7.22 Transforming referral pathways for Respiratory Patients in the Community.

Daphne Masterson [1], Niamh Julian [1], Sinéad Delahunty [1]

[1]Respiratory Integrated Care, South Tipperary Integrated Care Programme for Chronic Diseases

Background: Referral pathways for symptomatic respiratory patients were traditionally through hospital systems and subsequently to specialist nurses and physiotherapists. This joint Advanced Nurse Practitioner (ANP)/Physiotherapy pilot project accepts direct referrals from two General Practitioner (GP) practices. The absence of a Respiratory Consultant led to this pilot, which is consistent with the Integrated Care Programme for Chronic Disease (ICPCD) model of care.

Methods: Inclusion and exclusion criteria were developed. Clinical governance remains with the GP, with a Respiratory Consultant providing remote support. Meetings with the GP practices to discuss and establish inter-professional communication and referral systems. A standard operating procedure was developed and approved by stakeholders.

Results: Review occurs within four-weeks. Average distance to clinic is 4.5 kilometres. To date, 8% (n=2) are confirmed as no respiratory disease; 20%(n=5) asthma; 56%(n=14) COPD and 16%(n=4) unclear diagnosis and need further evaluation. Optimisation with education, self-management strategies and multi-disciplinary team referrals.

Conclusions: This interdisciplinary project demonstrates that referral to Community Respiratory teams is effective when delivering patient centred care locally and improves the patients overall experience. Using interdisciplinary collaborative teamwork, incorporating holistic assessment, advanced decision-making and optimisation of pharmacological and non-pharmacological interventions as appropriate improves overall outcomes, reduces symptom burden, and decreases unscheduled care.

Keywords: Integrated care, COPD, GP referrals

Disclosures. The authors declare that they have no conflict of interest.