Tracey's story

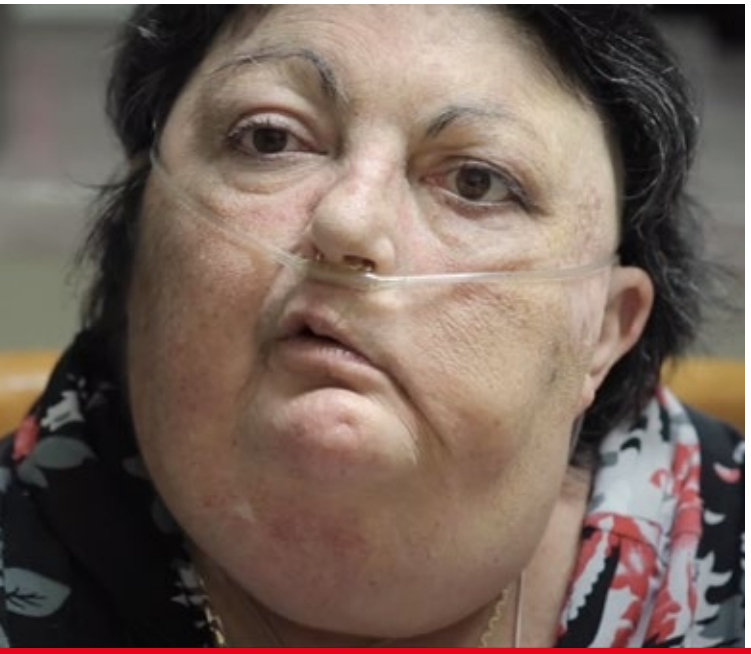
The challenge

Tracey lives with her young daughter, who relies on her for care. Tracey has also been living with Type 2 respiratory failure since 2008, which has become progressively worse.

As a result, Tracey has suffered from heart failure and fluid build up, requiring intensive care. While sedentary, her oxygen saturation was around 88-90, but as soon as she was active would drop to the low 50s. Any additional oxygen supply only seemed to exacerbate the situation, and she could not understand why.

Finally, following a particularly severe emergency and hospital admission, Tracey was referred to the Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) program.

> "The program is fantastic. It's so easy to monitor my health from home, and any issues I did have were quickly followed up by my care team."
>
> **Tracey**
>
> **COPD and CHF participant**



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 multi-disciplinary 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, Tracey was provided a Connected Health kit, including a tablet and Bluetooth-enabled health peripherals.

Tracey began measuring her vital signs daily, with her care team reviewing the data to help identify potential triggers and issues, and assist Tracey 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 Tracey to assess her general wellbeing, including:

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

Tracey 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 Tracey 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 Tracey to visit her GP.

The results

After just a few weeks of monitoring within the COPD and CHF program, Tracey found her quality of life dramatically improved.

Thanks to the ongoing measurements, and discussions with her care team, Tracey now understands her health better, and has come to recognise warning signs before they exacerbate and require hospitalisation. Tracey knows her condition well and she knows what she needs to do if her breathing is worse or if she has extra fluid in her body.

She believes that she has successfully avoided hospital at least 3 or 4 times since starting the program. She avoids going to hospital if she can, and would rather visit her local GP whom she has a good relationship with.

The clinical team will let her know if they think she needs to visit the GP, and they ask for her consent to send her trend reports to the GP so they have all the information in front of them during the visit. This is called an escalation. The clinical team also notify the Nurse that covers the Campbelltown/ Camden area as Tracey is one of their clients, and include the GP escalation for their viewing.

Tracey has found the Tunstall clinical team extremely friendly, flexible and supportive. "We're a team; working to improve my health and life overall" said Tracey.

Oxygen Saturation (%)

Weight (kg)

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8275-CS-08