The reality for most clinicians is that improving care for COPD patients can appear too huge a task to address. Implementation of a complex series of improvement interventions requires whole organisation change. The answer may lie with a simple quality improvement tool designed by clinicians for clinicians: the clinical care bundle. Developed originally in the USA to combat variance in mortality from across intensive care units, the bundle consists of a small number of high impact evidence based interventions known to make a difference to patient outcomes. The bundle forms the core of a management protocol for the patient with that condition and implementation of each element is recorded on a proforma. When enacted together the resulting clinical benefit is much greater than the sum effect of the individual interventions if used at different times.
times, or if partially implemented. The deployment of a ventilated patient care bundle across the USA brought about a massive reduction in ICU mortality and variation in outcomes across centres. This success led to the creation of others related to specific conditions or patient groups. More recently COPD discharge bundles have been researched demonstrating beneficial outcomes not just to patients but to the job satisfaction of staff too. A quality improvement sub set from the European COPD Audit participants has since met in London and Barcelona to consider the development of European Admission and Discharge bundles for COPD. Such a bundle might include: all patients to have an arterial blood gas within 1 hour of presentation, those with acidosis having a decision about ventilatory support made within 2 h, patients managed using controlled oxygen if hypoxic, and a chest radiograph taken and reported within 2 h of admission. All are simple measures which are recommended by the guidelines but demonstrated not to be applied in a significant proportion of patients in the European Audit. The benefits of the bundle is it provides aims for good care that are clear to everyone, that are possible to achieve, condenses a guideline of hundreds of pages to a few key processes, and which when documented provides a simple ongoing audit tool.

The evidence base for this approach to COPD quality of care improvement requires strengthening through further research evaluation. We spend a vast resource each year on research into COPD management to build an effective evidence base from which to derive guidelines, but what value does that have if that care is not implemented in real life clinical practice? The challenge for the respiratory community is to turn the data into better care for patients. It is possible but it requires a resource and a coordinated effort. We have yet to see evidence of either implemented across Europe.

References