Patricia's story

The challenge

Having developed what was thought to be a lung infection, Patricia found that she was having to visit the doctors nearly every other day, and required specialist appointments quite often. Ultimately, it was identified that Patricia had Chronic Obstructive Pulmonary Disease (COPD).

In 2014, Patricia's lung specialist recommended the Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) program to help track her health at home and avoid hospitalisation.

What we did

South Western Sydney Local Health District (SWS LHD) are the first point of patient identification.

The Telemonitoring Clinical Co-ordinator identifies patients that they think will be suitable for the program.

They do the initial home visit and talk to the patients about the program. The Clinical Coordinator engages with the patient's GP to establish the appropriate telemonitoring plan for the patient.

A referral and telemonitoring care plan is then sent to Tunstall and this is when we begin the enrolment and monitoring of the patient.

While the Tunstall Registered Nurses are monitoring the patients they work with SWS LHD as part of the multidisciplinary team. The Tunstall nurses can escalate any needs the patient has, such as requests for home help, additional education and reviews of monitoring.

Tunstall relies on the strong relationship between SWS LHD, the patient GP and ourselves to ensure the patient receives the care that enables them to be proactive with their own health management.

The COPD and CHF program helps people to understand and manage their health, all from their own home. With support from a remote clinical care team, people can measure their vital signs and wellbeing over time, with the knowledge that, should their vital signs fall outside of set parameters, their care team will review and intervene as necessary.

As part of the program, Patricia was provided a Connected Health kit, including a tablet and Bluetooth-enabled health peripherals.

> "It's like having a doctor at home. I can always rely on the nursing team for support"

Patricia

COPD and CHF participant

Patricia began measuring her vital signs daily, with her care team reviewing the data to help identify potential triggers and issues, and assist Patricia to improve her health.

Along with regular blood pressure, heart rate and weight checks, the clinical team also paid special attention to her oxygen levels and lung volumes. Additionally, questions were asked of Patricia to assess her general wellbeing, including:

- Breathing worse?
- Ankles swollen
- Chest pain?
- Cough?
- Reliever?
- Any other symptoms?

Patricia had alert limits set for vitals which are tailored to her 'normal' levels. If the Tunstall clinical team noticed anything out-of-range, or if Patricia answered yes to some/all of the health interview questions, a member of Tunstall's clinical team would ring her to chat about what is going on for her.

This chat usually involved asking the above questions again, and also others such as "Are you more short of breath than normal? Are you using your oxygen? Are you mobilising more today? Are you concerned? Have you taken your reliever? Have you taken your medication today?". This may result in some advice to help manage her health or a recommendation for Patricia to visit her GP.

The results

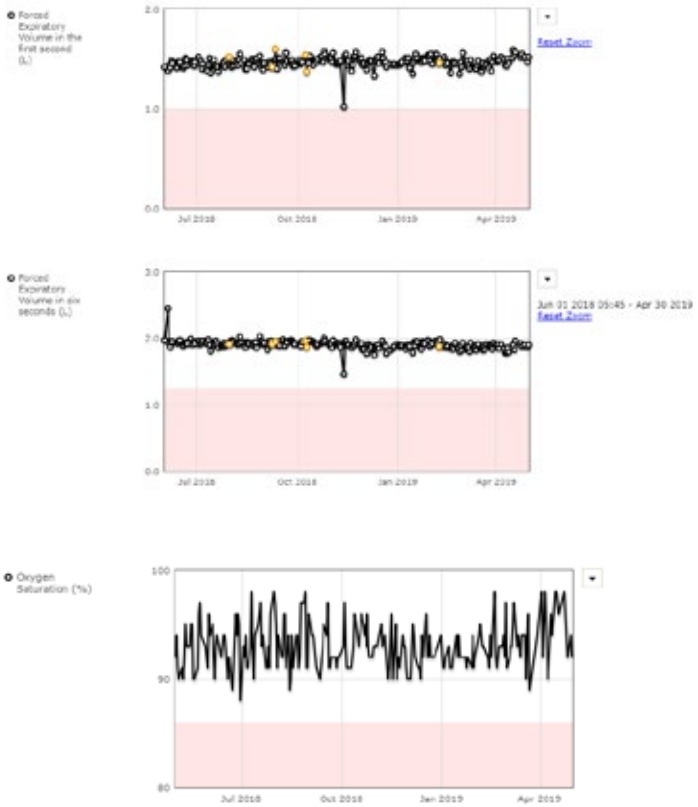
Patricia has found the COPD and CHF program and Connected Health devices extremely easy to use, and always found the support staff to be always friendly and helpful.

For Patricia, the program was "like having a doctor in the house". Her team were able to pick up on any health issues early, and helped her to avoid serious complications.

In one instance, as Patricia's blood pressure was below her target limits, her team were able to quickly identify and contacted her GP for consultation and further testing. Following this, her GP was able to review the data, adjustments to her medication were made, and she was able to return to her target blood pressure.

The program has given Patricia extra security and comfort, as she knew that she had the support of her nursing team at all times.

Since first starting the COPD and CHF program, Patricia has been able to do a lot more of what she loves, improving not only her health but her overall quality of life.



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