

Improving Outcomes in COPD Patients Through Clinical Audit

EXECUTIVE SUMMARY

In October 2007 NHS Wales published their service development and commissioning directives for chronic respiratory conditions. In order to develop their local services in line with the recommendations contained in the directive, A Welsh LHB identified 3 GP Surgeries to take part in a clinical audit programme in COPD designed and implemented by Oberoi Consulting.

Following the baseline assessment and data analysis a meeting was held with the 3 practices, the LHB staff and the COPD specialist nurse team to discuss the results and plan necessary actions.

The implementation stage was completed in line with the agreed action plan and the resulting improvements in both data collection and data quality have significantly improved the categorisation of COPD and in turn appropriate treatment of COPD patients.

ABOUT THE LHB AND THE PROVISION OF PULMONARY REHABILITATION

The LHB was responsible for the commissioning and provision of an adequate pulmonary rehabilitation service. According to NICE guidelines, 'pulmonary rehabilitation should be made available to patients who consider themselves functionally disabled by COPD - usually MRC grade 3 and above'. The pulmonary rehabilitation service needed to know the number of patients who might be referred through to them in order to plan their service provision accordingly. As this information was not currently recorded in any consistent manner, this was impossible.

A recent spirometry reading and up to date breathlessness scale score was required for every patient on the COPD register.

CHALLENGES

Although each GP surgery in the audit programme had a list of patients with COPD, only 18% of the patients had breathlessness score recorded.

Many of them were also not categorised as Mild, Moderate or Severe. The LHB had agreed a treatment protocol based on the severity and exacerbations of each individual patient, this needed to be addressed



oberoi
consulting

19 St. Christopher's Way,
Pride Park, Derby DE24 8JY

Tel +44(0) 1332 224 251
Email admin@oberoi-consulting.com

before the protocol could be used and patients optimally managed on treatment.

It also became evident during the audit process that there was a need for practice nurses to be trained on the interpretation and recording of spirometry results. The figures presented at the initial meeting showed the huge gaps in missing data and data recording.

SOLUTION

To support the LHB in their service development and commissioning directives for chronic respiratory conditions, Oberoi Consulting were contracted to design and implement a clinical audit programme that consisted of:

1. Development of a bespoke clinical audit programme for COPD and training guides for General Practice
2. Clinical audit of General Practice audit data
3. A template clinical protocol for completion by the clinicians for treatment of patients identified
4. Baseline assessment of practice processes in the management of their COPD patients
5. Creation of an action plan for each practice which in turn was agreed with the clinical lead
6. Training for practice staff on appropriate modules of their clinical system, including mail merge, searching and reports and amending data entry templates to include breathless scores
7. Monthly surveillance and follow up of each practice for 6 months
8. Re-audit of the data after 9 months to evaluate the outcomes

Amending of the data entry templates so that they included the breathlessness scoring was crucial as part of this programme and the accompanying training to ensure that all clinicians understood that they needed to record this information.

Nursing resource was also commissioned to support the recording and interpretation of spirometry results. This led to joint clinics being held by the practice nurse and the local specialist respiratory nurse. Where appropriate patients were reviewed by the practice clinicians and their therapy amended according to the agreed treatment protocol.



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RESULTS

Following a 9 month period significant improvements were made.

Changes in data recording were significant. Across the three practices 80% of patients were now correctly categorised as having mild, moderate or severe COPD, compared to 50% at the start of the programme.

This categorisation led to appropriate therapy management according to the agreed treatment protocol.

MRC GRADING

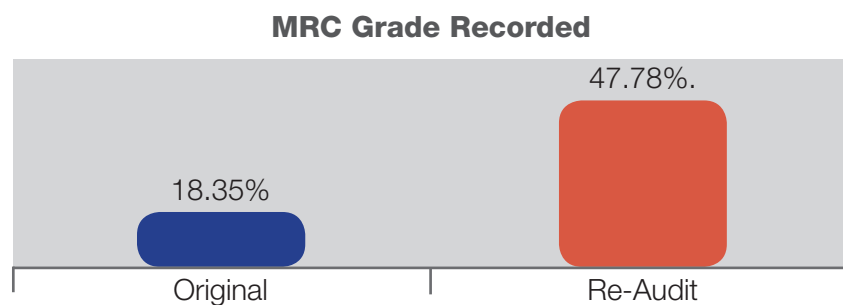
Data recording on breathlessness scores increased significantly across the 3 practices. 48% of patients across the 3 practices had a recording at the end compared to a starting figure of just 18%. This meant any patient with a scale of greater than 3 could be referred to the pulmonary rehabilitation service as recommended in the NICE Guidelines. One of the main driving forces behind the audit programme was to inform the pulmonary rehabilitation service of the potential numbers of patients in the community that may be referred to them, so this information was critical in terms of planning for service provision.

When the audit programme started, the recording of breathlessness was not part of the QoF framework, and therefore was not an established part of the COPD annual review. This explains why only 18% of the COPD Register patients across all three practices) had very poor recording of this measure.

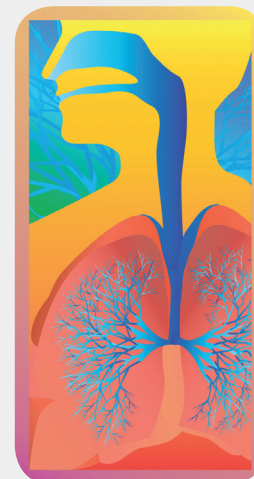
The clinical audit programme significantly contributed towards the practices' QoF achievement in a number of areas. From April 2009 a new indicator COPD 13 was introduced to support the recording of breathlessness scores

Figure 1

The difference in data recording for breathlessness based on the MRC dyspnoea score at the start of the project and 9 months later



(¹COPD 13; Percentage of patients who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months – 9 points).



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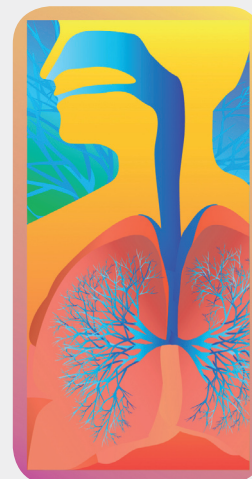
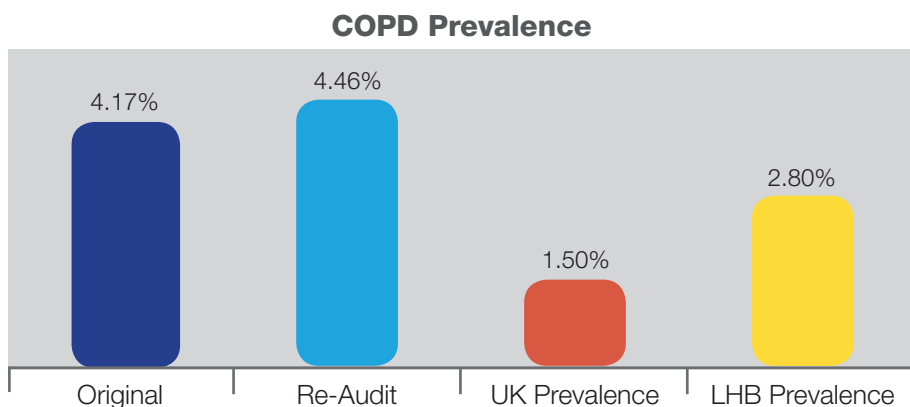
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PREVALENCE

The average prevalence for the three practices for COPD increased from 4.17% to 4.46%. As patients from the lists identified during the baseline assessment were reviewed and diagnosed or appropriately Read Coded.

Figure 2

The change in prevalence at start of the project and 9 months later

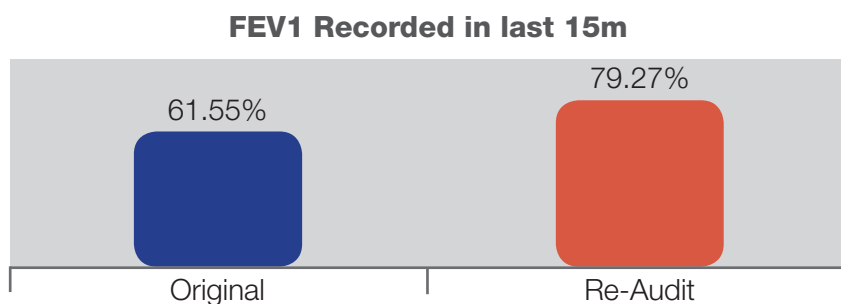


QOF INDICATORS

Other QoF indicators that significantly improved are shown below

Figure 3

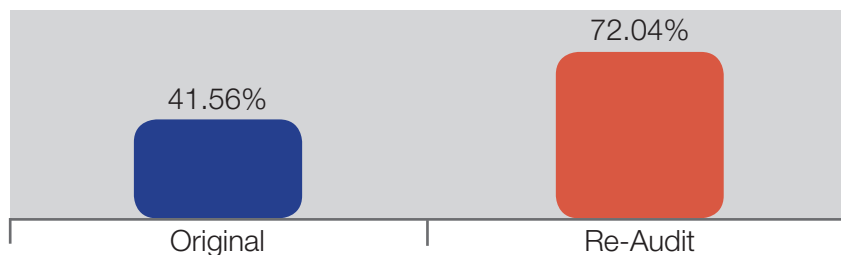
The change in FEV1 recorded in the last 15 months at start of the project and 9 months later.



COPD 10 (Percentage of Patients with a record of FEV₁ in the previous 15 months)

Figure 4

Inhaler Technique checked in last 15m



COPD 11 (Percentage of patients receiving inhaled treatment with a record of Inhaler Technique checked in previous 15 months)



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All three practices that took part in the audit programme continued to actively reviewing patient and working through those with missing or out of date readings and adapt to the improved processes put in place to sustain achievement

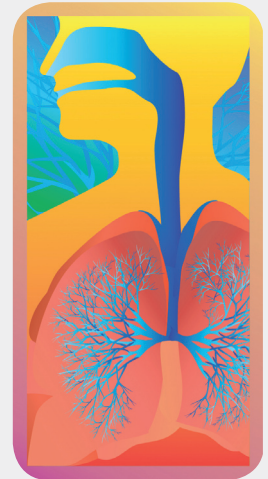
The treatment protocol is not part of working practice and is used to make decisions on patient's optimum medication. Referrals are made to the respiratory team, who offer Pulmonary Rehabilitation and assess patients for Home Oxygen Service if appropriate.

TESTIMONIAL

I just want to let you know that the input from Oberoi was extremely useful in helping us to identify which patients needed reviewing, formalising work practices and it certainly identified training issues.

I now feel more confident in knowing what needs to be done regarding COPD patients for QoF, NICE guidelines etc. and I have learned a great deal about spirometry. Dealing with these patients has led to me having a better understanding of COPD and identifying which medication is best suited for a patient and in what format.

Practice Nurse, Wales, 2009



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