MODEL OF CARE

Nurse-led respiratory disease management clinic

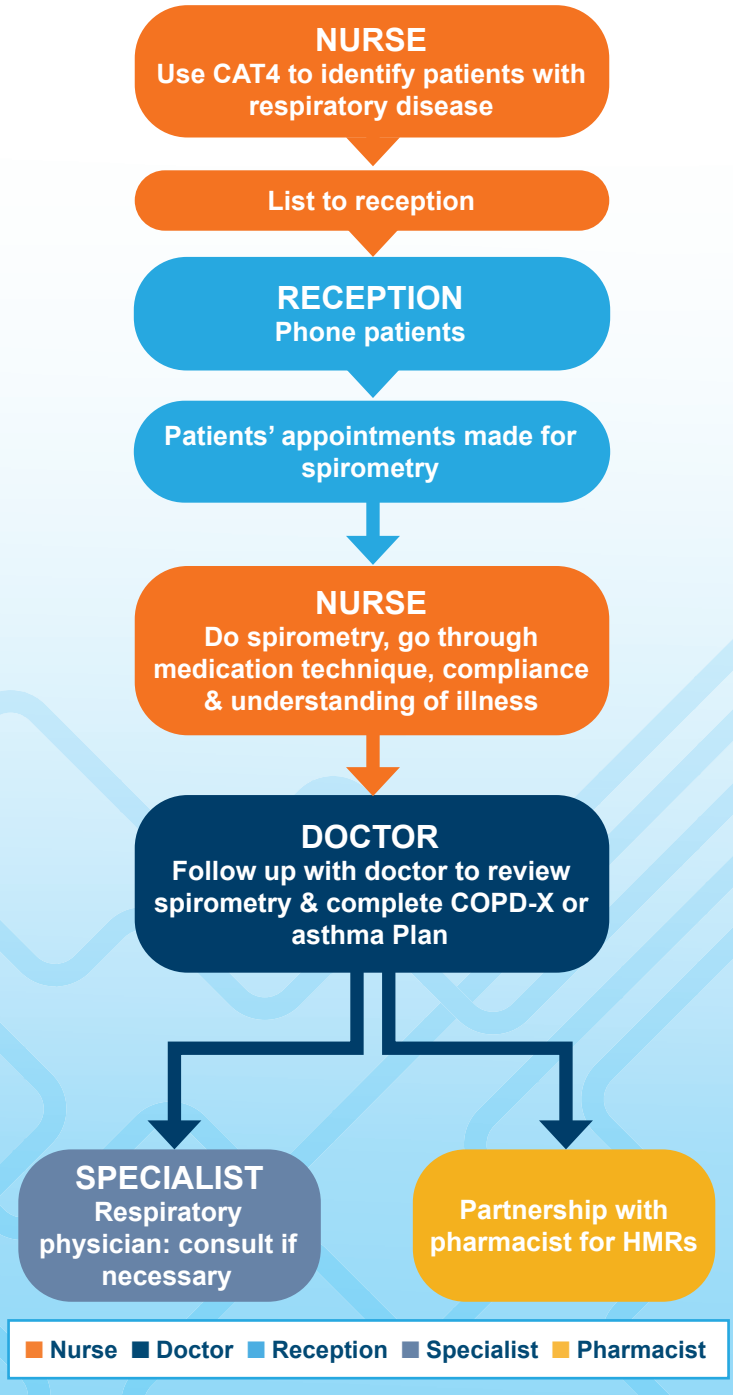
Workflow & resourcing

Project activities were included in the practice nurse's regular hours. Additional resourcing was provided by the practice manager.

- Patients with COPD and asthma were identified using CAT4 data collection.
- Patients on the CAT4 list were contacted by reception staff and invited to attend the practice for a review and update on the management of their respiratory disease. Clerical staff ensured patients' personal details were up to date and booked appointments with the nurse.
- Spirometry was performed on the first visit with the nurse and initial patient understanding of their disease was assessed. Education was given regarding use of puffers and spacers.
- Appointments were made with the Dr to review spirometry and check adherence to prescribed medication. COPD-X Plan: Australian and New Zealand guidelines for the management of chronic obstructive pulmonary disease. https://copdx.org.au/ or asthma action plans were explained and given to patients.
- Partnerships with community pharmacists can be utilised for provision of HMRs to support patient safety, compliance and self-efficacy.
- Referrals were made to a respiratory physician for patients on oxygen therapy or if exacerbation of disease occurred.
- A follow up appointment occurred in six months with the nurse (and GP if required) to evaluate patient progress and the effectiveness of management plans and the team-based nurse led clinic.

Figure 1. Model of Care flowchart

The following flow diagram outlines step by step how the project was implemented including all stakeholders and their roles.



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