

Innovative Strategies to Optimize the Demand on Pulmonary Rehabilitation Service

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National Context (HSE) All COPD patients should be offered effective/timely/accessible MDT pulmonary rehabilitation

Purpose Of Service Individualized Multidisciplinary Programme to improve functional status and foster self-efficacy

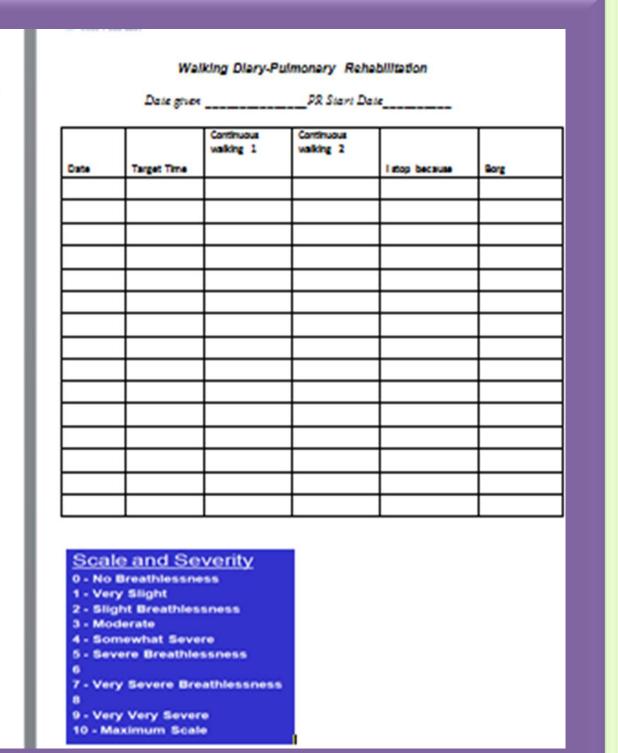
Scope of Pulmonary Rehabilitation

Local Context Manage demand Waiting times > Target appropriate people(needy)

Quality & Innovation



Time	Intensity/Pace	Borg
minutes	Walk at a comfortable pace to warm up	3-4
Minutes	Increase your speed or Inciline (or both) a few Increments until you're working harder than your warm up pace. You should feel you're working, but you should be able to carry on a conversation. This is your baseline pace	5
Minutes	Increase your speed and/or Incline once again until you're working alightly harder than baseline	5
Minutes	Decrease speed incline back to baseline	3
Minutes	Increase your speed and/or Incline once again until you're working alightly harder than baseline	5
Minutes	Decrease speed incline back to a comfortable level to cool down	4



Local PR Protocols

HIGH	MEDIUM	LOW
 Severe to very severe airflow obstruction/Diffusion capacity >= 4 chest infections per year MRCD=4 Poor Exercises Capacity (able to walk <= 200 m) /Physical activity (increased sitting >4hrs per day) High BMI >= 30 Low BMI <= 18 Rehabilitation for ventilated patients in HDU New or acute patients on NIPPV Review for sleep studies and oxygen therapy Post operative Rehab 	 Moderate airflow obstruction/Diffusion capacity >=3 chest infection per year MRCD=3 Moderate Exercise Capacity(able to walk >=250 m)/Physical activity (sitting <3 hrs per day) High BMI>=25 Low BMI<=20 Rehabilitation in HDU or following HDU stay Respiratory outpatients Rehab support for secretion clearance with adjuncts. Patients needing assessment prior to discharge Pre-operative Rehab 	 Mild airflow obstruction/Diffusion capacity or no definitive diagnosis >=2 Chest infection per year MRCD>=2 Normal BMI Good exercise capacity (able to walk >=400m) / Physical activity(sitting <2hrs day) Re-education on secretion clearance. Maintenance Exercise. Referrals with insufficient information regarding patient clinical conditions.

If a patient lives >30km distance from Rehab centre / lack of transport /clinically unstable would qualify för

Content of PR

Supervised Exercise Training Duration: 8weeks Dosage: 30 mins× 3 Sessions/ week Format of delivery: Non-Linear periodized training. **Components of Training: Aerobic/Strength/Flexibility/Breathing** train

Education Duration:8 weeks Dosage: 60 mins×2 Session/week Format of delivery: Didactic method (Presentations) **Topics: COPD and IPF** Role of pulmonary rehabilitation Role of oxygen in exercise training **Effective use of inhalers and nebulizer** Importance of healthy diet **Methods of energy conservation Outline on palliative care**

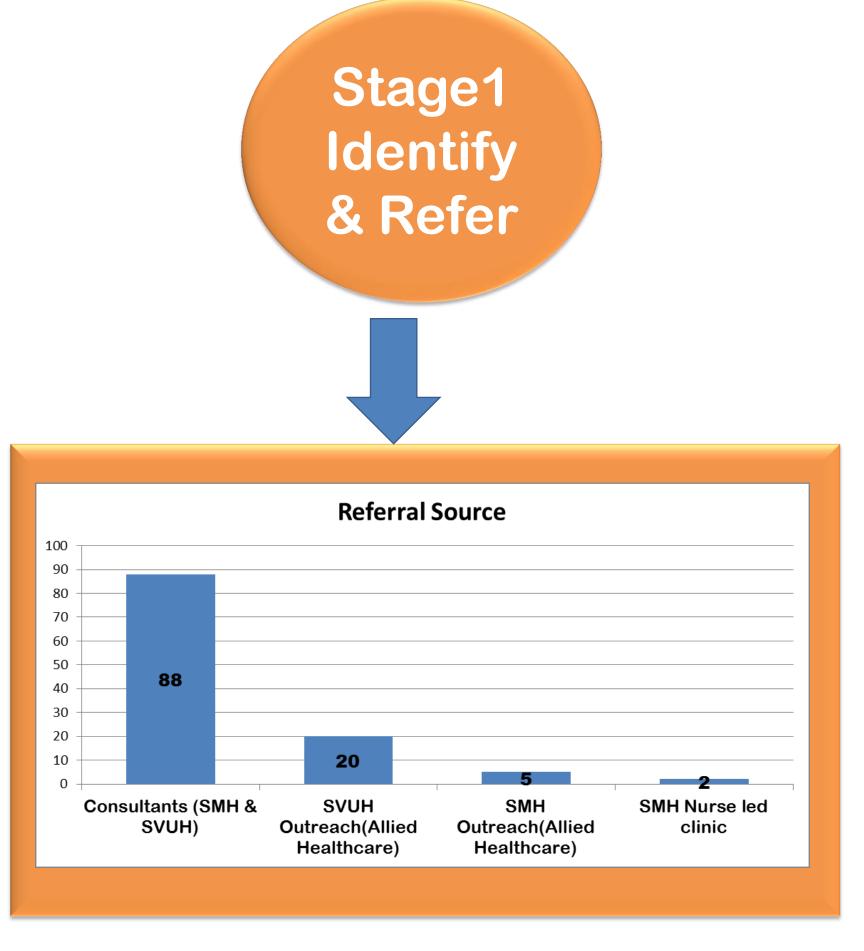
PR Service Delivery in 2014

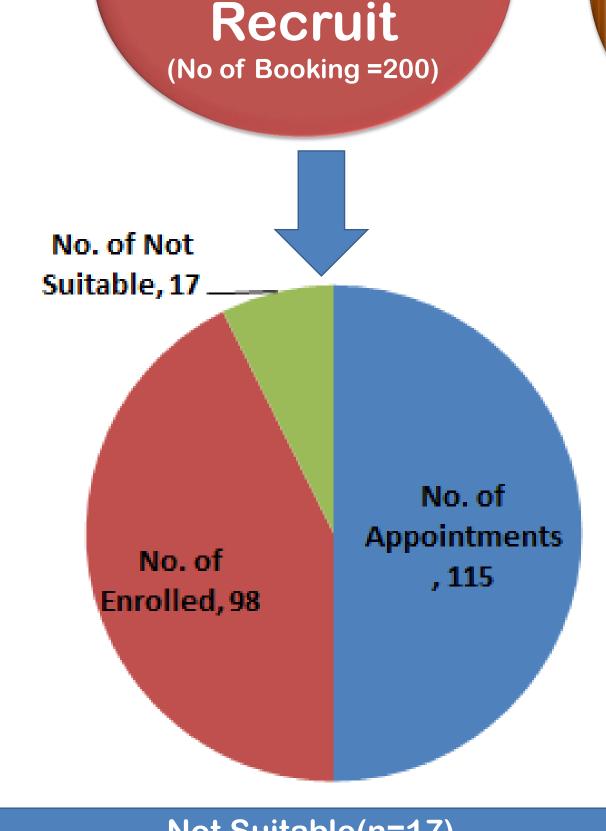
Stage3

Assess

(N=115)

inpatient pulmonary Rehabilitation for 2-3 weeks.





Stage 2

Manage &

- Not Suitable(n=17) Unstable Chest infection.
- Shoulder joint fracture
- Severe panic attacks
- Ankle tendonitis
- No relevant respiratory issues Patient denied PR due to
- Lack information and consent to PR prior to referral.
 - Lack of transport
 - Bowel disease
 - Very weak and frail Lack of motivation

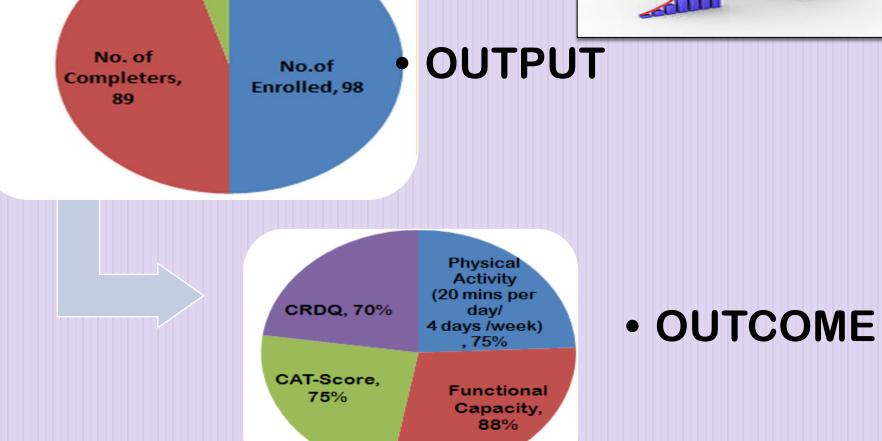
Non – completers(n=9) Cancer (Newly diagnosed) Communte to PR Venue-distance and time Home programme Lack of motivation

Deliver Review/ PR Discharge/ (N=98)Audit

Stage 4

No. of Non-

Completers, 9



Stage 5

 IMPACT Jarra Maria Mayra Juria Seria Moura

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