

# SKILLS OF THE HEALTH TEAM INVOLVED IN OUT-OF-HOSPITAL CARE FOR PATIENTS WITH COPD

AMERICAN THORACIC SOCIETY, MEDICAL SECTION OF AMERICAN LUNG ASSOCIATION

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The individual with chronic obstructive pulmonary disease (COPD) requires long-term, multidisciplinary care because of the physiologic and psychologic problems associated with this disease. The goals of this care are to diagnose the specific problem(s) that the individual is experiencing, design an optimal management regimen, and assist both the individual and family/caretaker in learning self-care skills required to implement this regimen at home. Because of the chronic, progressive nature of COPD, provision of care must be comprehensive and continuous, with particular attention given to outpatient and home care services.

This Position Paper identifies the skills or competencies required of health team members who provide outpatient and home care services to individuals with COPD. Successful management of each individual's care requires patient and family/caretaker education as well as the cooperation of all involved disciplines, services, and support systems. Health team efforts must be concerned with total physical, mental, and social functioning of the individual and family/caretaker as well as with the medical diagnosis.

The services required by COPD patients are many and varied. Essential services have been delineated by the ALA Report on Comprehensive Care for Patients with Chronic Lung Disease (1). When providing these services, there is often no clear boundary between disciplines. The roles of health team members are not mutually exclusive, but cooperative, depending on each team member's skills and patient need. For this reason, this paper does not concern itself with the specific role of each professional group, nor with the structure within which services are given to individuals with COPD.

Establishment of the diagnosis and the medical regimen is the responsibility of the physician. Provision for the services necessary to carry out the health care regimen is the responsibility of the health care team. This team may be multidisciplinary and include a physician, pulmonary nurse specialist, respiratory therapist, physical therapist, occupational therapist, **dietician**, social worker, vocational counselor, psychiatrist or psychologist, the individual with COPD, and his or her family or caretaker. Such multidisciplinary teams are most appropriate in settings in which large

numbers of patients are seen. Care may also be provided by a health care team that consists of a physician and one additional health team member, such as a pulmonary clinical nurse specialist or a respiratory therapist. Thus, the specific responsibilities of each team member may vary, depending on the needs of the individual, the availability of members of each discipline, and the organization of resources in the community. The effectiveness of team function depends on clearly defined goals, communication between health team members, articulation of available services and facilities, and ongoing evaluation and follow-up.

The skills identified in this paper are those that assist the individual to (1) control or alleviate symptoms of respiratory dysfunction, (2) maintain or improve ability to function as independently as possible, (3) cope with progressive impairment, and (4) minimize or prevent development of complications. To facilitate movement toward these goals, the health care team providing services should include practitioners who possess the following competencies:

1. Ability to examine the patient for the diagnosis and treatment of not only COPD but all other important associated health problems, using history, physical examination, and laboratory studies such as chest roentgenogram, electrocardiogram, and blood chemistries.

2. Ability to perform and interpret spirometry and selected additional pulmonary function tests; to perform and interpret arterial blood gas studies.

3. Ability to provide continuous medical follow-up, observation, and evaluation of individuals with COPD and referral for consultation, when necessary, to specialists.

4. Ability to teach patients and families or caretakers concepts concerning the illness and treatment, including assessing their readiness to learn, determining the appropriateness of material to be taught, and evaluating their response to teaching.

5. Ability to evaluate psychosocial response to illness, to interview individuals and their families or caretakers, and to intervene and counsel individuals and their families or caretakers in those aspects of care that will assist them to cope with problems of daily living.

6. Ability to recognize need for and to teach the specific techniques, such as bronchial hygiene, breathing retraining, relaxation exercises, exercise conditioning including muscle

strength/endurance programs, and energy conservation in activities of daily living.

7. Ability to recognize the need for and to teach the skills required for use and maintenance of respiratory equipment for the support of oxygenation and ventilation and for the therapeutic administration of gases, *mists*, and *aerosols*.

8. Ability to assess nutritional status and to provide counseling regarding methods of maintaining appropriate nutritional intake.

9. Ability to assist patients to identify and use appropriate community resources, including vocational rehabilitation.

10. Ability to plan, coordinate, and evaluate care.

11. Ability to effect safe transfer for an acutely ill patient to a general hospital and to provide for immediate admission to a unit competent to care for his or her needs.

It is important that the skills and competencies included here be available to each individual and family or caretaker, and that the care provided be coordinated by one professional health practitioner. The decision as to which health professional will provide and coordinate the services should be made on the basis of who on the health team possesses the greatest number of the skills required to provide the care.

It is recognized that a comprehensive respiratory care program can result in definite benefits to the individual with COPD (2, 3). Benefits include improved quality of life, improved ability to carry out activities of daily living, and reduction in anxiety, depression, and somatic concern (2-6). Home oxygen therapy has been shown to decrease mortality of patients with hypoxemic COPD (7, 8). Cessation of smoking can result in improved pulmonary function and decreased **symptomatology** (3). If airway abnormalities are detected early, it may be possible to alter the course of COPD (9). There are also limitations to the benefits achieved. Most studies have not documented increased survival or improvement in pulmonary function and there are limitations to the benefits COPD patients can achieve through exercise reconditioning (2, 10). Problems include failure of individuals to stop smoking permanently, the tendency to seek care late in the disease, and unevenness in our capacity to deliver quality outpatient and home care services. Future ef-

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forts need to be directed toward identifying behavioral strategies that motivate individuals to seek earlier treatment and to follow preventive advice, and toward improving the distribution and delivery of quality outpatient and home care.

This paper was prepared by the Ad Hoc Committee of the Section on Nursing, Scientific Assembly of Clinical Problems. The Committee members are:

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### References

1. ALA Report on Comprehensive Care for Patients with Chronic Lung Disease, 1975.
2. Hodgkin JE, Farrell MJ, Gibson SR, *et al.* Pulmonary rehabilitation: official ATS Statement. *Am Rev Respir Dis* 1981; **124**:663-6.
3. Hodgkin JE, ed. Chronic obstructive pulmonary disease: current concepts in diagnosis and comprehensive care. Park Ridge IL: American College of Chest Physicians, 1979.
4. Bebout DE, Hodgkin JE, Zorn EG, Yee AR, Sammer EA. Clinical and physiological outcomes of a university-hospital based pulmonary rehabilitation program. *Respir Care* 1983; **28**:1468-73.
5. Moser KM, Bokinsky GE, Savage RT, Archibald CJ, Hanson PR. Physiological and functional effects of a comprehensive rehabilitation program upon patients with chronic obstructive pulmonary disease. *Arch Intern Med* 1980; **140**:1596-601.
6. Sahn SA, Petty TL. Results of a comprehensive rehabilitation program for severe COPD. In: Petty TL, ed. Chronic obstructive pulmonary disease. Vol. 9: Lung biology in health and disease. New York: Marcel Dekker, Inc., 1978; 203-20.
7. Nocturnal Oxygen Therapy Trial Group. Continuous or nocturnal oxygen therapy in hypoxemic chronic obstructive lung disease. *Ann Intern Med* 1980; **93**:391-8.
8. Medical Records Council Working Party. Long term domiciliary oxygen therapy in hypoxic cor pulmonale complicating chronic bronchitis and emphysema. *Lancet* 1981; **1**:681-6.
9. Fletcher C, Peto R, Tinker C, Speizer FE. The natural history of chronic bronchitis and emphysema. New York: Oxford University Press, 1976.
10. Hughes RL, Davidson R. Limitations of exercise reconditioning in COLD. *Chest* 1983; **83**:241-7.

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