiotherapist in caring for patients with chronic lung disease within Primary Care.
- Ensure the best possible treatment and management of patients with respiratory conditions, to manage their symptoms effectively, provide optimal treatment, prevent hospital admissions, and maximise the ability of patients to manage their own condition effectively.
- Define the process whereby members of the Community Respiratory Service advise patients, their carers', and other professionals, in respect of the correct technique and administration of their inhaler, nebuliser or oxygen therapy.
- Define the process whereby members of the Community Respiratory Team provide Pulmonary Rehabilitation for patients with respiratory conditions.

2.2 These protocols are not static and will be developed as required in line with up to date guidelines issued by the British Thoracic Society and NICE, and the commissioning of new services.

3. Definitions.

3.1 Respiratory conditions covered include Chronic Obstructive Pulmonary Disease (COPD), Asthma, and Interstitial Lung Disease.

4. Duties and Responsibilities.

4.1 The **Chief Executive** has overall responsibility for the safe care and treatment of patients and the implementation of this policy.

4.2 The **Director of Governance** is ultimately responsible for the content of all professional policies and their implementation.

4.3 **Directors/Locality Managers** are responsible for ensuring that all staff follow the standards set out in this policy and for ensuring that sufficient resources are provided to support the requirements of this policy.

4.4 **Unit / Ward Managers / Service Managers/Matrons** are responsible for ensuring that the policy and its supporting standards and guidelines are built into local processes to ensure compliance. Managers are also responsible for identifying the training needs of their staff groups and seeking appropriate training opportunities. Managers are also responsible for ensuring that the electronic staff record (ESR) is updated following assessment by forwarding any training information to the ESR Manager.

4.5 **All staff** involved in clinical practice must adhere to the guidelines and codes of their professional bodies and are responsible for assuring they are aware of the requirements of this policy and implement it accordingly.

4.6 Staff must reflect on their own personal professional accountability for achieving and maintaining competence in clinical practice.

5. Team Experience and Education

5.1 All trained nurse within the Community Respiratory Team will be first level nurses holding or working towards a Degree in Nursing. They will also hold, or be working towards, relevant respiratory qualifications in COPD, Asthma and Spirometry, and ENB 998 in teaching and assessing, or other appropriate teaching qualification.

5.2 Physiotherapists within the team will have a Degree or Graduate Diploma in physiotherapy and be State Registered (Health Professions Council) and have 4 years post graduate experience including 2 years at a senior level in respiratory care. It is also desirable that they complete qualifications in COPD and Asthma.

5.3 Trained staff providing Pulmonary Rehabilitation must have an appropriate qualification, or be willing to undergo specific training.

5.4 It is desirable for any nursing assistant (HCA) on the team to have obtained

an NVQ Level 3 (care) and received appropriate in-house training.

5.5 All team members are expected to attend Mandatory Training, and maintain and develop their skills and knowledge, as per their professional registration requirements, and as per LSW policy, by attending the following:

- Required Mandatory training.
- Recognised professional courses and study days, including on-line study.
- Update sessions, including some evening sessions.
- Maintain competencies as per competency policy.
- Attend and participate in Clinical Supervision sessions.
- Participate in quarterly line management, and yearly appraisals, with their manager.

5.6 All new staff will be expected to undergo a 4 week induction programme, to acquaint them with their new role, and to check their required competencies.

5.7 Nurses supporting the oxygen clinic at Derriford Hospital, will be required to undergo further training (and sign an honorary contract with PHT) as stated below under 'Nurse Led Oxygen Clinic'.

5.8 All team members are expected to maintain a portfolio of their experiences, qualifications and study.

6. Referrals

6.1 Referrals to the Community Respiratory Service should be made using the modified Universal Referral Form, Pulmonary Rehabilitation Referral Form or Derriford Hospital 'In-reach' Form. In very urgent cases, referrals can be taken over the phone, but must be followed up with one of the above forms (see Appendix A). Pulmonary Rehabilitation referrals may be accepted from other areas within the Western Locality if space is available.

6.2 Referral criteria (see Appendix B).

6.3 Except for Pulmonary Rehabilitation, which has a separate pathway below, new referrals are to be triaged by the nurse on duty, and passed to the team secretary, who will complete entry into SystmOne, and enter the patient onto the patient information board. Any recent hospital discharge, or hospital consultant, letters are to be included. SystmOne is to be checked for warnings, and to see if any other health professional has recently, or currently, seeing the patient, and obtain a copy of any recently completed assessments, if not already on SystmOne.

6.4 The duty nurse will arrange for urgent cases to be seen that day or next, if appropriate, or otherwise pass onto the appropriate nurse/physiotherapist to be seen within 2-4 weeks (see lone working below). Discharges from other services will be contacted within 72 hours, as per LSW policy, for pressure area assessment.

6.5 The referrer, and the patient, will be informed that a referral has been received, by the team secretary or duty nurse, and that the nurse/physiotherapist will make an appointment to see them directly. This is recorded in the individual patient's records.

6.6 The individual nurse/physiotherapist is responsible for contacting non urgent patients within their locality, to arrange a mutually agreed time to be seen.

6.7 If the individual nurse/physiotherapist cannot see the patient within 4 weeks, the team lead, or in their absence, the duty nurse, will arrange for another member of the team to see the patient.

7. Assessments

7.1 Apart from Pulmonary Rehabilitation referrals, each patient will receive a full assessment using the Universal Assessment Form, and the Respiratory Assessment Form (see Appendix C). Further assessments may be carried out depending upon initial findings.

7.2 Ideally, the assessment should be completed on the first visit, but it is recognised that a second visit may be required.

7.3 At the end of the assessment an action/care plan will be agreed between the nurse/physiotherapist and the patient.

7.4 The patient's GP, and referrer if different, will receive a report on the assessment within 7 days of the assessment taking place.

7.5 Further assessments and/or follow up visits will be arranged between the nurse/physiotherapist and the patient as required, at a mutually agreed time.

8. Care Plans

8.1 A care/treatment plan will be agreed with the patient following the assessment process above.

8.2 Care plans will be reviewed at every visit, and amended as necessary, with the patient's agreement.

8.3 If not already issued, patients will be given a self-management plan (see Appendix D) which should be reviewed as required, but at least once per year, by the Community respiratory Team, if still actively involved with the patient, or the patients' Practice Nurse or GP.

9. Referrals to other services.

9.1 Referrals to other services will be made only with the patient's consent, on any service specific referral form, and accompanied by the Universal Assessment form if appropriate.

9.2 The patient's GP will be informed of referrals to other services at the time of referral.

10. Discharge.

10.1 Patients will be discharged from the service as per the discharge criteria (see Appendix E).

10.2 The patient's GP and, if different, the referrer, will be informed of discharge from the service within 7 days.

11. Supported hospital discharges.

11.1 Patients who are still acutely ill, but are deemed safe to be discharged with support from the Community Respiratory Team, will be seen at home the same day, if discharged before 2.00pm, or the next day if discharged after 2.00pm.

11.2 Following assessment, the nurse/physiotherapist attending the patient will use their clinical expertise to decide, in consultation with the patient and their carer, how often the patient then needs to be seen. The maximum that a patient can be seen is twice a day.

11.3 The need to visit will be reviewed at each visit by the attending nurse/physiotherapist.

11.4 Should the patient's condition deteriorate, the nurse/physiotherapist will discuss with the patient's GP, or the Acute GP Service at Derriford Hospital, or with Devon Doctors on call at weekends and Bank Holidays, who can arrange re-admission if necessary. If the nurse/physiotherapist considers the patient's condition to be life threatening, they should dial 999.

11.5 If daily visits are no-longer required, the patient will be followed up, as required, or discharged as per discharge criteria above.

11.6 All new referrals must be received in the office by 14:00hrs on a Friday if needed to be seen at the weekend. If received after 14.00hrs there will be no follow up until Monday, due to the need to make safety checks for lone working, currently there is no guarantee of access to SystmOne or patients' records at their GP surgery.

11.7 There will be no respiratory physiotherapy cover over the weekend.

11.8 All supported discharge patients, that require social support, must have had their social support arranged prior to being accepted onto the scheme, and details included on the referral form.

11.9 All patients requiring oxygen and nebulisers on discharge must have had this arranged prior to being accepted onto the scheme. Confirmation of this should

be included on the referral form, including a copy of the HOOF form (oxygen prescription form).

12. Pulmonary Rehabilitation Programme. (See flow chart, Appendix F).

12.1 All referrals for Pulmonary Rehabilitation must be made using the Pulmonary Rehabilitation referral form (Appendix G). Failure to do so will result in the referral being returned with a request to complete the correct form.

12.2 On receipt of the referral form, the referral is triaged by one of the Pulmonary Rehabilitation team. Referrals will be accepted, referred to the physiotherapists for a home exercise programme, or declined as inappropriate. The referrer will be informed in each case.

12.3 The first week of every month, letters will be sent to patients referred for Pulmonary Rehabilitation, asking them if they are still interested in taking part, and offering them several venues, and dates, for Pulmonary Rehabilitation. Patients are asked to respond within one month to register their interest.

12.4 If the patient fails to respond after one month, a telephone call is made to the patient to check that they have received the letter inviting them to participate, and if so, do they wish to participate in Pulmonary rehabilitation. Referrers of those patients who decline to participate are informed.

12.5 One month prior to the start of their chosen Pulmonary Rehabilitation course, the patient is contacted inviting them to an assessment day. If they cannot attend they are offered an alternative course. Usually after three refusals, patients are removed from the waiting list, and their referrer, and/or GP, informed, unless there are exceptional circumstances.

12.6 Each patient is assessed prior to starting their Pulmonary Rehabilitation course as to their suitability and ability to take part. Those suitable are enrolled on the programme. Those deemed inappropriate, will be offered a home exercise programme, or referral to a maintenance class, if appropriate. The reason why they are not suitable is explained to the patient, and the patient's referrer, and/or GP informed.

12.7 On successful completion of the Pulmonary Rehabilitation course, the patient's referrer and/or GP are informed. All patients are encouraged to maintain an exercise program independently and are offered referral on to continued exercise with an appropriate gymnasium.

12.8 Those that fail to complete the course are offered the opportunity to complete another course if appropriate, and their referrer, and/or GP informed of the outcome.

13. Pulmonary Rehabilitation Course Planning.

13.1 Community venues are booked for assessment day, and program duration,

one year in advance, and the service invoiced accordingly (budget code available from the team manager). Venues need to be fit for purpose in terms of accessibility, space for assessment and exercise, storage and Health and Safety.

13.2 A risk assessment on the venue is completed in accordance with Health and Safety policy.

13.3 Equipment, including steps, weights, trampet, and cones, are kept in the outside store room, Cumberland Centre, when not being used at a venue, and transported to each venue at the start of the programme by the porters. Ideally the equipment is then stored at the venue for the duration of the programme.

13.4 Educational sessions are planned to suit each client group, any outside speakers are booked.

14. Pulmonary Rehabilitation Assessment.

14.1 Each patient will attend a comprehensive assessment, by a specialist(s) in chronic respiratory care, where they participate in a review of their general health, respiratory condition and its medical management. This may result in recommendations to the referrer to either optimise treatment, or conduct further investigations, or refer to a more appropriate service prior to proceeding onto the programme.

14.2 The room is set up for:

- Welcome area (chairs, table, hand gel, paperwork including notes, hand outs and questionnaires.
- Medical Assessment (chairs, table, BP, spo2 monitor, spirometry, weighing scales).
- Walk test – CD player, CD, cones measured distance apart, chairs, spo2 monitor, and Emergency equipment.

14.3 Patients are assessed using pulmonary rehabilitation assessment pro forma (see appendix H).

14.4 The individual needs of the patient are identified at the assessment, and a pulmonary rehabilitation programme is tailored accordingly.

14.5 Any patients with medical issues identified at the assessment that need addressing prior to starting the programme will be referred to primary care or secondary care as necessary.

14.6 Any other issues identified at the assessment that need addressing shall be referred onto the appropriate services.

14.7 Any risks identified at assessment are managed accordingly.

14.8 Goals are agreed with the patient and education needs are identified for all patients.

14.9 Patients are issued with an information pack including contact details, questionnaires, programme content and educational materials.

14.10 Staffing/skill levels are to match the case mix of the patients taking part, the venue being used, and the rehabilitation programme, ensuring safety to exercise. In general, the ratio of staff to patients to supervise exercise classes is 1 to 8, and 1 to 16 for education sessions. There should be a minimum of two supervisors in attendance, one of whom must be a qualified respiratory specialist health care professional to supervise the exercise component. A greater staff to patient ratio is required if oxygen users are included.

15. Daily Preparation for Pulmonary Rehabilitation.

15.1 The venue is prepared in advance of patient's arrival to accommodate a welcome table – clipboards, attendance sheet, Spo2 monitors, and fitness to exercise disclaimer.

15.2 The exercise area is prepared with equipment and chairs set out safely, and instructions clearly displayed.

15.3 Patients are welcomed as they arrive and any changes since they were last seen are discussed, particularly changes to medication, exacerbation of symptoms or new medical/musculoskeletal problems.

15.4 Prior to starting exercise, patients are shown how to record their spo2 and heart rate independently and advised on exercising safely including the use of salbutamol pre-exercise and the need to take water during exercise. Housekeeping arrangements (fire drill, toilets, access to water) are also explained.

15.5 Every exercise session begins with a demonstrated warm up, during which patients are observed/monitored.

15.6 The exercise component comprises of both aerobic and strengthening exercises. Aiming for 20-30 minutes of continuous exercise, this is increased in intensity once achieved. Patients are encouraged to carry out unsupervised exercise sessions at home twice a week for 20-30minutes.This may be comprised of two or more bouts of shorter time periods until the patient is able to achieve the desired 20-30 minutes continuous aerobic exercise.

15.7 For the initial session all exercises are demonstrated and gauging intensity using the Borg scale is explained.

15.8 All patients are observed whilst exercising, modifying as appropriate.

15.9 Patients who de-saturate during exercise and require ambulatory oxygen (the prescription of which has been determined by an ambulatory oxygen

assessment) attend Pulmonary Rehabilitation with their own ambulatory supply. If an increase, either temporary or permanent, in the prescription is required for the PR programme, the team will liaise with the local oxygen service to arrange.

15.10 At the end of each exercise session a cool down is carried out.

15.11 Resuscitation equipment, including oxygen and defibrillator, must be at hand at all times, and staff supervising pulmonary rehabilitation, up to date with resuscitation training. In the case of emergency, suitable interventions are administered that are appropriate to the location.

15.12 After each exercise component, a short rest period is followed by an educational session that covers a range of issues, including but not limited to:

- Normal Respiratory Physiology and mechanics.
- Understanding COPD/chronic respiratory diseases their pathophysiology, causes and treatment.
- Self- management.
- The roles of exercise and relaxation.
- Medicines management and exacerbations.
- Psychological impacts and minimising their effects.
- How to manage breathlessness - smoking and smoking cessation services if appropriate.
- The benefits of regular physical activity and exercise, and how to undertake physical activity and exercise safely and effectively.
- Nutritional advice and eating strategies, including nutritional supplements where appropriate.
- Sputum clearance.

15.13 Written information is made available with consideration for literacy or language and vision issues.

15.14 At end of the session all equipment is cleaned, and recorded, in accordance with infection control policy, and put away safely.

15.15 At each session notes and SystmOne are completed.

15.16 Those patents that fail to attend are contacted to ascertain reason, and determine if they are suitable to continue with programme, defer to another programme, or if they should be discharged from the programme.

16. Completion of Pulmonary Rehabilitation Programme.

16.1 Patients are asked to complete feedback forms and objective markers (questionnaires) as well as completing a walk. These are used to illustrate to the patients how much they have improved, and to set them new objectives. They are also used for audit purposes (see ‘Audits’ below).

16.2 Patients are referred on to next phase as appropriate, and issued information on other agencies, and further exercise options, locally.

16.3 The team will audit and review each course on completion, and at the end of each year, using the above objective markers, attendance rates, any incidents or problems encountered, to improve the service provided, and to ensure achieving commissioned service.

17. Lone Working.

17.1 All members of the Community Respiratory Team are expected to follow the LSW Policy on lone working. It is the employee's duty to co-operate and to ensure the following guidelines are put into practice and followed to ensure safe working practice. If at any time any member of the team have any concerns or issues this should be discussed with the Team Lead at the earliest possible time.

17.2 Information regarding individual members of contact details, home address, next of kin and vehicles details are to be kept on file, in the team office, in case concerns arise regarding a member of staff.

17.3 All team members will be responsible for completing a visit log within the office diary giving details of patients they are visiting, area which are to be recorded roughly in the order they are visited and stating AM or PM. If additional visits are acquired during the day or progress is hindered for one reason or another the staff member must ring in to the office, or if the office is not manned, to a colleague, to inform them of this.

17.4 For those staff leaving from home to commence their duties they must ring in to the office, or the designated person, to report for duty.

17.5 At the end of each day, if unable to return to the office, team members will be responsible for contacting the office, or the designated person, that they have safely completed their duties with no problems.

17.6 Communication is essential for lone workers and it is vital that staff keep in contact with colleagues regarding movements during the course of the day.

17.7 A code word should be agreed with the team so if contact is made the nature of threat will initiate their colleague or team lead to provide an appropriate response such as contacting the police.

17.8 All staff should carry their Lone Working Device (ensuring it is fully charged) and use as trained i.e. Identifying location before entering a patient’s home and pushing the emergency contact button if feel threatened in any way.

17.9 Week-end and bank holiday working practice. During the weekend and bank holiday periods, when members of the team are the only member of staff on duty, a ‘buddy’ system will put in place for them to be the ‘designated person’ to make contact with at the start, middle and end of each shift.

17.10 During visits team members should carry at all times their ID badge with their Lone Working Device.

17.11 Staff should ensure they carry their mobile phone (and ensure that they are fully charged).

17.12 Prior to visiting any patient a risk assessment should be made by the individual member of staff, taking into consideration:

- The information they have been given regarding the patient and if there is a risk to the lone worker.
- The area they are visiting.
- Is the area well lit and within a built up area.
- Is the area or property isolated.
- Park close to the location visiting and avoid taking short cuts to save time and don't leave any property on show. It is advised not to park in the patients driveway unless you know the patient you are visiting.
- When visiting a patient a "10 second" risk assessment should be carried out when first arriving at the property and the front door is opened. If staff do not feel comfortable and feel they may be at risk, they should have an excuse ready not to enter the property and arrange for an alternative appointment.
- If any animals are present staff may ask politely for them to be removed prior to entry. If this is not possible then an alternative appointment should be made when this can be done.
- When entering the property try not to walk in front of the patient but ask them to lead the way to where you conducting their care and make yourself familiar with the door lock.
- Always ensure that when seated you are not positioned lower than the patient. If sitting at a table sit on the outside rather than in the corner where it might be difficult to make an exit.
- When conducting an assessment of the patient be aware of both your own and your patients/carers body language and leave immediately if a confrontation situation should arise.
- Always keep equipment and possessions close to hand in case a quick exit is required.
- On leaving the property have car keys ready to hand to avoid having to look for them which may compromise personal safety.
- Might be important to consider locking vehicle doors, if in a vulnerable area or in inner city areas, when driving away.
- In case of vehicle breakdown the member of staff should contact the designated person and the Team lead or senior team member on duty.

17.13 If team members have any doubts about visiting a patient in their own home, or feel uncomfortable while visiting a patient, they must not put themselves at risk, but arrange to visit with another colleague, or arrange to meet the patient at their GP surgery or other suitable venue.

17.14 All staff should receive appropriate formal training, or in house training, which relates to them working alone such as the following:

- Conflict resolution training.
- Training on health and safety issues encompassing employee responsibilities.
- Manual handling.
- Breakaway.
- Cultural awareness, diversity and racial equality training.
- Conducting a risk assessment.
- Training in use of the Lone Worker Device.

17.15 Where there is a genuine concern, that as a result of a member of staff failing to attend a visit or phone in at the agreed time, the team lead or, in their absence, the 'duty nurse', or designated person, should be immediately informed.

17.16 The member of staff should be contacted on their mobile phone, and other members of the team contacted, to ascertain if any contact has been made through the day.

17.17 If no contact, the information in the visiting log should be used to help trace the individual staff member's tracks by making calls to patients to enquire if the staff member visited and at what time they left.

17.18 The Reliance Contacting Service Desk (**0800 8407121)** should be contacted to identify the member of staff's last reported location.

17.19 The Locality/Deputy Locality Manager, or in their absence the Manager on-call should be contacted via Mount Gould Hospital Switchboard (**272420)**.

17.20 A record of people contacted and time should be documented.

17.21 As a last resort contact staff members next of kin in case they have been taken sick or were called home for some emergency.

17.22 If still no contact, the police should be informed.

17.23 An Incident form should be completed.

17.24 The Respiratory Team should review the incident at the next Team meeting to see what can be learnt from the incident, and amend practice accordingly.

18. Medication.

18.1 While the team does not prescribe medication (apart from oxygen) directly at present, GP's and other prescribers rely on the recommendations of the Community Respiratory Team to prescribe for their patients. Team members should ensure that the latest NICE guidelines are followed at all times. Suggestions outside these guidelines must be supported with sound clinical

arguments, and discussed with the patients' GP or Respiratory Consultant. It should be made clear that it is the GP's responsibility to ensure that prescriptions are correct, are not contradicted by other medication, and that the purpose of the medication explained, including any possible side effects. Verbal instructions from GP's should be repeated back to them, and the name of the doctor, and his instructions clearly recorded.

18.2 Oxygen is prescribed using a HOOF form (see Appendix I). Only temporary short-burst oxygen, or palliative oxygen, should be prescribed before a patient has been formally assessed, either as an inpatient, or at the oxygen clinic (see below).

18.3 Oxygen may be removed when it is no-longer required due to improvements in oxygen levels, when the oxygen is not used by the patient, or on the death of a patient. It may also be removed when there is a significant risk of injury to the patient/carers i.e. when a patient continues to smoke and uses oxygen simultaneously. This situation must be discussed and agreed by the patients GP.

18.4 When oxygen is prescribed, the prescription altered, or the oxygen is to be removed, a HOOF forms will need completed. Copies are to be kept in their notes. In those patients requiring oxygen for the first time a consent form (HOCF) signed by them, or their carer if appropriate, must be completed and filed in their notes, in order to share information with the PHT, GP and the supplier (see Appendix J). A patient information leaflet must be provided to those newly on LTOT (Appendix K). Copies of the HOOF must be faxed to the oxygen supplier and GP.

18.5 Medication should be checked to ensure it is in date, being taken correctly, stored correctly, and for patient concordance. The cleanliness and, where appropriate, the safety of delivery systems should also be checked (inhalers and nebulisers) at every opportunity.

19. Nebulisers.

19.1 Regular nebulised bronchodilator therapy in the home is commonly prescribed for patients with respiratory disease. If this therapy is administered inappropriately it exposes patients to potential side effects and has considerable financial cost to the health service. It is recommended that before such treatment is prescribed every patient should be assessed fully by a respiratory clinician who has had training in the supervision of nebuliser treatment. Nebulisers are useful when large doses of inhaled drugs are needed, when patients are too ill or otherwise unable to use hand held inhalers and when drugs are not available in hand held inhalers. In patients experiencing an exacerbation of COPD, if the exacerbation is relatively mild treatment with a hand held inhaler should be given using 200-400mg salbutamol. In more acute cases nebulised bronchodilators using 2.5-5mg salbutamol should be given [British Thoracic Society, Nebuliser Treatment Best Practice Guideline, 1997]. There is no significant difference in outcomes between patients treated with regular 2.5mg of salbutamol instead of 5mg

[NICE COPD Guidelines 2010].

19.2 Currently nebulisers are obtained from the Chest Clinic, Derriford Hospital. A supply of nebulisers is obtained and kept at the Cumberland Centre. They are returned to the Chest Clinic for repair or yearly servicing. A record is kept of all nebulisers received and returned in the 'nebuliser folder'.

19.3 Nebulisers are only issued to patients already being treated with nebulised medication, for palliative care, or after a nebuliser trial. In special circumstances, nebulisers can be delivered on behalf of the Chest Clinic (housebound patients who have no other means of obtaining a nebuliser).

19.4 Disposable equipment for the nebuliser is supplied by the team for patients currently under their care only.

19.5 Nebulisers are to be transported in individual carrier bags to prevent contamination.

19.6 Returned nebulisers are to be cleaned with a 'Sanicloth', and clearly labelled with a 'Decontamination Certificate', the patient's details and the equipment number, before returning to the Chest Clinic.

20. **Nebuliser Trial** (see pathway Appendix L).

20.1 Patients should be identified from the following indications BEFORE being referred for an assessment:

1. Experiencing persistent symptoms despite adequate bronchodilator therapy.
2. Frequent exacerbations.
3. Inability to use inhalers.
4. Require therapies that can only be given by nebulisation.

20.2 The respiratory nurse should carry out the following assessment BEFORE starting the patient on a nebuliser trial:

1. Confirm diagnosis - if diagnosis is in doubt refer to the appropriate community respiratory team or secondary care.

2. Confirm optimal therapy of bronchodilators via Metered Dose Inhaler [MDI] and spacer and check patients understand the correct use and technique.

3. Carry out treatment review.

4. Confirm that the patient, or carer, has a good level of understanding and dexterity required to take part in a nebuliser trial.

20.3 All patients discharged from hospital with a nebuliser, should be reviewed within one month post discharge by a nurse from the Respiratory Team.

20.4 All urgent requests should be triaged by the duty nurse at the time they are presented. For patients presenting with an exacerbation, it should be sufficient to increase their current reliever medication via a hand held inhaler and spacer device.

(If a patient is already on maximal bronchodilator therapy with stable oxygen saturation, who have demonstrated an improvement in symptoms post nebulised bronchodilator therapy, it may be appropriate to issue the patient with a nebuliser).

20.5 Once it has been ascertained that a patient is suitable for a nebuliser trial, the respiratory nurse should arrange for a 4 week trial.

20.6 At the end of the trial, the results should be discussed with the patient, and the patient's GP. Nebulisers should be removed if there is no clinical reason for the patient to continue with nebulised medication.

21. Annual Leave.

21.1 All staff are required to follow LSW policy on taking leave.

21.2 All requests for annual leave should be made using the annual leave request form and submitted to the team lead/manager.

21.3 No annual leave is granted until request form signed by manager.

21.4 All requests to be entered into off-duty request book by manager.

21.5 No more than 2 staff working 30+ hours, or 1 working 30+ hours and 2 working less than 30 hours, to be on leave at any one time.

21.6 Annual leave requests at the most popular times (i.e. school holidays) are to be discussed at team meeting, so that they are fairly distributed.

21.7 Everyone is expected to take their turn at covering Bank holidays, including the Christmas period. Generally speaking, if a member of staff has had last Christmas off they can expect to work this Christmas.

21.8 Off duty is generally planned 3 months in advance. If off duty already done, request for annual leave in this period should be discussed with the manager.

21.9 It is against LSW policy to carry leave over from one year to the next.

21.10 Staff will be expected to evenly space their leave, with no more than 2 weeks leave to be taken between January and April, our busiest time, without the prior agreement of the manager.

22. Nurse Led LTOT (Oxygen) Clinic (also see combined LSW/PHT LTOT Clinic Policy).

22.1 Introduction. The Community Respiratory Team offers a Long Term Oxygen Therapy (LTOT) service, in conjunction with PHT. This service provides quality, evidence-based, cost effective care, led by specialist nurses to meet the 2006 DOH oxygen recommendations. Although the nurses will function as autonomous practitioners, they are supported by a Respiratory Nurse Consultant and a Respiratory Medical Consultant.

22.2 The Community respiratory team will provide a suitably trained Respiratory Nurse for 3 Fridays a month to support the LTOT clinic. This requires the following training:

- Completed the PCTs ABG (Arterial Blood Gas) sampling programme, which includes at least 10 passes in supervised arterial punctures
- Have a sound knowledge of the BTS Guidelines for domiciliary oxygen (Jan, 2006),
- The NICE COPD Guidelines (updated 2010) and
- The oxygen administration protocol agreed by the Department of Respiratory Medicine, Derriford (Appendix iii)
- Be able to conduct a risk assessment prior to any ABG/oxygen administration.

22.3 The Respiratory Nurse will:

- Assess newly referred patients for oxygen requirements.
- Review follow up patients for oxygen requirements after an initial assessment.
- Recommend optimisation of treatment for COPD patients as appropriate, in accordance to NICE Guidelines (which may avoid the need for supplementary oxygen).
- Perform oxygen analysis as indicated, including ABGs to determine oxygen requirements.
- Remove domiciliary oxygen when not indicated for patient use.
- Ensure supplementary oxygen is ordered by completing HOCFs and HOOFs.
- Provide education for patients requiring oxygen therapy.
- Visit Plymouth city patients at home to review their oxygen needs and provide on-going education, support and assessment as appropriate.
- Arrange on going oxygen reviews in clinic as appropriate.
- Provide clear documentation of assessment and outcome, ensuring clear communication between primary and secondary care.

22.4 Prior to embarking on an LTOT assessment, a confident clinical diagnosis must be made supported by a Respiratory Consultant/Specialist Medical Registrar/GP with Special Interest in Respiratory Medicine, the patient must be on optimum medical management for at least 1 month, and exacerbation free for at least 5 weeks.

22.5 Conditions suitable for LTOT are:

LTOT Indication	Condition
1. Chronic hypoxemia (PaO2 ≤ 7.3 on air) N.B. Patient must be 5 weeks exacerbation free	COPD, severe chronic asthma, interstitial lung disease, cystic fibrosis, bronchiectasis, pulmonary vascular disease, primary pulmonary hypertension, pulmonary malignancy, chronic heart failure. NB. LTOT can be prescribed in borderline ABGs (PaO_2 7.3 - 8 kPa on air) in secondary polycythaemia or if evidence of pulmonary hypertension (e.g. peripheral oedema, echocardiographic).
2. Nocturnal hypoventilation (SaO2 < 90%)	Obesity, neuromuscular/spinal/chest wall disease, obstructive sleep apnoea (with CPAP therapy).
3. Palliative Use	Pulmonary malignancy, other causes of disabling dyspnoea due to terminal disease.

22.6 Referrals can be made by GP's, Practice Nurses, Consultants and Hospital Doctors, and Respiratory Nurses. New referrals are made direct to the Chest Clinic, Derriford Hospital (PHT). Patients discharged from hospital on newly prescribed oxygen should be followed up in 8-10 weeks at the Oxygen Clinic.

22.7 Patients already on oxygen can be referred to the Community Respiratory Team as usual (see referrals above) for home follow up and review of oxygen use, safety issues, and problems with compliance and side effects.

22.8 All Respiratory Nurses involved in the LTOT clinic will be responsible for completing accurate, clear written documentation in accordance to local policies and NMC Guidelines (see record keeping). This includes: key data (appendix ii) documentation of verbal consent if ABG required, recording the results of the Allen's Test, ABGs and outcome in the patient's medical notes, GP letters and, if known to the Community Respiratory Team, in their case notes (also see medication above).

22.9 Whenever possible a clear month's notice must be given to the PHT if the respiratory team is unable to provide a nurse for a specific clinic.

23. Working with GP Practices.

23.1 One Respiratory Nurse Specialist will be assigned to each of the LSW Localities.

23.2 The Respiratory Nurse will offer to visit each of the GP Practices within his/her locality at least once every 3 months to review patients, and to provide education, advice and support to GP's and Practice Nurses in caring for respiratory patients.

24. Public Education.

24.1 All members of the Respiratory Team members are expected to take part in public health education events, and support the work of other health educators.

24.2 All members of the Respiratory Team are expected to support the work of local patient support groups (such as Breathe Easy).

24.3 All members of the Respiratory team are expected to support, and promote the public and professional awareness, of the services and work of the British Lung Foundation.

25. Audits.

All members of the Community Respiratory Team will carry out yearly patient satisfaction and record keeping audits. In addition other audits may be undertaken from time to time, as required (see Pulmonary Rehabilitation for example).

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Locality Manager

Date: 15th July 2015

Appendices:

Appendix A. Community Respiratory Services Referral Form.
(Press 'control' and click on the link)

Community Respiratory Services Referral Form

Appendix B. Referral Criteria.

Patients with Moderate to Very Severe COPD, registered with a Plymouth GP, and one or more of the following apply:

- Acute exacerbations where it is felt the intervention of the COPD Service would prevent admission to hospital.
- Early supported discharge from hospital.
- Acute chest physiotherapy.
- 2 or more hospital admissions a year with exacerbation of COPD not managed by GP/Practice Nurse.
- Post hospital discharge needing more than GP/Practice Nurse follow-up.
- Frequent 999 or GP callers.
- Pulmonary Rehabilitation (or Home Exercise Programme to housebound patients).
- Oxygen assessment via the Oxygen Clinic.
- Nebuliser assessment.
- Complex patients.
- Supporting Palliative Care.

Appendix C. Respiratory Assessment Form.
(Press 'control' and click on the link)

Respiratory Assessment Form

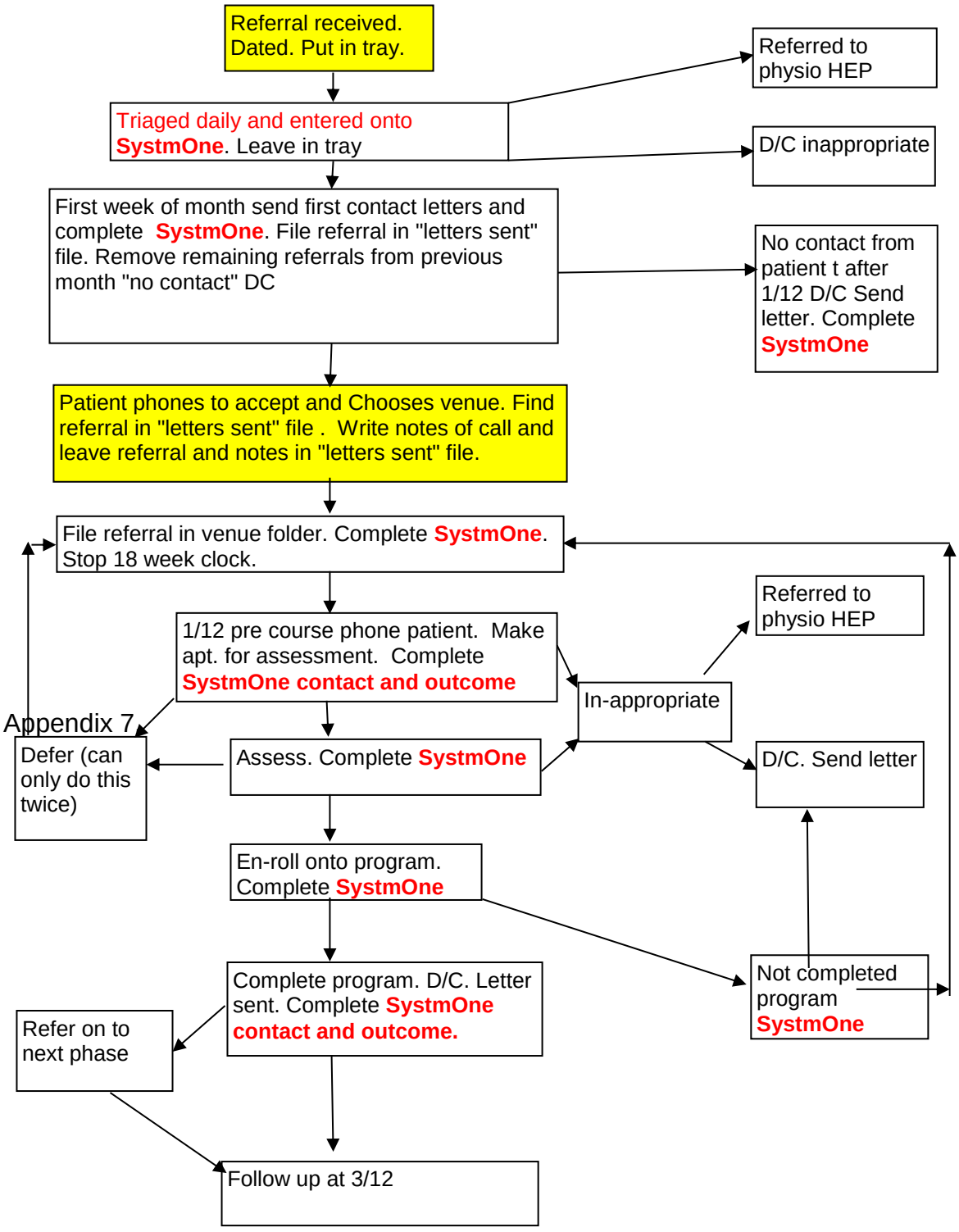
Appendix D. Self-management Plan.
(Press 'control' and click on the link)

Self Management Plan

Appendix E. Discharge Criteria.

- Patients who are stable symptomatically and have a self-management plan.
- Patients who have had no re-admissions or contact with service for 6 months.
- Patients who have declined any support or advice.
- Patients that the service is unable to help due to mental health issues (dementia for example). Each case to be individually assessed.
- Patients that have potential to place staff highly at risk.
- Regularly monitored by other health services (i.e. Long Term Condition Matrons, Heart Failure Team or in Nursing Home).

Appendix F. Pulmonary Rehabilitation Flow Chart.



Appendix G. Pulmonary Rehabilitation Referral Form.
(Press 'control' and click on the link)

Pulmonary Rehabilitation Referral Form

Appendix H. Pulmonary Rehabilitation Assessment Pro Forma.
(Press 'control' and click on the link).

Pulmonary Rehabilitation Assessment Pro Forma

Appendix I. HOOF Form.
(Press 'control' and click on the link)

HOOF Form

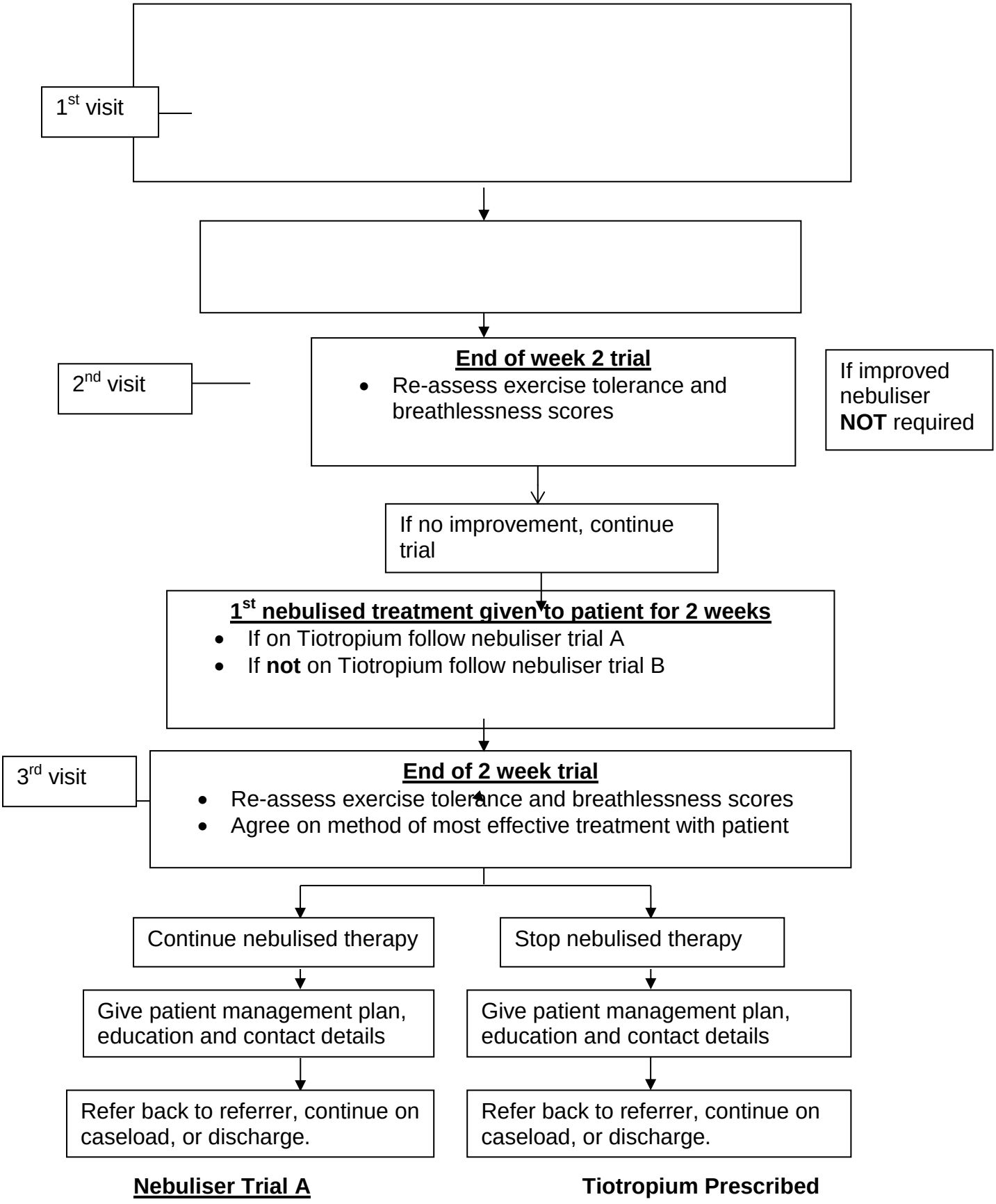
Appendix J. HOCF Consent Form.
(Press 'control' and click on the link)

HOCF Consent Form

Appendix K. LTOT Referral Form.
(Press 'control' and click on the link)

LTOT Referral Form

Appendix L. Nebuliser Assessment Pathway.



Patient Name: NHS No:	Date of Birth: Date of trial:

Medicine	Dose
Salbutamol 100mcg Inhaler. 4 PUFFS 4 times a day with SPACER DEVICE	

ANSWER THE FOLLOWING QUESTIONS AT THE END OF WEEK 2

QUESTION	Y or N	COMMENTS
Has the treatment made any difference?	Y or N	
Is your breathing easier in any way?	Y or N	
Can you do some things that you could not do before?	Y or N	
Can you do the same things but faster?	Y or N	
Are you lass breathless when you do things that you did before?	Y or N	
Has your sleep improved?	Y or N	

STEP TWO – week 3 and 4

Medicine	Dose
Salbutamol 2.5mg Nebuliser Solution.	1 Nebule 4 times a day in nebuliser

ANSWER THE FOLLOWING QUESTIONS AT THE END OF WEEK 4

QUESTION	Y or N	COMMENTS
Has the treatment made any difference?	Y or N	
Is your breathing easier in any way?	Y or N	
Can you do some things that you could not do before?	Y or N	
Can you do the same things but faster?	Y or N	
Are you lass breathless when you do things that you did before?	Y or N	
Has your sleep improved?	Y or N	

Patient Name: NHS No:	Date of Birth: Date of trial:

YOUR TRIAL WILL LAST FOUR WEEKS
STEP ONE – week 1 and 2

Medicine	Dose
Salbutamol 100mcg Inhaler.	4 PUFFS 4 times a day with SPACER DEVICE
Ipratropium 20mcg Inhaler.	4PUFFS 4 times a day with SPACER DEVICE

ANSWER THE FOLLOWING QUESTIONS AT THE END OF WEEK 2

QUESTION	Y or N	COMMENTS
Has the treatment made any	Y or N	
Is your breathing easier in any way?	Y or N	
Can you do some things that you could not do before?	Y or N	
Can you do the same things but faster?	Y or N	
Are you lass breathless when you do things that you did before?	Y or N	
Has your sleep improved?	Y or N	

STEP TWO – week 2 and 3

Medicine	Dose
Salbutamol 2.5mg Nebuliser Solution.	1 Nebule 4 times a day in nebuliser
Ipratropium 500mcg Nebuliser Solution	1 Nebule 4 times a day in nebuliser

ANSWER THE FOLLOWING QUESTIONS AT THE END OF WEEK 4

QUESTION	Y or N	COMMENTS
Has the treatment made any difference?	Y or N	
Is your breathing easier in any way?	Y or N	
Can you do some things that you could not do before?	Y or N	
Can you do the same things but faster?	Y or N	
Are you less breathless when you do things that you did before?	Y or N	
Has your sleep improved?	Y or N	