Recognising Quality Respiratory Care in Practice

Award Scheme Modules

PCRS-UK

www.pcrs-uk.org

PCRS – UK Quality Award

"Recognising Quality Respiratory Care in Practice"

The award sets out the standards that best define quality respiratory care. Our aim is for it to be straightforward for practice to complete, whilst at the same time offering a valuable developmental experience

The Standards

The Award is made up of 7 modules. There are three clinical modules, two organisational modules and one education & training module. They require the practice to submit various forms of evidence of the quality and standard of work they are undertaking on a regular basis in the practice. The evidence we are asking for ranges from full two-year cycle audits, to copies of protocols and policies. The practice can submit this evidence in various formats, including pdf and word documents, along with written descriptions where necessary.

In this booklet you will find all 7 modules, in a read-only format. Each has a set of web links to the relevant references which will not be live for the consultation, but for your convenience the references that pertain to audit, case studies and critical event analysis have been attached at the end in appendix 1.

Please read the booklet and answer the relevant questions in the questionnaire with your own practice in mind, thinking about how achievable, how relevant and how easy this would be to do in real life. Your honest feedback is vital to the success of the award project.

Module 1 Clinical Care

Section 1; Prevention

Standard 1 The Practice can demonstrate a Health Promotion policy to prevent respiratory disease for all patient groups.
Rationale **Smoking is known to be a major cause of respiratory illness – COPD (1, 2), lung cancer (1, 2) asthma (1,3). Smoking cessation advice to all patient groups, offered in primary care is an effective intervention in helping smokers to quit.** **Vaccination programmes to prevent respiratory infection in vulnerable groups offers effective protection against respiratory infection, and prevention of complications (4)**
Evidence to support application (2 parts, both must be completed)

Evidence 1.1	**Smoking Cessation**
	The practice will submit a policy for smoking cessation, which will cover opportunistic brief interventions and structured smoking cessation programmes by trained smoking cessation advisors. Referral to specialist services will be included in the policy. Special groups to be included are; • adolescence, • pregnant women and • ethnic minorities. The practice will provide evidence of the prevention of smoking, to include the following; • % current smokers • % smokers given brief intervention in a 1 year period. • % Smokers referred on to smoking cessation programmes in 1 year. • No of quitters at 4 weeks in the last year (in accordance with Department of Health guidance)

Evidence 1.2	Vaccination
	The Practice will submit their most recent QOF data (or equivalent) to demonstrate practice at least achieves it's immunisation targets for Pneumococcal and influenza vaccinations in vulnerable groups. (ref 5) If the practice is unable to achieve this, they will provide an explanation as to why and an action plan to show what they are doing to rectify this.

References

(1) NICE .Smoking cessation services in Primary Care, Pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities (2008) Available from: http://www.nice.org.uk/nicemedia/live/11925/39596/39596.pdf [accessed 1/4/10]

(2) BTS Consortium. Chronic Obstructive Pulmonary Disease. National clinical guidelines for the management of chronic obstructive pulmonary disease in adults in primary and secondary care.. Thorax 2004; 59 (suppl 1): 1-232

(3) 1. Piipari R, Jaakkola JJK, Jaakkola N, Jaakkola MS. Smoking and asthma in adults. *Eur Respir J*. 2004;24:734-739

(4) WHO. Influenza (seasonal) Fact sheet 211 (2009) Available from: http://www.who.int/mediacentre/factsheets/fs211/en/ [accessed 1/4/10]

(5) JCVI http://www.dh.gov.uk/prod consum dh/groups/dh digitalassets/@dh/@ab/documents/digitalasset/dh 112679.pdf

Other resources:

Tobacco Dependency Clinical Strategy, Feb 2010.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH 111749

Module 1 Clinical Care

Section 2; Early & Accurate Diagnosis

Standard 2 **Early & accurate diagnosis of respiratory disease is vital for appropriate and successful interventions.**	
Rationale **The ability to investigate appropriately and then interpret the information leads to accurate diagnoses and then relevant, successful treatments.** **The practice will demonstrate evidence of a system for early and accurate diagnosis of respiratory disease.** **There is significant under diagnosis of COPD in the Community**	
Evidence to support application (2 parts, both must be completed)	
Evidence 1.2.1	**Case Finding**
	The practice will submit a protocol for case finding in COPD. The practice will also submit a policy for making an accurate diagnosis of Asthma & COPD to include routine investigations undertaken to determine diagnosis. This will also include the process for referral between members of the team and other health care professionals in reaching a diagnosis.
Evidence 1.2.2	**Case Studies** – a case study should describe the care pathway from presentation to diagnosis**.**
	1. The practice will submit 4 case studies, of which at least 1 must be COPD, 1 childhood (under 12 years) asthma, 1 asthma and one other respiratory-related cases, which demonstrate: • Describe in your case study the systems in your practice for making a diagnosis and how these are utilised by the team to make this diagnosis. • How diagnosis was made (to include a copy of the relevant spirometry tracings, or peak flow reading and interpretation of these)

	• The submitted spirometry should meet current diagnostic standards, interpretation should be in keeping with ATS/ERS standards (2) • Submission of guidelines/protocols used within the practice to confirm diagnosis.

References

1. Clinical Strategy for COPD http://www.dh.gov.uk/prod consum dh/groups/dh digitalassets/@dh/@en/documents/digitalasset/dh 113279.pdf
2. ATS/ERS Spirometry standards. http://www.thoracic.org/statements/resources/pfet/PFT2.pdf

Module 1 Clinical Care

Section 3; Chronic Respiratory Care

Standard 3 People on the COPD and asthma register are offered regular structured review of their condition.
Rationale **Proactive structured review for asthma and COPD is associated with an improvement in clinical outcomes such as reduced exacerbation rates, reduced hospitalisations and improved symptom control. (1)** **A structured review offers the opportunity to :** a) **Assess the impact of the disease, any co-morbidities and of any therapeutic intervention upon the patient.** b) **Review and adjust pharmacological and non-pharmacological therapy including the need for specialist respiratory referral.** c) **Promote patient self management and empowerment.**

Evidence to support application (4 parts, all must be completed)	
Evidence 1. 3.1	**Practice Registers**
	Practices will produce a register of COPD and Asthma patients including a list of patients who are at higher risk of hospital admission. Practices will provide descriptions of how these registers are complied and how higher risk patients are identified. Note: Practices will need to show the means by which higher risk patients have been identified. e.g by exacerbation frequency, treatment level in asthma DOSE score in COPD (2)
Evidence 1.3.2	**Regular Review**
	Practices will submit a brief report outlining how they organise regular review of patients with COPD and Asthma in accordance with the timescales specified in National Guidelines. This should include how many patients with COPD were reviewed in the preceding 12 months, and how many patients at “high risk” were reviewed more frequently. The Practice will submit a policy for review of higher risk patients including

<table>
<tr><td></td><td>routine review after hospital admission.</td></tr>
<tr><td>Evidence 1.3.3</td><td>Data Recording</td></tr>
<tr><td></td><td>Practices will provide evidence of:

1. The method of recording data for COPD and Asthma patients. Who records this and how often should be included in this.
2. The method by which the team reflect upon and act upon the data collected. This might include minutes of meetings where the practice have reviewed their current practice and changed this on reflection.
3. The Practice will submit a statement of which leaflets they use and how they use them in educating their patients.
4. The Practice will submit evidence of the use of self management plans for COPD and Asthma, in annonymised format. Please attach the practices own copies.

The practice may wish to submit a template with the following inclusions as per the example below.
<table>
<tr><th>COPD</th><th>ASTHMA</th></tr>
<tr><td>FEV-1 (and % predicted)</td><td>Measure of airflow(spirometry / PEFR)</td></tr>
<tr><td>Patients Occupation</td><td>Patients Occupation</td></tr>
<tr><td>Smoking status and action(referral, leaflets etc)</td><td>Smoking status and action</td></tr>
<tr><td>Influenza and pneumococcal immunisation status</td><td>Influenza immunisation status</td></tr>
<tr><td>BMI</td><td>Height & Weight</td></tr>
<tr><td>Record of inhaler technique</td><td>Record of inhaler technique.</td></tr>
<tr><td>MRC dyspnoea score</td><td>Record of co-existing rhinitis.</td></tr>
<tr><td>Use of structured assessment tool e.g CAT CCQ</td><td>Use of structured assessment tool e.g R questions , ACT ACQ, AQLQ</td></tr>
<tr><td>Record of exacerbations / hospital admissions</td><td>Record of exacerbations/hospital admiss</td></tr>
<tr><td>Discussion of self management</td><td>Discussion of self management</td></tr>
<tr><td>Pulse oximetry measurements</td><td>Review date</td></tr>
</table>
</td></tr>
</table>

	Depression and or anxiety assessment.
	Pulmonary rehabilitation offered **
	Review date
	** If Pulmonary Rehabilitation is not available, please state what the practice is undertaking to address this.
Evidence 1.3.4	**Audits**
	Practices will submit **3 audits** demonstrating that patient review is being carried out and acted upon according to national/local guidance. One audit must include a change of treatment for Asthma or COPD. Examples of possible audits are : • Patients with COPD score of MRC score ≥ 3 who have been offered pulmonary rehabilitation (excluding housebound) • Patients with COPD/asthma given action plans(including stand by antibiotics and oral steroids for COPD patients) • COPD patients with FEV-I < 50% predicted and exacerbations on appropriate doses of ICS/LABA combination • % people with asthma on ICS dose >400mcg per day who are not on add on therapy • % Patients reviewed within x days (e.g. 30 days) of a hospital admission for asthma or COPD. • Patients with asthma who meet the BTS/SIGN criteria for good asthma control and who have had a step down of their therapy. • A treatment audit in other respiratory disease areas would also be acceptable. e.g % patients presenting with haemoptysis referred for urgent assessment. Submission of evidence of structured review in other respiratory areas is encouraged but does not from part of the essential evidence.
References	
PCRS-UK Primary Care Guidelines http://www.pcrs-uk.org/asthmaguide/ http://www.pcrs-uk.org/resources/copd_guidelinebooklet_final.pdf RCGP Revalidation Guidelines http://www.rcgp.org.uk/PDF/PDS_Guide_to_Revalidation_for_GPs.pdf	

Module 1 Clinical Care

Section 4; Acute Respiratory Care

Standard 4 **Practices can demonstrate an effective system for the recognition, assessment and immediate management of patients with acute respiratory problems**
Rationale **Patients with respiratory disorders can often present to primary care centres when in crisis. It is good practice to have systems in place to recognise, assess and manage acute respiratory problems promptly. By having protocols, systems and equipment in place to deal with acute respiratory problems will enable the practice to deliver prompt, safe and effective management for the patients. These protocols should link all team members from reception to doctors to recognise respiratory distress early. (reference NICE guideline on COPD & Sign –BTS guideline on asthma management)**

Evidence to support application (2 parts, all must be completed)	
Evidence 1.4.1	**Practice systems and equipment**
	The Practice will submit a protocol for Acute Respiratory Care which will include: • Recognition and initial management of an acute presentation of COPD. • Recognition and management of Acute Asthma. • Access to emergency anaphylaxis medication, its use, management, organisation and line of responsibility. • The practice will submit a Patient Group Directive (PGD) for the use of drugs, including oxygen, prescribed by non prescribing health care personnel in the management of the acute Asthma attack. The Practice will give a description of the equipment available to treat acute respiratory conditions, its use and location. This should cover both main and branch surgeries plus home visits. ▪ Oxygen cylinder and masks (children and adult) ▪ Pulse oximeter (▪ Nebuliser, with or without spacer, with salbutamol and ipratropium.

Evidence 1.4.2	Case studies
	Practices to submit **3 case studies** to include 1 asthma, 1 COPD, 1 acute respiratory condition in childhood * (under 12 years) which describe the management of acute respiratory illnesses and how they were managed including: ▪ Presenting Symptoms ▪ What was the immediate treatment ▪ What was the outcome ▪ What was the follow-up ▪ Description and use of patient management plan ▪ Details of delays in treatment (if any) ▪ What were the learning points & how were they implemented. ▪ What were the team learning points. Case studies should include details of all members of the practice team who were involved in the care of these patients including, for example, reception staff, community staff etc. * e.g. Croup, Bronchiolitis

References

PCRS-UK website
http://www.pcrs-uk.org/

RCGP QPA case study definition
http://www.rcgp.org.uk/docs/QPA%20Case%20Study.doc

Module 2 Organisational

Section 1; Equipment

Standard 5 Practices have access to, and the ability to use effectively, the equipment necessary to assess, diagnose, review and treat patients with respiratory conditions.
Rationale **Respiratory conditions such as asthma and COPD present to clinicians in primary care. The ability to establish or exclude a diagnosis, to review and treat such patients within a primary care setting is a mark of a quality service.** **Key components of an effective equipment policy include;** a) **Identifying equipment necessary to meet the needs of clinicians and patients within the framework of other local services** b) **Calibration or verification/maintenance** c) **Infection control policy & procedures** d) **Health and safety (including manual handling)** e) **Staff Training**

Evidence to support application (3 parts, all must be completed)	
Evidence 2.1.1	**Equipment Register**
	Practices will submit a list of equipment held in the practice. This should include; • Stethoscopes • Sphygmomanometers • Peak Flow meters • Pulse Oximeters • Accurate weight measurement scales • Height measure • Disposable Mouthpieces • ECG machine • Demonstration placebos • Oxygen plus equipment appropriate to you usage • Nebuliser – including face masks & mouthpieces, tubing & chambers • Resuscitation - please list equipment and drugs available. Please include any other additional equipment that enhances the care you provide in your practice for your respiratory patients.

	Where equipment within the practice is influenced by patients accessing diagnostic services within a community setting (such as direct access spirometry) please describe these services and show how effective they at meeting your practice needs.
Evidence 2.1.2	**Calibration , verification and safety**
	The Practice will submit a log of any calibration, verification and inspection for all equipment, as per manufacturer's guidance and /or accepted guidelines or standards. Plus a named member of staff responsible for the upkeep of the log.
Evidence 2.1.3	**Infection control**
	The Practice will submit a copy of their infection control policy including evidence of application.

Module 2 Organisational

Section 2; TEAMWORK

Standard 6 The Practice works in an effective, comprehensive multi-disciplinary way to meet the needs of patients with respiratory conditions. The practice supports its staff to fulfil their role, and works across organisational boundaries for the benefit of patients and staff.
Rationale **Respiratory conditions such as asthma and COPD present to clinicians in primary care. The ability to establish or exclude a diagnosis, to review and treat such patients within a primary care setting is a mark of a quality service.** **Key components of an effective approach to teamwork are;** f) **Identifying a clinical lead with responsibility for respiratory care within the practice** g) **A practice training plan based on the needs of both patients and staff, reflecting the particular challenges and working practices of the practice and area** h) **Effective interaction with other health and social care providers** i) **Contingency planning**

Evidence to support application	
Evidence 2.2.1	**Lead GP & Nurse**
	Practices should have a named GP and /or Nurse responsible for Respiratory Care and provide a description of the role and responsibilities of each, including relevant up to date qualifications, in line with the PCRS-UK skills document. (Ref; website)
Evidence 2.2.2	**Teamwork**
	The Practice will submit a description of the whole practice approach to providing excellence in respiratory care. This should demonstrate a practice team approach. This should include one of the following: • How a patient presenting with breathlessness would be managed • How the team manages palliative care for people with end stage respiratory problems. It will describe the role of key team members (GP, Nurse, reception staff, community staff, pharmacy etc) and how the practice team interfaces with other

	local providers. It should demonstrate the teamwork between at least 3 members of the team and the lessons that emerged, eg via annual survey of staff practices and opinions.
Evidence 2.2.3	**Interaction with other providers**
	Practices will submit a policy for effective communication across health and social care boundaries, to include both: • Referral Guidelines & care pathways. • Out of hours notification policy (at risk and palliative). Specifically how the practice notifies the out of hours service and what triggers such a notification. Please include how the communications come back to the practice from the out of hours service and how this information is processed and actionned as appropriate. Additionally, one of the following three: • Exception coding rate • Description of links with community staff, eg pharmacists and school staff. • Description of the links with schools and school nurses.
Evidence 2.2.4	**Contingency Planning**
	The Practice will describe how it deals with the temporary loss of key staff members, in particular the respiratory lead GP and Nurse**.**
Evidence 2.2.5	**Patient Experience/Involvement**
	The Practice will submit a plan of how services are organised and reviewed, to meet patient needs and how these needs are assessed and acted upon over time. Examples and evidence of how patients are involved in this process is essential. Examples of patient involvement could include: • Patient Focus Groups (experience) • Patient Participation Groups (involvement) • Interview with a patient with respiratory disease • Interview with a Respiratory Patients carer. • Patient Survey

References
PCRS-UK Skills Document http://www.pcrs-uk.org/resources/quickrefguide_webversion_v13_final_301009.pdf

Module 3 ; Education & Training

Standard 7

People with respiratory disease should have access to an effective, co-ordinated service provided by appropriately skilled health care professionals

Rationale

Quality care depends not only on the skills and talents of individuals, but in their ability to work within a flexible team. This should be supported by protected time and resources to allow individual and team development in order to promote a high quality service for respiratory patients and their carers. Within this context professionals need to be clear about their identified roles and responsibilities and these should be under-pinned by appropriate education.

Evidence to support application (3 parts, all must be completed)

Evidence 3.1	**Practice Learning Plan/ activity**
Criteria *The practice has a current practice development plan and educational activity record which provides information on training and education requirements, continuing professional development and the dissemination of relevant and appropriate guidance for the management of respiratory patients.*	
Evidence 3.1.1	**Development Plan**
	The Practice will submit a current development plan for the practice (highlighting those sections relevant to respiratory care). This will highlight short and longer term plans, it should also highlight appropriate in house mentorship / preceptorship and reference to appropriate local or national quality assured courses where possible. This plan should be reviewed annually and clearly dated.

Evidence 3.1.2	**Educational activity**
	Provide a record of the educational activity within the practice linked to respiratory care (this will be in detail for leads, and highlight in house and external educational activity for other team members). It will provide evidence that training / education is appropriate to the level of responsibility and duties provided. (practice nurses; reference PCRS-UK guidance (1))
Evidence 3.1.3	**Mechanism for updates**
	The Practice should have a mechanism, and evidence of the use of this mechanism, by which relevant, new and changing information is disseminated to all in the practice team. This might be records of practice respiratory team meetings (minimum 4 per year) which serve as a way of disseminating new research, clinical guidelines and providing implementation of this guidance within the practice. This can be part of a more general practice meeting provided there is dedicated time allocated to respiratory care. Please submit all relevant evidence.
Evidence 3.2	**Lead GP and Nurse**
Criteria *There is a named lead GP and nurse who are appropriately skilled in organising and delivering respiratory care within the practice. This lead role will involve leadership in changing the practice to improve care for patients and ensuring that new guidance is adopted in the practice. The systems for the lead clinicians remaining up to date will be explicit within their (personal) professional development plan.*	

Evidence 3.2	**Continuing Professional Development**
3.2.1	The lead GP will have appropriate Continuing Professional Development identified in their professional development plan ensuring their maintenance of high level respiratory skills. Please submit a list of the education and/or Continuing Professional Development activities that they have undertaken in this area in the last year. The lead nurse will have appropriate qualifications and have maintained their Continuing Professional Development following this to ensure maintenance of high level respiratory skills. Please submit evidence of this Continuing Professional Development for the last 2 years.
3.2.2	Please submit a copy of the last Continuing Professional Development plan for both lead GP and Nurse and how this has been discussed, implemented and evaluated within the practice.
Evidence 3.3	**Audit and Significant Event Analysis**
Criteria *The practice regularly undertakes audits and reviews significant events*	
Evidence 3.3.1	**Audits**
	The practice will submit **2 non Quality Outcome Framework respiratory audits** undertaken in the last two years. (This will cover areas highlighted in the RCGP revalidation guide.(1)) These can be audits provided earlier in 1.3.4 Please see guidance notes for criteria for audits.
Evidence 3.3.2	**Significant event analyses**
	The practice will submit at least **3 significant event analyses** relating to care for people with respiratory conditions, undertaken in the last two years. These may be linked to palliative care, hospital admissions, late diagnoses. The practice will describe these, the learning from the analysis and the actions taken. (1)
Reference	
1. RCGP Revalidation Guide http://www.rcgp.org.uk/PDF/PDS_Guide_to_Revalidation_for_GPs.pdf	

Appendix 1

1) A GUIDE TO AUDIT – ref; RCGP- QPA

Definition:

An audit is a measurement of the quality of clinical or organisational performance.

It is important to be aware of the difference between a survey and an audit. A survey is a single data collection exercise in which activity is observed and measured. An audit also measures activity but compares the results or standards achieved with an initial target standard which is usually set before data collection commences. After making appropriate changes, the performance is re-measured.

The naming of parts:

An audit should contain the following elements -

(a) Title
(b) Aim and reason for choice of audit
(c) Criteria
(d) Initial standard setting (where possible)
(e) Preparation and planning
(f) First data collection
(g) Comparison to standard
(h) Analysis and changes made – standards reviewed
(i) Second data collection
(j) Comparison to standard
(k) Conclusions

2**) A guide to writing a Case Study –** ref; RCGP-QPA

EXAMPLE OF EARLY DIAGNOSIS

Case Number/patient ID 11/123 (Age 66)

Diagnosis	Rectal Carcinoma Dukes Stage A
Date/place of diagnosis	06.03.06 at local hospital
When were symptoms first noted?	? 10.05
When were symptoms first presented to primary care	05.02.06
History prior to diagnosis?	05.02.06 - Treated as haemorrhoids by a junior clinician on the basis of short history of bleeding when straining. Abdominal examination normal, external haemorrhoids seen but no rectal done. Safety netted by advising that early referral would be appropriate if not settling. 25.02.06 - Symptoms no better. Rectal performed, no mass felt but blood on examining fingertip. Referred urgently to surgeon using electronic cancer referral pathway. 06.03.06 - Had colonoscopy. High rectal tumour seen. 15.04.06 - AP resection. 29.04.06 -Seen at home by GP following discharge
Who else was involved prior to diagnosis?	Urgent referral pathway co-ordinator Colonoscopist Surgeon
After discussion, what lessons have you learnt from this case?	High rectal tumours cannot be felt and even lower ones if the examining finger is short It is all too easy to ascribe rectal bleeding to external haemorrhoids Should we encourage all clinicians in training to discuss such cases with an experienced colleague? We have failed to find out why the patient delayed in telling us of his symptoms for 4 months. It would be useful to understand the reasoning for that delay.

OR

The practice can submit a case study in their own words, approximately 100 words in length, using type face “Ariel” with all guidelines etc referenced appropriately.

3) A Guide to Significant Event Analysis.

This guidance enables primary care teams to conduct an effective **Significant Event Audit** (SEA) with the aim of improving care for all patients. SEA enables primary care teams to learn from patient safety incidents and 'near misses', and to highlight and learn from both strengths and weaknesses in the care they provide.

The guidance gives primary care teams a tool to develop a structured and effective SEA process and embed it as an improvement tool within their practice. The guidance defines the process, outlines effective practices and demonstrates what can be achieved through examples.

Improving the quality and safety of patient care is a key clinical governance priority in primary healthcare and SEA has an important role in contributing to this aim.

The seven stages of SEA:

1. Awareness and prioritisation of a significant event
2. Information gathering
3. The facilitated team-based meeting
4. Analysis of the significant event
5. Agree, implement and monitor change
6. Write it up
7. Report, share and review

http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61502&type=full&servicetype=Attachment