**Guideline for operating Nurse led Respiratory Integrated Care Services during Covid 19 pandemic**

Is this document a:

Policy [ ] Procedure [ ] Protocol [ ] Guideline [X]

*Insert Service Name(s), Directorate and applicable Location(s):*

**Nurse led Respiratory Integrated Care clinics**

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|---|---|
| Title of PPPG Development Group: | |
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| Version | Date Approved | List section numbers changed | Author |
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## Table of Contents:

**Part A: Outline of PPPG steps**

**1.0 Pathway to Virtual Respiratory Integrated Care (RIC) clinic during Covid 19 Pandemic**

**2.0 Procedure for nurse-led Respiratory Integrated Care (RIC) clinics**

2.1 RIC referral criteria, process and clinic procedures
2.2 Appointment Process for all RIC clinics
2.3 Clinics held in General Practice - Referral process and appointments:
2.4 Did Not Attend (DNA)/Appointment Cancellation
2.5 Assessment of patients
2.6 Discharge of patients
2.7 Contingency planning if a surge in Covid Cases occurs

**Part B: PPPG development cycle**

**1.0 INITATION**

1.1 Purpose
1.2 Scope
1.3 Objectives(s)
1.4 Outcome(s)
1.5 PPPG Development Group
1.6 PPPG Governance Group
1.7 Supporting Evidence
1.8 Glossary of Terms

**2.0 DEVELOPMENT OF PPPG**

2.1 List the questions (clinical/non-clinical)
2.2 Describe the literature search strategy
2.3 Describe the method of appraising evidence
2.4 Describe the process the PPPG Development Group used to formulate recommendations
2.5 Provide a summary of the evidence from the literature
2.6 Detail resources necessary to implement the PPPG recommendations
2.7 Outline of PPPG steps/recommendations

**3.0 GOVERNANCE AND APPROVAL**

3.1 Outline formal governance arrangements
3.2 List method for assessing the PPPG in meeting the standards outlined in the HSE National Framework for developing PPPGs
3.3 Attach any copyright/permission sought
3.4 Insert approved PPPG Checklist

**4.0 COMMUNICATION AND DISSEMINATION**

4.1 Describe communication and dissemination plan

**5.0 IMPLEMENTATION**

5.1 Describe implementation plan listing barriers and /or facilitators

5.2 Describe any education/training required to implement the PPPG

5.3 Identify lead person(s) responsible for the Implementation of the PPPG

5.4 Outline specific roles and responsibilities

**6.0 MONITORING, AUDIT AND EVALUATION**

6.1 Describe the plan and identify lead person(s) responsible for the following processes:

6.1.1 Monitoring

6.1.2 Audit

6.1.3 Evaluation

**7.0 REVISION/UPDATE**

7.1 Describe the procedure for the update of the PPPG

7.2 Identify the method for amending the PPPG if new evidence emerges

7.3 Complete version control update on the PPPG template cover sheet

**8.0 REFERENCES**

**9.0 APPENDICES**

Appendix I Signature Sheet

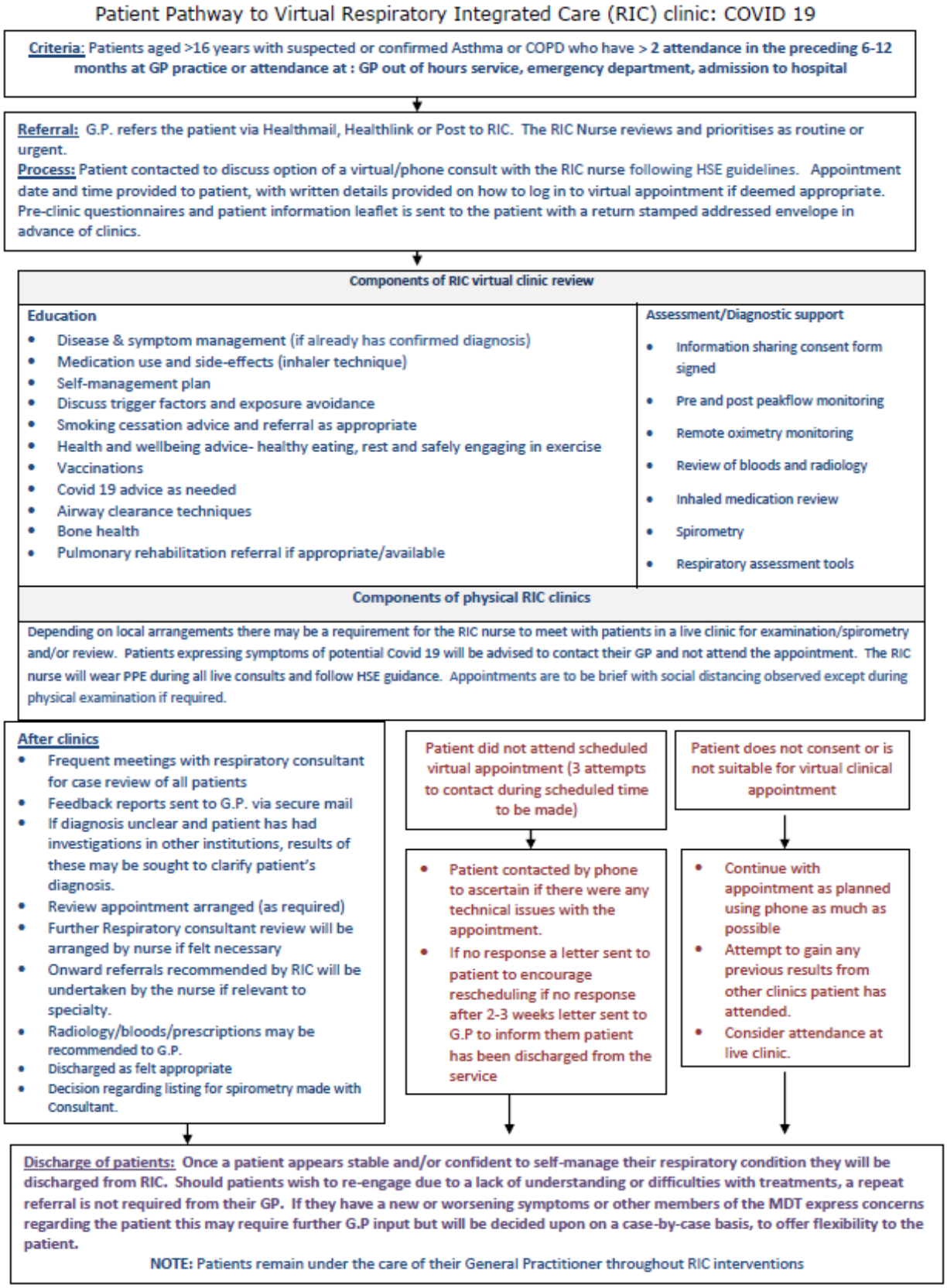
Appendix II Membership of the PPPG Development Group Template

Appendix III Conflict of Interest Declaration Form Template

Appendix IV Membership of the Approval Governance Group Template

**PART A: Outline of PPPG Steps.**

1.0 Pathway to Virtual Respiratory Integrated Care (RIC) clinic during Covid 19 Pandemic



2.0 Procedure for nurse-led Respiratory Integrated Care (RIC) clinics

## 2.1 RIC referral criteria, process and clinic procedures

2.1.1 Criteria for patients being referred to RIC are based on an enhanced version of the original proposal for the RIC demonstrator projects. These are patients' ≥ 16 years of age with suspected or confirmed COPD and/or Asthma who have had an emergency attendance for their Respiratory disease:

- At their GP ≥2 times
- In an out of hours GP service
- To an Emergency Department or
- Medical Admissions Unit
- Or have had an inpatient stay relating to an exacerbation of their Respiratory illness in the last 6-12 months

2.1.2 A copy of the inclusion criteria for Respiratory Integrated Care is supplied to participating GPs, Respiratory Consultants and NCHDs, Respiratory nurse or physiotherapy team members in the nurse's catchment area. RIC nursing staff may need to request that GPs in their discussions with patients advise of the potential virtual (by telephone or video consultation) aspect of the RIC services.

2.1.3 Referrals to the RIC are accepted from GPs, Respiratory Consultants and NCHDs, from Respiratory nurse and physiotherapy team members. Referrals received from staff outside of these teams will require a letter from the patient's GP or Consultant.

2.1.4 Suitable patients are referred to the nurse-led RIC service via healthlink, post or healthmail depending on local arrangements.

2.1.5 Currently the National Standard Referral form, RIC referral form (Appendix 1) and GP/Consultant letters are used to refer patients to the service. This is agreed locally within each RIC practice.

2.1.6 Referrals, when received, are reviewed and prioritised as urgent or routine by the RIC nurse.

2.1.7 Patients are contacted by phone to discuss the option of a virtual consult with the RIC nurse and to assess their level of digital literacy. Access to suitable technology and broadband requirements are discussed with the patients to ascertain suitability for virtual (video/telephone) appointments. Verbal consent is also sought during the phone call in line with existing RIC information sharing agreement (Appendix 2).

2.1.8 If the patient declines an appointment this will be noted in the patients notes and the Referrer/GP will be informed.

## 2.2 Appointment Process for all RIC clinics

2.2.1 Face to face contact with patients (where possible) should be kept to a minimum. The use of phone consultations and virtual consultation platforms will assist RIC nurses to complete a comprehensive assessment. Currently, the Attend Anywhere virtual consultation platform is being recommended and is available within the HSE. If there is difficulty with the Attend Anywhere platform MS Teams, WhatsApp video messaging or Webex can also be utilised in accordance with HSE guidelines[1]. Documentation of the platform used should be made in the patient's notes.

2.2.2 As per section 2.1 when a patient is referred to RIC, staff will contact the patient by phone to assess their suitability and seek their consent for a virtual appointment.

2.2.3 If the patient is suitable a virtual appointment a date and time is then provided to patient over the phone with text and/or card/letter posted to remind of same. A patient information leaflet or link (Appendix 3) is sent to the patient with details of how to access the virtual clinic appointment.

2.2.4 For patients who may not be suitable for a virtual consultation as much information as possible should be gained via phone consultation prior to a face-to-face appointments.

2.2.5 As deemed necessary by the RIC nurse, some patients may require both a virtual and face to face review to complete their full assessment.

2.2.6 Prior to all face to face consultations a COVID 19 risk assessment is completed, as per HPSC guidance, either the day of or day before the consultation. (Appendix 4)

2.2.7 Patients risk assessed for potential COVID 19 symptoms are advised this will be re-checked again by phone prior to all face-to-face appointments. They will be advised: not to attend if they have symptoms suggestive of COVID 19, to attend alone where possible, to wear a mask for the appointment and to wait in their car until contacted by staff to enter the building.

2.2.8 Anyone accompanying patients to their face-to-face appointment must also be risk assessed for possible COVID 19 symptoms. For the purpose of contact tracing their name and contact number should be stored in the patient's confidential notes. They should be advised of this and that they may be contacted by Public Health should a contact tracing issue arise.

2.2.9 Local procedures on how to prepare clinical space before and after appointments, PPG for use of PPE and the donning and doffing of appropriate PPE must be adhered to.

2.2.10 Every effort should be made to have a separate entrance and exit to the clinical space.

2.2.11 A copy of electronic letters/emails sent to the patient/GP or other healthcare staff should be saved in a secure database held on a shared folder accessed via an encrypted password protected laptop. Databases should be connected to internal HSE server as they are backed up daily.

## 2.3 Clinics held in General Practice - Referral process and appointments:

2.3.1 Clinics restarting in GP practice will depend on local Clinical Lead guidance

2.3.2 The referring GP discusses the referral with the patient, emphasising possible need for virtual consult first.

2.3.3 The GP will make reference to the referral on the patient's record/notes on the relevant IT system used in the practice i.e. Socrates, HealthOne etc.

2.3.4 Appointments will be made as per local arrangements and a patient information leaflet will be sent to the patient.

2.3.5 For face to face appointments in the GP practice a discussion should take place with each practice before re-starting clinics. This is to ensure that HSE health protection protocols for seeing patients face-to-face can continue to be adhered to in GP clinics. If space is no longer available to RIC staff in GP clinics due to physical distancing regulations alternative arrangements can be discussed locally.

## 2.4 Did Not Attend (DNA)/Appointment Cancellation

2.4.1 Patients who DNA their initial or return appointment for RIC will be sent a letter (Appendix 5) requesting that they phone to re-schedule the appointment. If they do not contact the service within 2 weeks of letter date a letter will be sent to their GP to inform them of same.

2.4.2 Patients who Cannot Attend (CNA) twice or more will be sent an appointment letter to urge them to keep their next appointment date. (Appendix 6)

## 2.5 Assessment of patients

2.5.2 Where possible patients are required to sign information sharing agreement form (Appendix 2)

2.5.3 Virtual or phone consultations should be recorded on an assessment sheet/report that can be forwarded to the referrer, the patient's GP and/or the patient. Appendix 7 provides a sample virtual or phone assessment template that can be adapted to suit each RIC area. Assessments of patients can include but is not limited to:

- History of presenting complaint
- Past medical/surgical history including any allergies, current medications and adherence to same
- History taking to include smoking, alcohol, occupational, childhood and travel exposures
- Information on quality of life scores/outcome measures/exacerbation history and vaccinations
- Review of previous correspondence and radiology/bloods if available
- Inhaler and peakflow technique assessment and education – if available RIC may need to post placebos or peak flow meters to patients pre-consultation.

2.5.4 Face-to-Face assessments of patients can include:

- Spirometry as per guidelines
- Physical examination
- Chest auscultation
- 6 Minute walk tests
- Overnight oximetry
- Inhaler technique assessment and education if not possible virtually

2.5.5 The nurse will assess patients using appropriate quality of life scores; these will also be re-checked at follow-up appointments

2.5.6 Education is a key component of the RIC service and should include, but is not limited to the following:

- Disease profile and disease management
- Medication and its use
- Monitoring symptoms and Self-Management/Action plan
- Trigger factors and exposure avoidance
- Smoking cessation advice
- Health and wellbeing advice- healthy eating, rest and appropriate exercise programmes
- Vaccinations
- Airway clearance and breathing control techniques
- Bone health
- Pulmonary rehabilitation
- Peak flow monitoring

2.5.7 Details of the assessment and suggested changes to treatment/prescriptions are forwarded to the patients' GP and/or referrer or documented in the patient's file on the GP IT system if applicable.

2.5.8 All relevant reports and results are reviewed and discussed during "dry rounds" with the Respiratory consultant depending on local arrangements. A record of this meeting should be recorded in the patient's notes and/or as per the sample handover sheet (Appendix 8). Any detail on patients recorded on handover sheets need to be stored securely or destroyed as per local confidential documentation policy.

2.5.9 Any comments or recommendations from the Respiratory Consultant are documented in the patient's notes or inputted electronically onto the final report and sent to the patient's GP and/or referrer.

2.5.10 If it is deemed appropriate that a patient requires onward referral to the Respiratory Consultant or another service this will be facilitated by the RIC nurse. The patient's GP will be advised and included on all onward referrals

2.5.11 Basic details of each patient reviewed by the RIC nurse are stored on an Excel spreadsheet to facilitate data collection.

2.5.12 As the RIC nurse does not have remote access to the GP practice IT system a report may be printed from the GP software, with permission. This and any other documents related to the patient are stored in confidential folders in a locked filing cabinet in the nurse's office base or are stored electronically on the RIC shared network drive.

**2.6 Discharge of patients**

2.6.1 Patients who have had their diagnosis confirmed by the RIC nurse-led service, have been provided with disease specific education and a disease specific self-management plan can be discharged from the service at the discretion of RIC staff.

2.6.2 Patients who have had their care/management taken over by the Respiratory Consultant clinic and are deemed to no longer require the services of the RIC nurse can be discharged from the service.

2.6.2 Patients who have attained clinical stability and appear confident in their ability to self-manage their respiratory disease can be discharged from the service at the discretion of RIC staff.

2.6.3 Patients continually not presenting or cancelling more than two appointments can be discharged from the service.

2.6.4 Patients can be discharged from the service at the discretion of RIC staff if felt no further input is required.

2.6.5 Reference to discharge is made in final letters to the patient's GP and/or referrer.

2.6.6 Patients that contact the service post discharge can be reviewed in liaison with their GP a renewed referral is not required unless it is over two years since last seen and/or RIC records/notes are unavailable.

**2.7 Contingency planning if a surge in Covid Cases occurs**

2.7.1 During the Covid pandemic, until a vaccine is widely available, the health service may continue to experience surges in cases of Covid 19, nationally and locally. If this situation arises essential support services for respiratory patients should remain as operational as possible. Support to the patients with severe disease and thus at higher risks of complications is essential. Patients with severe respiratory disease should be targeted for support and educational advice on staying well during this time.

2.7.2 During any surge in cases, whereby another reduction in service is expected, virtual or phone support clinics should continue to take place where possible. Face-to-face contact should only take place when absolutely unavoidable with PPE worn as advised by HPSC.

2.7.3 Where appropriate PPE is unavailable face-to-face appointments should not occur and an alternative source of review should be sought/advised via the patients GP or emergency department.

2.7.4 For clinics held in primary care centres RIC staff are obligated to follow local guidance from the primary care senior management teams as variances may occur across the country.

2.7.5 Clinics held in GP practices during a surge must take into account local policies and in close liaison with GPs within the practice.

**PART B: PPPG Development cycle**

## 1.0 INITIATION

COPD is the most prevalent respiratory disease in adults. Based on international figures, at least 440,000 people in Ireland have COPD, of who over 180,000 have moderate or severe disease, and only half of whom may have been diagnosed.[2] Early detection and staging of COPD are important to optimise treatment and reduce costs. [3] Ireland has the highest rate of hospital admissions for exacerbations of COPD in the Organisation for Economic Co-operation and Development (OECD) countries. [4] It accounts for over 15,000 acute hospital admissions per year, over 115,000 inpatient bed days and more than 1500 deaths per annum.

Effective integrated management of people with COPD will slow disease progression, optimise quality and quantity of life and provide care in the most appropriate setting. The Irish College of General Practitioners report 'The Management of Chronic Obstructive Pulmonary Disease in General Practice' noted that much of the management of these patients takes place in primary care and most patients who get exacerbations of COPD are managed by their GP. [5]

Ireland has among the highest incidence of Asthma in the world, 7 -9.4 % of the adult population a have Asthma. Ireland still has greater than 1 death per week from Asthma, greater than 5000 Asthma admissions to hospital each year and 20,000 Asthma related emergency attendances. This demonstrates a significant burden on our health care system.[6]

### 1.1 Purpose

Nurse – led Respiratory Integrated Care (RIC) clinics take place in Primary care centres and General Practitioner (GP) practices. The service is provided by nurses working in Respiratory Integrated Care such as Clinical Nurse Specialists (CNSps), Registered Advanced Nurse Practitioners (RANPs) or candidates ANPs (cANPs). Potentially in the future Clinical Nurse Managers 2 (CNM2) and Registered General Nurses (RGNs) may be part of RIC services and will be included under this guidance document.

Some changes in usual practice have occurred due to the current COVID-19 Global Pandemic. Restrictions have been put in place in response to Public Health policy in relation to social distancing, PPE and cocooning. This includes limited face to face consultation time, use of PPE and restrictions on AGPs. This has prompted services to review their practice and develop pathways for referral and patient assessment in line with Health Protection Surveillance Centre (HPSC) guidelines. The COVID-19 situation is changing rapidly and this document is to provide guidance only and can be superseded by local policy depending on incidence rates.

RIC services provide a strong focus on supporting patients diagnosed with COPD and/or Asthma in self-managing their conditions. The purpose of these clinics is to offer a respiratory specialised

service to patients in primary care. Recommencement of RIC clinics will assist respiratory patients in minimising their risk of severe disease if infected with COVID 19 by improving community management of COPD and Asthma.

### 1.2 Scope

This guideline is intended for use by nursing staff employed in Respiratory Integrated Care. It does not provide guidance to other staff who may be involved in the patients care at the same time.

1.2.1 Target users: This guideline is for use by nursing staff working within Respiratory Integrated Care

1.2.2 Target population: Patients aged >16 meeting referral criteria as laid out in this policy

### 1.3 Objective(s)

1.3.1 To ensure a clear method of referral for suitable patients to the nurse-led respiratory integrated care service

1.3.2 To provide information to General Practitioners on the service provided by the nurse which aims to assist and support the diagnosis and management of patients with COPD and Asthma

1.3.3 To provide a safe and specialist service to patients attending the clinic

1.3.4 To minimise risks to staff

1.3.5 To enable implementation of evidence based care

### 1.4 Outcome(s)

By supporting nurses in Respiratory Integrated Care it is anticipated that this guidance document will improve patient outcomes by:

1.4.1 Ensuring patients who meet the criteria are referred appropriately

1.4.2 Ensuring patients are reviewed in a safe and guideline driven way

1.4.3 Enhancing the treatment and management options available during the COVID 19 pandemic

1.4.4 Providing opportunities to improve patient education on their condition and treatments

1.4.5 Potentially reducing specialist outpatient attendance, hospital admissions, attendance at OOHs services, ED's and GP visits.

1.4.6 This guidance document is underpinned by evidence-based international and national guidelines/bundles of care identified within the NCP- COPD Model of Care[7] and the Asthma model of care once pulished. It is anticipated that this model will provide clear information on how services can continue through the COVID 19 pandemic. It can be adapted, reviewed and evaluated locally for compliance.

### *1.5 PPPG Development Group*

See Appendix II for Membership of the PPPG Development Group Template.
See Appendix III for PPPG Conflict of Interest Declaration Form Template.

### 1.6 PPPG Governance Group

See Appendix IV for Membership of the Approval Governance Group.

### 1.7 Supporting Evidence

This integrated service is underpinned by evidence-based guidelines/bundles of care identified within the NCP- COPD and Asthma Models of Care.

1.7.1 An Bord Altranais (2007) Guidance to Nurses and Midwives on Medication Management

1.7.2 HSE Spirometry Performance and Analysis by Clinical Nurse Specialist (CNSp) Respiratory- Integrated Care Guideline 2016

1.7.3 HSE, Health Surveillance Centre (2020) Interim Guidance for HCP in relation to the management of individuals which suspected COVID-19 infection presenting to the community health care setting other than general practice.

1.7.4 HSE Interim Guidance on Infection Prevention and Control Practice for PHN service during COVID-19 CHO Midlands June 2020

1.7.5 HSPC guidance Donning and Doffing of PPE

1.7.6 HSCP algorithm: COVID-19 Telephone assessment and testing pathway for patients who phone general practice and healthcare settings other than receiving hospitals

1.7.7 https://irishthoracicsociety.com/wp-content/uploads/2020/03/Guideline-on-lung-function-testing-V3210520.pdf

1.7.8 https://www.atsjournals.org/doi/full/10.1164/rccm.201908-1590ST

1.7.9 https://goldcopd.org/gold-covid-19-guidance/

1.7.10 National Treasury Management Agency States Claims Agency – Risk advisory Notice –Providing Telehealth: Virtual Sessions

1.7.11 Nursing and Midwifery Board of Ireland (2014), The Code of Professional Conduct and Ethics for Registered Nurses and Midwives

1.7.12 Nursing and Midwifery Board of Ireland (2015) Scope of Nursing and Midwifery Practice Framework

1.7.13 Nursing and Midwifery Board of Ireland (2015) Recording Clinical Practice Professional Guidance

1.7.14 Standardisation of spirometry ATS/ERS task Force: standardization of lung function testing ERJ 2005; 26:319-338

### 1.8 Glossary of Terms

- AGP: Aerosol generating procedure
- ANP: Advanced Nurse Practitioner
- cANP: Candidate Advanced Nurse Practitioner
- COPD: Chronic Obstructive Pulmonary Disease
- CNSp: Clinical Nurse Specialist
- DON: Director of Nursing
- DPHN: Director of Public Health Nursing
- ERS: European Respiratory Society
- GINA: Global Strategy for Asthma Management and Prevention
- GOLD: Global Initiative for Chronic Obstructive Lung Disease Guidelines
- ICMSS: Irish Institute of Clinical Measurement Science
- ITS: Irish Thoracic Society
- NCP: National clinical Programme
- NMBI: Nursing and Midwifery Board of Ireland
- GP: General Practitioner
- PN: Practice Nurse
- PHN: Public Health Nurse
- PIL: Patient information leaflet
- PPE: Personnel protective equipment
- RIC: Respiratory Integrated Care

## 2.0 DEVELOPMENT OF PPPG

**2.1** This guideline was devised due to awareness of changing practices in the HSE due to the Covid 19 pandemic and the need to adjust the nurse led RIC services accordingly.

**2.2** For the purposes of drafting a national policy existing RIC nurses came together to devise a national guideline on how nurse led clinics can proceed during the Covid 19 pandemic.

**2.3** The information gathered and reviewed resulted in the devising of this guideline document and associated documents.

**2.4** The PPPG development group examined legislation along with current Irish and International practices to ascertain a viable structure to clinics that would work within current HSE structures.

**2.5** A final draft of the guideline was circulated to members of the National Clinical Programme - Respiratory for final consultation before being approved.

## 3.0 GOVERNANCE AND APPROVAL

**3.1** This document was developed by the Respiratory Integrated Care Network (RICN) CNSp group with the support/approval of the NCP Respiratory. Local governance and approval structures are in place to adapt and approve all PPPGs at a local level

**3.2** The final document is submitted to the National Clinical Programme – Respiratory. Once approved the final version is converted to a PDF document to ensure the integrity of the PPPG. A word version of the guidance document and appendices will be made available to all service who require it for local adaptation.

## 4.0 COMMUNICATION AND DISSEMINATION

**4.1** The programme manager and/or nurse planner for National Clinical Programme – Respiratory will disseminate to relevant services and professional bodies.

## 5.0 IMPLEMENTATION

**5.1** This document will be available for each CHO RIC service.

**5.2** Resources required: No additional resources required. Procedure can be implemented and operated within existing resources.

**5.3** Training: Information required locally to brief relevant staff on this new procedure.

### 5.4 Specific roles and responsibilities:

#### 5.4.1 Respiratory Consultant

The Respiratory Consultant will provide overall clinical governance and respiratory expertise to the RIC service. They will maintain clinical responsibility for the RIC nursing team, provide support and will be available to discuss patient care. The Respiratory Consultant will oversee the outcomes process and service evaluation.

#### 5.4.2 General Practitioner

The GP has overall clinical responsibility for the patients referred to the RIC service. They will provide support and expertise for the RIC nurse and be available to discuss patient care.

#### 5.4.3 Director of Public Health Nursing/ Assistant Director of Public Health Nursing:

- The nurse's professional reporting relationship is with Public Health Nursing management
- Ensures that each nurse working in this service has read and understood this guideline and signed the 'Policy/Guideline read and understood sheet'
- Ensures that work practices are in line with this guideline and that records of staff attending training are maintained
- Discusses the implementation of this guideline with all nursing staff
- Monitors resources within their network, escalating any concerns to the DPHN
- Escalates identified risks to the DPHN
- Arrange prompt provision of PPE and access to alcohol hand rub when required

#### 5.4.4 Respiratory Integrated Care Nurse to:

- Read and sign the 'Policy/Guideline read and understood sheet'
- Undertake specialist and mandatory training as required
- Identify gaps in service provision
- To utilise the appropriate PPE as clinically indicated based on the latest HPSC 2020 recommendations

**5.4.5** Local Governance Groups for chronic disease or respiratory will be responsible for ensuring relevant staff are familiar with and following this guideline.

**5.4.6** The PPPG development group chair will ensure this guideline is disseminated to all relevant staff working within RIC.

## 6.0 MONITORING, AUDIT AND EVALUATION

**6.1** **Monitoring:** Each RIC service should implement a systematic process of gathering information and tracking over time to achieve the objectives within this procedure.

**6.2** **Audit:** Each RIC service should audit compliance with this procedure at least annually.

Each RIC service can assess to what degree they comply with the statements held within this PPPG. It is intended that this audit will provide each area with baseline information through which they can identify areas which require improvements.

**6.3** **Evaluation**: Each RIC service will define a mechanism to measure how access has improved for service users who require the service of respiratory integrated care

## 7.0 REVISION / UPDATE

**7.1** This procedure should be reviewed three years from date of issue.

**7.2** In the event of new supporting evidence identified by findings from audit and evaluation, scope of practice changes or advances in technology or research the PPPG development group will review the new evidence and amend and update as necessary.

## 8.0 REFERENCES


1. https://healthservice.hse.ie/staff/coronavirus/working-from-home/virtual-health/virtual-health.html

2. National Respiratory COPD Framework (Draft 2008). Irish Thoracic Society. Health Service Executive. Irish College General Practitioners

3. Health Service Executive. (2011). COPD Outreach Programme . Model of Care. National COPD quality in Clinical Programme.

4. National Medicines Information Centre (2013).Chronic Obstructive Pulmonary Disease. Vol. 19. No. 4.

5. ICGP Quality in Practice Committee (2009). Management of Chronic Obstructive Disease in General Practice..Irish College of General Practitioners.

6. Respiratory Health of the Nation (2018) Irish Thoracic Society. https://irishthoracicsociety.com/wp-content/uploads/2018/12/RESP-Health-LATEST19.12.pdf

7. https://www.hse.ie/eng/about/who/cspd/ncps/copd/moc/end-to-end-copd-model-of-care-december-2019.pdf

## Appendix I:

## Signature Sheet

*I have read, understand and agree to adhere to this Policy, Procedure, Protocol or Guideline:*

| Print Name | Signature | Area of Work | Date |
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## Appendix II:

## Membership of the PPPG Development Group (Template)

Please list all members of the development group (and title) involved in the development of the document.

| | |
|---|---|
| Cherry Wynne | Clinical Nurse Specialist – Respiratory Integrated Care. CHO 9 |
| Johanna Callaghan | Clinical Nurse Specialist – Respiratory Integrated Care. CHO 9 |
| Niki Byrne | Clinical Nurse Specialist – Respiratory Integrated Care. Galway |
| Pauline Mc Fadden | Clinical Nurse Specialist – Respiratory Integrated Care. Donegal |
| Rosaleen MacUistin | Clinical Nurse Specialist – Respiratory Integrated Care. Carlow/Kilkenny |
| Rosie Hassett | Clinical Nurse Specialist – Respiratory Integrated Care. Mullingar |
| **Chairperson:** | |
| Patricia Davis | Interim Nurse Service Planner, Clinical Nurse Specialist – Respiratory Integrated Care. Wicklow |

## Appendix III: Conflict of Interest Declaration Form (Template)


**CONFLICT OF INTEREST DECLARATION**

This must be completed by each member of the PPPG Development Group as applicable

**Title of PPPG being considered:**

_____

**Please circle the statement that relates to you**

**1. I declare that I DO NOT have any conflicts of interest.**

**2. I declare that I DO have a conflict of interest.**

**Details of conflict (Please refer to specific PPPG)**

_____
_____
_____
_____
_____

**(Append additional pages to this statement if required)**

**Signature**

**Printed name**

**Registration number (if applicable)**

**Date**

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that committee members act in the best interests of the committee. The information provided will not be used for any other purpose.

A person who is covered by this PPPG is required to furnish a statement, in writing, of:

(i) The interests of the person, and

(ii) The interests, of which the person has actual knowledge, of his or her spouse or civil partner or a child of the person or of his or her spouse which could materially influence the person in, or in relation to, the performance of the person's official functions by reason of the fact that such performance could so affect those interests as to confer on, or withhold from, the person, or the spouse or civil partner or child, a substantial benefit.

**Appendix IV:**

**Membership of the Approval Governance Group (Template)**

Please list all members of the relevant approval governance group (and title) who have final approval of the PPPG document.

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|---|---|
| Type Name here<br>Type Title here | Signature: _____<br>Date: _____ |
| Type Name here<br>Type Title here | Signature: _____<br>Date: _____ |
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| **Chairperson:**<br>Type Name here<br>Type Title here | <br>Signature: _____<br>Date: _____ |