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Attendance

Session 3 - Thursday 3rd Dec

Advanced Practice in Pulmonary Rehabilitation

Participant	Message	Likes	State
Host	Please submit your questions here		1 Archive
Host	Welcome to the Advanced Practice in Pulmonary Rehabilitation		0 Archive
Anonymous	Is it possible to download the slides from the pre course videos?		1 Archive
Anonymous	Claire's sound is not great could she use a head set instead		0 Archive
Anonymous	We are doing face to face rehab in Leicester		3 Archive
Host	Thanks for your question. The recordings (pre-recorded and live presentations) will be available for four weeks after the end of the course, but are not available for download.		0 Archive
Anonymous	Is the SPACE manual available outside of UK? How to obtain? Cost ?		0 Archive
Anonymous	thank you Dr Mann - Do you think there is evidence that people are more able to use tech over the pandemic time?		0 Archive
Anonymous	Is training needed to administer SPACE MANUAL		0 Archive
Anonymous	Will the slides in raw form be made available? ie without recordings?		2 Archive
Anonymous	How is training progressed In these non digital Homebased models		1 Archive
Anonymous	Thank you Dr Mann. I think baseline MRC dyspnoea scale will also effect people's preference to attend these sessions and the bias that you mentioned. Do you agree? Was this different in the arms in studies shown by yourself?		0 Archive

Host	The slides won't be available in raw format, thanks for your question.	0 Archive
Anonymous	What do you think about home based PR where the COPD population is from poor socioeconomic demographic, non English speaking and there is poor engagement with home based PR	0 Archive
Anonymous	G	0 Archive
Anonymous	Any evidence about education competence improvements in home based vs centre based care?	0 Archive
Anonymous	Given this evidence would the ultimate ideal be to offer digital, non-digital and centre-based PRG?	2 Archive
Anonymous	What do you feel the best way to check compliance and how was this done in these studies?	0 Archive
Host	Thanks for all of the questions. Sorry that we weren't able to address all of them. If your question hasn't been answered, we will include it in the discussion section of session 4.	0 Archive
Anonymous	Are there any supports in the UK to help people engage in tech hardware or IT education to help support them?	0 Archive
Anonymous	What exactly was the tele rehab intervention in the Hansen study ? And again re SPACE - Can SPACE online or manual Version be used outside of UK? What is the cost ?	1 Archive
Anonymous	It would be helpful if the national audit collected data for alternative exercise test such as sit to stand	2 Archive
Anonymous	Email spaceforcopd@uhl-tr.nhs.uk for space manual or web enquiries	0 Archive
Anonymous	We added a falls risk assessment too	0 Archive
Anonymous	Home hazard assessment, emergency access to property if exercising alone	0 Archive

Anonymous	Safety - peripheral neuropathy, balance and falls hx. Dog out of room while exercising, NOK info for digital programmes, recognising deteriorating sx such as light headed, chest pain and to escalate as appropriate.	0 Archive
Anonymous	We discussed safety checklists and the ABC scale (activity, balance and confidence) that can be completed over the phone	0 Archive
Anonymous	Safety- we also thought someone needed to make sure Toby didn't get in the way	0 Archive
Anonymous	We discussed safety checklists and the ABC scale (activity, balance and confidence) that can be completed over the phone	0 Archive
Anonymous	Using the BLF exercise handbook. Patients can record on the exercise diary and the walking diary.	1 Archive
Anonymous	Use space for virtual as evidence based, family to assist supervision, consider outside space and patient willingness to access outdoor environment	1 Archive
Anonymous	The sound quality from Claire Nolan is often rather unclear. Other speakers seem to be ok.	0 Archive
Host	Content from Zoom chat	0 Archive
Host	Content from zoom chat: Question 1: keeping Betty safe: we also mentioned balance assessments (Berg, FESI, Activity Specific Balance Scale), looking at the experience of staff carrying out the assessment, Send out a booklet of the exercise, also an option of setting the patient up with the technology in a face to face manner	0 Archive
Host	Content from Zoom chat: Amazing innovative and imaginative community solutions: Bottles with water or sand, council supported tablets, supportive volunteer coaches, and using the showground for PR!	0 Archive
Anonymous	With regards to PPE when exercise testing - would you change it between every patient? As we sometimes have an overlap of patients in our gym in a socially distanced manner and may go between them	2 Archive

Anonymous	I would need to change PPE between patients and clean equipment in between	0 Archive
Host	Your infection control department will be able to provide specific guidance on PPE requirements in your institution. Typically, you should change gloves and gown between each patient and wash your hands and any equipment used.	1 Archive
Anonymous	What tool is Emma referring to please? It cut out	0 Archive
Anonymous	This is just a general question regarding the PR audit data sets. As many GP practices aren't doing spirometry at present on our referrals there is old- over 1 year old spirometry. Should we not report this on the data sets as it's not recent and leave this blank?	1 Archive
Anonymous	I am surprised that 4mgs was highly correlated to both 6mwt and iswt as resp patients (even those with PR improvements) are always limited by speed, especially over longer periods ... Can you explain why you think this is so?	1 Archive
Anonymous	I am surprised that 4mgs was highly correlated to both 6mwt and iswt as resp patients (even those with PR improvements) are always limited by speed, especially over longer periods ... Can you explain why you think this is so?	0 Archive
Anonymous	MUST score is possible over the phone if patient has own scales. Important to ascertain BMI weight loss etc.	0 Archive
Anonymous	Could be not get the walk test from the the ambulatory o2assessment and perhaps prescribe a walking program based on that	0 Archive
Host	The EASY tool - I'll ask her to write it in the chat.	0 Archive
Anonymous	Re singing for breathing/singing for lung health: https://www.blf.org.uk/support-in-your-area-details/singing-group	0 Archive
Host	I would imagine that 1-year old spirometry may be out of date and so not reflective of the current lung function.	1 Archive

Host	I would imagine that 1-year old spirometry may be out of date and so not reflective of the current lung function.	0 Archive
Host	4MGS is highly correlated with ISW and 6MWT as both are walking-based measures and so similar domains are being measured. This data is reflected in COPD, IPF and elders.	2 Archive
Anonymous	Has anyone trialled conference calls for the education for patients doing self management in place of live digital sessions?	0 Archive
Host	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3717896/ T Link for EASY tool	1 Archive
Anonymous	In the Ward study did pts watch DVD at home or was it shown at the PR centre ?	0 Archive
Anonymous	How can we measure health literacy?	1 Archive
Anonymous	Peer assessing education sessions would be helpful. Any suggested templates for this? To not be taken personally	0 Archive
Anonymous	Could you recommend a motivational interviewing course or resources?	0 Archive
Anonymous	In Ireland MECC "make every contact count"	1 Archive
Anonymous	Digital PR education difficult. Many pts would be unable to use chat function in my experience. And if mics are muted you are talking AT patients .	0 Archive
Anonymous	Virtual is not ideally placed as a platform for discussion in PR Ed	0 Archive
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Anonymous	Motivational interviewing training by Pip Mason Consultancy. https://pipmason.com/remote-learning/	0 Published
Anonymous	Does anyone have any useful resources or good ideas for cough suppression if not wanting a patient to cough too soon in ACBT	0 Reviewed
Anonymous	Can Iannis mute the sound effects everytime he clicks the screen...	0 Published
Host	Sorry, but that's the sound of his finger tapping the keyboard to move to the next slide	0 Published

Anonymous	How comparable is the 'low intensity' aspect of exercise with 'active recovery' principles that they use in cardiac rehab?	0 Published
Anonymous	In practice, how transferrable do patients find interval training to daily functional activities in terms of pacing strategies??	0 Published
Anonymous	If we don't have bikes to do interval training in community what alternatives best work patients to mirror the results you were getting in your study?	0 Published
Anonymous	Do you think interval training would be safe to do in the home environment?	0 Published
Anonymous	Do you need more staffing for this type of training? Are bikes pre programmed ?	0 Published
Anonymous	Ho	0 Archive
Anonymous	How long does it take to administer mini BEST?	0 Published
Host	Q3: as discusses earlier I would performed a modifies endurance shuttle walk protocol alternating 1-min of walk with 1 min of rest or slow walking. In practice because of the audio sequence of the ESWT, I prefer to alternate 1-min walk with 1-min of rest	0 Published
Host	Q4: in practice lung disease patients undergo intermittent daily physical activities, so interval exercise training resembles closely the real life physical requirements	0 Published
Host	I do not reassess max workload, but increase workload every week by 5-10% of initial peak work rate: this way the training load is continuously increased throughout the training programme so as to maximise the physiological training effects	0 Published
Host	Q2: Interval training is safe to be performed at home where there is less access to exercise equipment. With intermittent exercise, there is the possibility of regular recovery periods, meaning time for oxygen saturation to recover. At home the exercise bouts should be short to avoid a great deal of physiological stress.	0 Published
Anonymous	Wonder what was Staffing required to deliver this balance intervention from beauchamp paper	0 Published

Host	the exercise to rest interval can vary; you may allow a longer recovery phase if the patients needs more time to recover his/her breathlessness. The intermittent principle also applies to resistance training; the key is to provide intense stimuli to the muscles for few seconds and then allow sufficient recovery before another bout. With resistance exercise I would allow 2 min rest intervals to recover phosphocreatine stores	0 Published
Anonymous	We do an interval training programme with our patients, but we do our resistance training exercises as part of this, alternating between aerobic and resistance exercises. Would it be better to do just aerobic as part of the interval training exercise and do the resistance training element afterwards, sticking to the specific reps and sets for strength/ endurance effects?	0 Published
Host	Q1: my experience is that once the patient learns to follow the time sequence of work and rest, then patients manage on their own. You need to have a clock on the wall for patients to follow the time sequence, unless your cycle ergometer comes with a timer.	0 Published
Host	I would focus to complete aerobic intermittent training first and then perform the resistance training element agin by adopting an intermittent approach allowing rest periods between resistance exercise bouts.	0 Published
Anonymous	How long would an assessment take for someone who has been screened as having falls risk?	0 Published
Anonymous	How long is class if balance training incorporated? So usual PR plus education plus balance training equals how long a session?	0 Published
Anonymous	Have many sites been including balance training as part of virtual PR and how can you ensure safety with this compared to F2F classes?	0 Published
Anonymous	We delivered 30mins balance training in addition to the PR class so 90mins in total.	0 Published

Anonymous	The length of an assessment including a balance assessment depends on the test selected. A simple screening test (TUG or SLS) take 5mins. A comprehensive balance assessment (mini BEST or BBS) takes 15mins aprox.	1 Published
Anonymous	In the beauchamp study a staff to patient ratio of 1:3 was used but check out the study by OHoski 2020 in Physiotherapy Canada who found 2:11 was feasible. I'll post the link on here.	0 Published
Anonymous	https://www.utpjournals.press/doi/abs/10.3138/ptc-2019-0111	0 Published
Anonymous	Mel, how do you have any suggestions on how to manage patients who are current smokers but have significant desat on 6MWT?	0 Published
Anonymous	It takes 15-20mins to administer the mini BEST	1 Published
Anonymous	Does AOT decrease dynamic hypertension. For Melanie	0 Published
Anonymous	Have you much experience with patients recovering from COVID who require AOT who might have slight-mod desat on 6MWT but overall feel they are symptomatically improving? How often should they be followed up i.e yearly or 6monthly?	0 Published
Anonymous	It is always challenging when patients referred for PR who desaturate decline amb o2 despite discussion of the rationale and trying to address the barriers. Do you have any tips to manage this?	0 Published
Anonymous	For Melanie. Can AOT DECREASE dynamic hyperinflation?	0 Published
Anonymous	Do you need all three criteria fulfilled - walk further , less breathless, better sats - to order AOT? Or just one of those criteria met and you order ?	1 Published
Anonymous	I'm afraid I don't know of any pulm rehab programs that are delivering balance training virtually. Few F2F PR programs include BT. Home-based BT is being delivered in Canada by Marla Beauchamp. I believe a F2F balance assessment is performed and a home visit is done to assess the environment. If anyone knows of any virtual or home-based BT being offered in the UK I would love to hear about it!	0 Published

Anonymous	Thanks Mel;- so if a patient drops below 80% but they don't meet criteria for AOT due to risk Ax- can you still admit them to PR?	0 Published
Anonymous	Hi there, if the first walk test is stopped at 80%. Then the walk is repeated on oxygen, how do you determine benefit as the first walk was discontinued? Thank you	0 Published
Anonymous	Hi there, if the first walk test is stopped at 80%. Then the walk is repeated on oxygen, how do you determine benefit as the first walk was discontinued? Thank you	0 Published
Anonymous	Is there any evidence for	0 Published
Anonymous	In a patient who desaturates on exertion but declines AMBOT or is not suitable, What oxygen level would you allow them to exercise to in order to keep them safe	0 Published
Anonymous	Q - In a patient who desaturates on exertion but declines AMBOT or is not suitable, What oxygen level would you allow then to exercise to in order to keep them safe A - thank you for your question. we would keep them above 80% throughout exercise testing and training. We have a form that we ask them to sign to put in their notes to state that they had declined oxygen. All cases would be discussed with our consultant lead.	0 Published
Anonymous	Q - Hi there, if the first walk test is stopped at 80%. Then the walk is repeated on oxygen, how do you determine benefit as the first walk was discontinued? Thank you. A - thank you- great question. We would essentially discount the first walk test. We would need to complete 2 ISWTs, so this would mean they would complete 3 in total (including the one that was cancelled). We are lucky as we have a long assessment time so can allow for the 30 min rest in between.	0 Published

Anonymous

Q - Thanks Mel;- so if a patient drops below 80% but they don't meet criteria for AOT due to risk Ax- can you still admit them to PR?
A - thank you. Yes. We might consider interval training to keep sats above 80%, or train them in a hospital setting where we can use our oxygen to support safe training/exercise testing.

0 Published

Anonymous

Q - Do you need all three criteria fulfilled - walk further , less breathless, better sats - to order AOT? Or just one of those criteria met and you order ?
A - thank you. we need to ensure that the oxygen we provide during the test is effective so we would want sats above 90% (otherwise we might consider what we had tested them on was ineffective). Then we would consider just change in ether breathlessness or exercise capacity as positive.

0 Published

Anonymous

Q - It is always challenging when patients referred for PR who desaturate decline amb o2 despite discussion of the rationale and trying to address the barriers. Do you have any tips to manage this?
A - thank you. Yes we find this really difficult too. I am not sure I have any tips you wouldn't have already tried. Some times we have to try a softly softly approach, by providing education and information and allowing patients time to consider these things. We encourage patients to call us to discuss things further and try and engage family members within the decision making process. It's a very tricky and emotive subject for some individuals.

0 Published

Anonymous	<p>Q- Mel, how do you have any suggestions on how to manage patients who are current smokers but have significant desat on 6MWT?</p> <p>A - we try and encourage smoking cessation - we have a great hospital team so can keep close links with their progress. We wouldn't prescribe AOT to patients currently smoking (in-line with BTS guidance and guidelines from the London clinical oxygen network) essentially though we would want to work with the patient and support them as much as we can.</p>	0 Published
Anonymous	<p>As a respiratory doctor , should we be referring patients to pulm rehab team if we think they might benefit from ambulatory oxygen assessment even if they have previously declined engaging with pulm rehab for regular training sessions?</p>	0 Published
Anonymous	<p>Q - Does AOT decrease dynamic hypertension.</p> <p>A - great question, thank you. Somfay (2001) completed a small study (n=17) gave oxygen at varying flow rates during a exercise test. They associated the improvement in dyspnea may have decreased dynamic hyperinflation. My understanding is that if AOT improves shortness of breath, thus lowering RR during exercise, this would improve or delay the onset of dynamic hyper inflation.</p>	0 Published
Anonymous	<p>Question for Mel. a patient who has EID on PR assessment attends AMb o2 assessment and improves in sats to >90% but no change in Breathlessness score or distance walked. Would you prescribe O2 for use in PR or discharge this type of patient? We find it difficult to know if they are safe to exercise in PR with no supplemental o2. Thank you.</p>	0 Published

Anonymous

Q- As a respiratory doctor , should we be referring patients to pulm rehab team if we think they might benefit from ambulatory oxygen assessment even if they have previously declined engaging with pulm rehab for regular training sessions?

A - thank you. We are always so keen for patients to be referred to PR services. It maybe that a physio team have more time to explain about the course & we will happily try and encourage patients to attend PR in some format.

You would also be welcome to refer directly for a AOT assessment. Most services are commissioned locally but would see a patient for assessment if they met criteria (some evidence they desaturate when walking even if is just across the ward/clinic room).

0 Published

Anonymous

Q - Have you much experience with patients recovering from COVID who require AOT who might have slight-mod desat on 6MWT but overall feel they are symptomatically improving? How often should they be followed up i.e yearly or 6monthly?

A - honestly, I don't (yet). I would imagine we would review more regularly (similar to patients with ILD). We tend to review 3/6/12 months depending on stability- so if you think clinically they are changing I would go for a sooner review date.

0 Published

Anonymous

Q - Question for Mel. a patient who has EID on PR assessment attends AMb o2 assessment and improves in sats to >90% but no change in Breathlessness score or distance walked. Would you prescribe O2 for use in PR or discharge this type of patient? We find it difficult to know if they are safe to exercise in PR with no supplemental o2. Thank you.

A - thank you, we wouldn't use oxygen during PR for this person. We used to, but found we were giving really mixed messages. We wanted to promote independence with exercise following our programme, but was sending a message that saturation's needed to be monitored and exercise could only take place with oxygen (which they didn't qualify for at home). We try now to be deliberately subtle about checking sats, and concentrate on patients being responsive to their own symptoms. The majority of our patients we would only check sats once post cardio exercise, though for patients who drop closer to 80% we would monitor more closely.

0 Published