Developing self management plans to help people with COPD to control their condition

People with long term conditions should be involved in the development of self management tools. A trust explains how they consulted patients to meet their needs.

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This article describes how a self management plan for people with chronic obstructive pulmonary disease was developed and implemented following consultation with patients and the multidisciplinary team.

**INTRODUCTION**

The Department of Health (2010; 2006) recommends self management tools for all people with long term conditions, such as those with chronic obstructive pulmonary disease (COPD).

The Harrogate and District Foundation Trust respiratory team consulted extensively with patients who have COPD and the respiratory team to inform the development of an individualised management plan for use in primary, intermediate and acute care.

The framework underlying the hand held record has three components: patient centredness; collaboration; and evidence based practice.

**IDENTIFYING THE PLAN’S CONTENT**

We asked 50 patients with a COPD diagnosis to complete the Bristol COPD Knowledge Questionnaire (White et al, 2006). While the mean length of time from diagnosis was more than five years, the results revealed many patients knew little about the condition and were unaware of strategies to manage it.

Six patients and four carers, recruited from the local British Lung Foundation Breathe Easy group, then attended a focus group.

A second focus group involving the respiratory multidisciplinary team was held. This group consisted of nurses, doctors and a physiotherapist in primary, intermediate and acute care. It was set up to discuss the findings from the questionnaires and patient/carer focus group and decide the content, design and implementation of the management plan. The plan’s aims are listed in Box 1.

**MANAGEMENT PLAN STRUCTURE**

The final document includes an envelope containing information on:

- Aims of COPD care;
- How the condition affects the lungs;
- The benefits of keeping physically active;
- Individual respiratory and medical history;
- Information about respiratory medicines and individual medication plan;
- Use of oxygen and nebulised therapies;
- Identifying symptoms of an exacerbation and individual management plan;
- Goal setting for patients, carers and staff.

**IMPLEMENTATION**

At a launch meeting, all staff working with people with COPD in the community and hospital were invited to find out more about the management plan. Patients were then given the record following hospital admission, at routine outpatient appointments or at their GP surgery.

Community nurses gave records to those who were confined to home.

A pilot patient and carer education group, involving nine patients and four carers, met for one hour a week for four weeks. Specialist and community nurses facilitated the group in the community, and attendees were given the management plan on the first week.

Sessions included: how respiratory drugs work; concordance; managing breathlessness; identifying exacerbations; and self management. Evaluation was very positive and more such groups have been organised.

**USING THE RECORD**

The record contains information about patients’ normal health status and they are encouraged to bring their record to all consultations. It is anticipated that it will be useful when patients see staff who do not know them, such as out of hours GPs.

**REFERENCES**


**KEYWORDS** COPD | LONG TERM CONDITIONS | RESPIRATORY CARE

**BOX 1. MANAGEMENT PLAN AIMS**

- Improve patient knowledge of the condition.
- Give patients control of their illness.
- Provide information about sources of support to patients and carers.
- Provide rapid access to advice and treatment.
- Improve continuity of care.

The hand held record is being used widely throughout the primary care trust. The community respiratory nurse specialists are training practice nurses and GPs on using it. A palliative care insert is being developed, to be given to patients at an appropriate time.

**CONCLUSION**

The aim of this initiative was to improve the patient experience by developing new ways of working. It was the first nurse led initiative in the local acute trust that looked prospectively at patients’ knowledge gaps and information needs before developing a new service.

Developing and implementing the COPD hand held record has highlighted the knowledge gaps of patients and healthcare professionals. Working in an integrated way with patients, carers and colleagues from all settings has helped bridge these gaps.

* This project was runner up in the poster presentation competition at the ARNS conference in 2009
practice guided learning