ACHSM Asia-Pacific Journal of Health Management

ACHSM CONGRESS 2025

A NURSING LEADERSHIP-DRIVEN COLLABORATIVE TO IMPROVE ACUTE COPD CARE: PRACTICE LESSONS FROM TEN VICTORIAN HOSPITALS

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INTRODUCTION

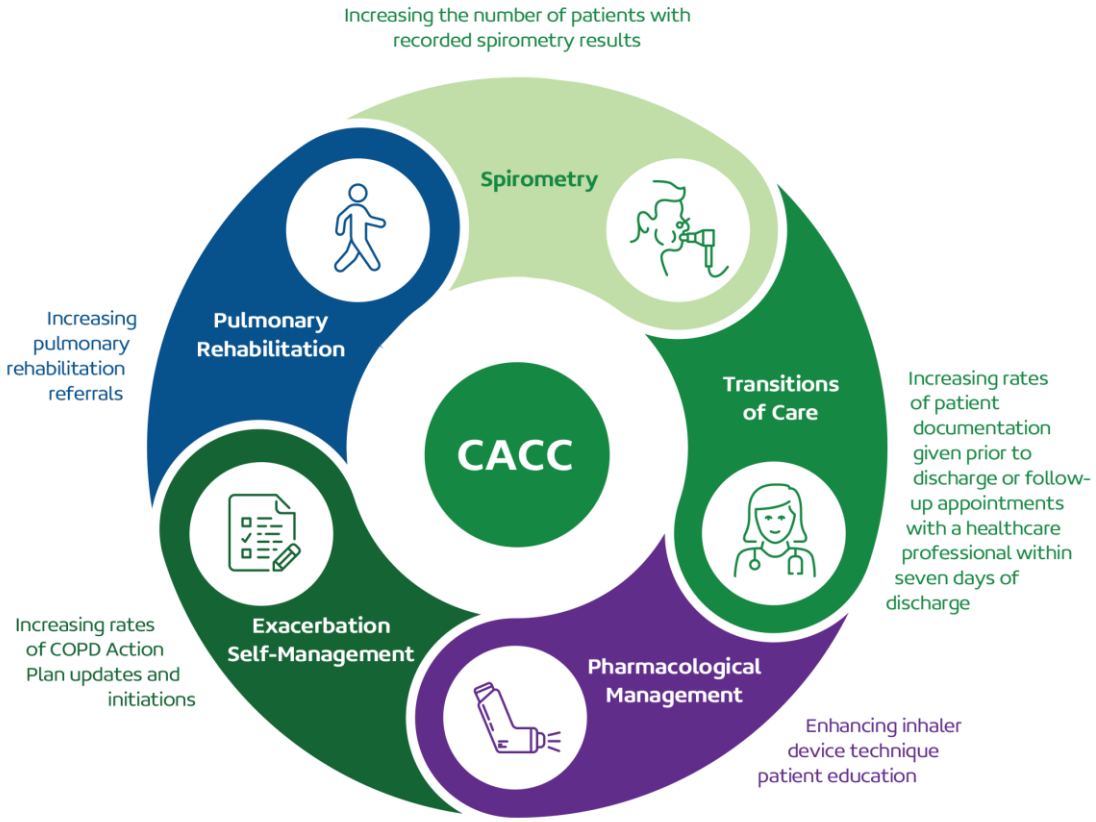
Hospitals are increasingly focused on strengthening systems and workforce capability to deliver consistent, evidence-based care for people admitted with chronic obstructive pulmonary disease (COPD) to align with the COPD Clinical Care Standard [1]. Although national guidelines exist [1, 2], many health services continue to face challenges in translating these recommendations into routine practice [3]. Persistent difficulties in operationalising standardised processes, coordinating multidisciplinary teams, and developing workforce capability to reliably implement best-practice care contributes to ongoing variation in care delivery. These challenges highlight the need for system-level reform that strengthens leadership, reduces variation, and supports sustainable redesign.

The COPD Acute Care Collaborative (CACC) Project was delivered by Lung Foundation Australia (LFA) with support from Safer Care Victoria (SCV). The collaborative was formed by a group of ten Nurse Ambassadors working in acute care across ten Victorian hospitals. Each Nurse Ambassador was supported by an Executive Sponsor from their hospital to provide organisational leadership and guidance. Nurse Ambassadors led project activity within their local sites, performing quality improvement work, identifying and testing change ideas, auditing COPD care against the five quality-of-care indicators, and engaging multidisciplinary teams. LFA provided project management, data collection monitoring, a nurse educator, evidence-based resources, training and Ambassador support. SCV partnered with LFA to provide project governance and funding and supported Ambassadors through provision of improvement science resources and education. This project formed a part of SCV's broader 100,000 Lives Program.

Five quality-of-care indicators were used to guide focus areas (Figure 1), and iterative Plan-Do-Study-Act (PDSA) cycles informed the development of a COPD Acute Care Quality Improvement Toolkit, including three practical, downloadable resources. The quality-of-care indicators were increasing: the number of referrals to pulmonary rehabilitation, rates of COPD Action Plan initiation or updating, number of patients with documented spirometry results, inhaler device technique assessment, and rates of discharge information given or a GP follow-up made within 7-days of discharge.

Asia Pacific Journal of Health Management 2025; 20(3):i5425. doi: 10.24083/apjhm.v20i3.5425

FIGURE 1. FIVE QUALITY-OF CARE INDICATORS FOR THE COPD ACUTE CARE COLLABORATIVE PROJECT



Executive leadership proved central to progress, enabling alignment with adequate resourcing, and protected time for Nurse Ambassadors to lead change. The collaborative Nurse Ambassadors performed group problem solving, supported by LFA and SCV who strengthened workforce capability through coaching and learning workshops and evidence-based change management tools. PDSA cycles helped adapt interventions to local context and supported incremental staff behaviour and practice change. Challenges included data access, competing workload demands, and differing levels of organisational readiness.

The three toolkit resources (Figures 3, 4, & 5) offer transferable, scalable solutions to support ongoing improvement in the acute care of COPD across Australia. This initiative was undertaken as a quality improvement activity and did not require ethics approval.

PROBLEM / ISSUES

There is growing recognition among hospitals that system-level approaches are essential to improve acute care for chronic conditions. The burden of COPD, one of Australia's leading preventable causes of hospitalisation (4), demonstrates why these approaches are needed. Variation in care practices across acute health services reflects gaps in process standardisation, multidisciplinary coordination, and capability to sustain quality improvement. Managers are challenged to translate evidence and national standards into operational workflows while simultaneously addressing competing priorities, staff turnover, and limited access to reliable data.

Across the ten participating hospitals, baseline consultation revealed inconsistent admission and discharge processes for COPD, potential to optimise multidisciplinary integration, and variable confidence among frontline staff in using improvement science. These capability gaps, together with system fragmentation indicate the need for a structured, leadership-driven redesign initiative.

INTERVENTION / APPROACHES

LEADERSHIP-DRIVEN MODEL

Each participating site nominated an Executive Sponsor to act as a senior change champion and a Nurse Ambassador to lead local practice change. This pairing created a vertical leadership structure that aimed to support organisational alignment while empowering frontline workers to have ownership of the change initiative. LFA approached the project by holding a mix of face-to-face orientation workshops, three learning workshops, a summative event and fortnightly drop-in sessions with guest-speakers aligned to topics requested by Nurse Ambassadors. An expert reference panel consisting of expert COPD clinicians and stakeholders helped to design the project, timeline and the five quality-of-care indicators. This ensured the project strongly reflected the current evidence that supports reduction in avoidable readmissions, to achieve better care for people living with COPD in Victoria.

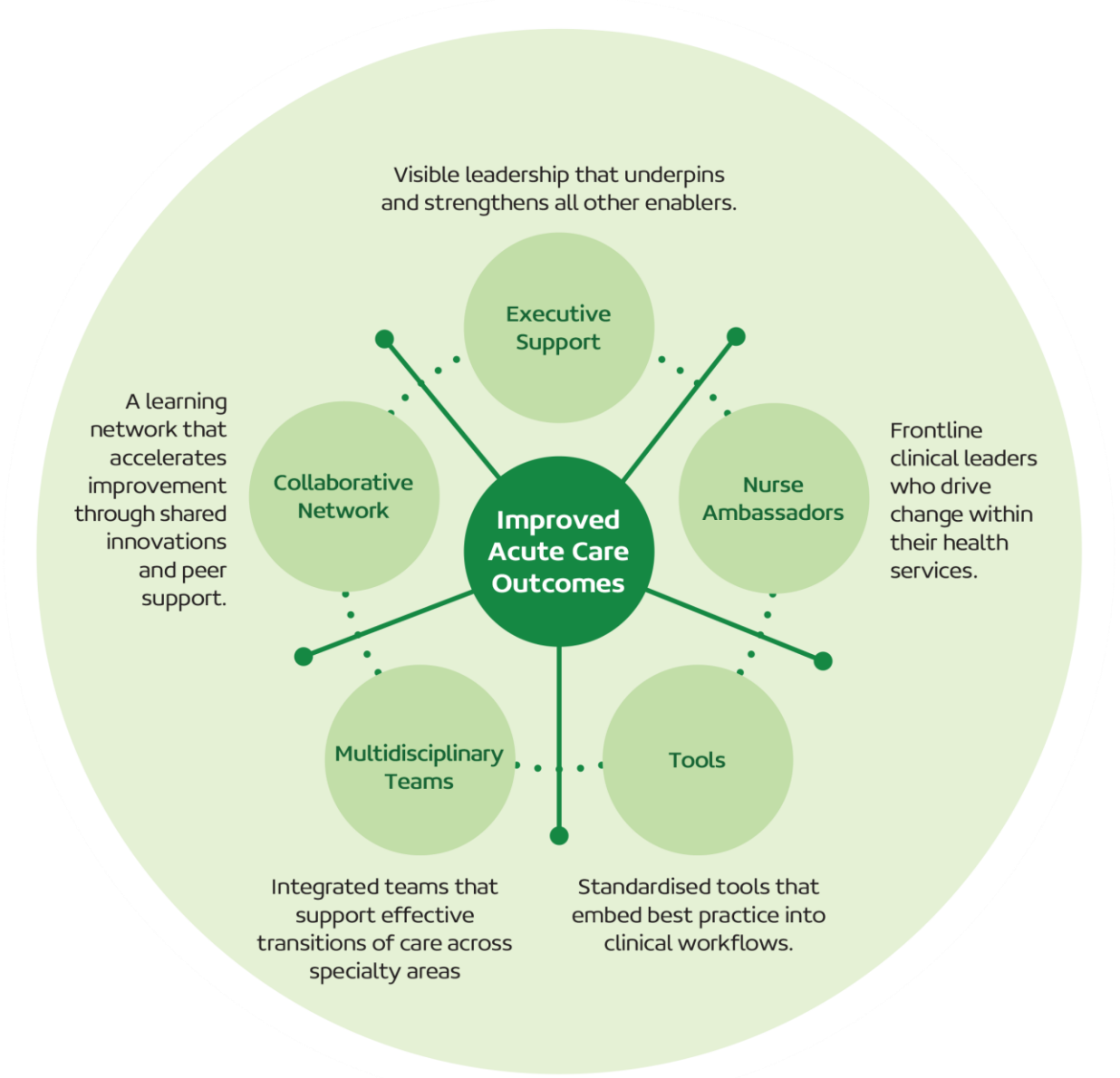
WORKFORCE CAPABILITY BUILDING

Nurse Ambassadors recruited multidisciplinary healthcare professionals - including nursing, pharmacy, medical, physiotherapy, administration, and digital health teams - to co-design solutions that address inconsistent care of acute COPD management. Across participating hospitals, best practice care of COPD became a regular agenda item in meetings, ward rounds, and safety huddles. Nurse Ambassadors delivered targeted training on inhaler technique, COPD Action Plans, and spirometry, and displayed project information on the ward for visibility and reminders. This approach strengthened local capability, engaged the wider clinical team and laid foundations for sustained improvements beyond the pilot. LFA provided education to Nurse Ambassadors about managing and interpreting data, establishing teams, using COPD assessment tools, utilising the LFA Respiratory Nurse program, and techniques to optimise staff education techniques. Nurse Ambassadors contributed feedback and guidance for the Multidisciplinary Checklist to ensure applicability across all hospital areas mentioned in the COPD Clinical Care Standard. Education sessions on Quit services and training provided support for nicotine cessation conversations. SCV provided education on the psychology of change and LFA supported conversations with Ambassadors about applying this to specific clinical challenges experiences across sites. SCV also provided expertise and training in the Model of Improvement and the Quality Improvement Toolkit [(5].

IMPROVEMENT SCIENCE IN PRACTICE

Thirty-five PDSA cycles were undertaken by Nurse Ambassadors to test the feasibility of quality improvement initiatives suited to diverse acute clinical environments – from small regional hospitals through to large metropolitan hospitals. Examples included integrating inhaler device technique assessments into existing workflows, using reminders and checklists, improving access to printed patient education materials, refining discharge information packs, automating a daily COPD admission list to prompt timely review by Respiratory Clinical Nurse Consultants and use of iPads to demonstrate videos for inhaler use. These iterative cycles assisted to identify practical solutions while reducing the resource burden of large-scale change. PDSA Cycles were reviewed with the Nurse Ambassadors and LFA, with feedback provided to optimise impact at a broader system level and across different clinical settings, underpinned by SCV's suite of resources and expertise.

FIGURE 2. FIVE COPD ACUTE CARE COLLABORATIVE PROJECT CHANGE ENABLERS



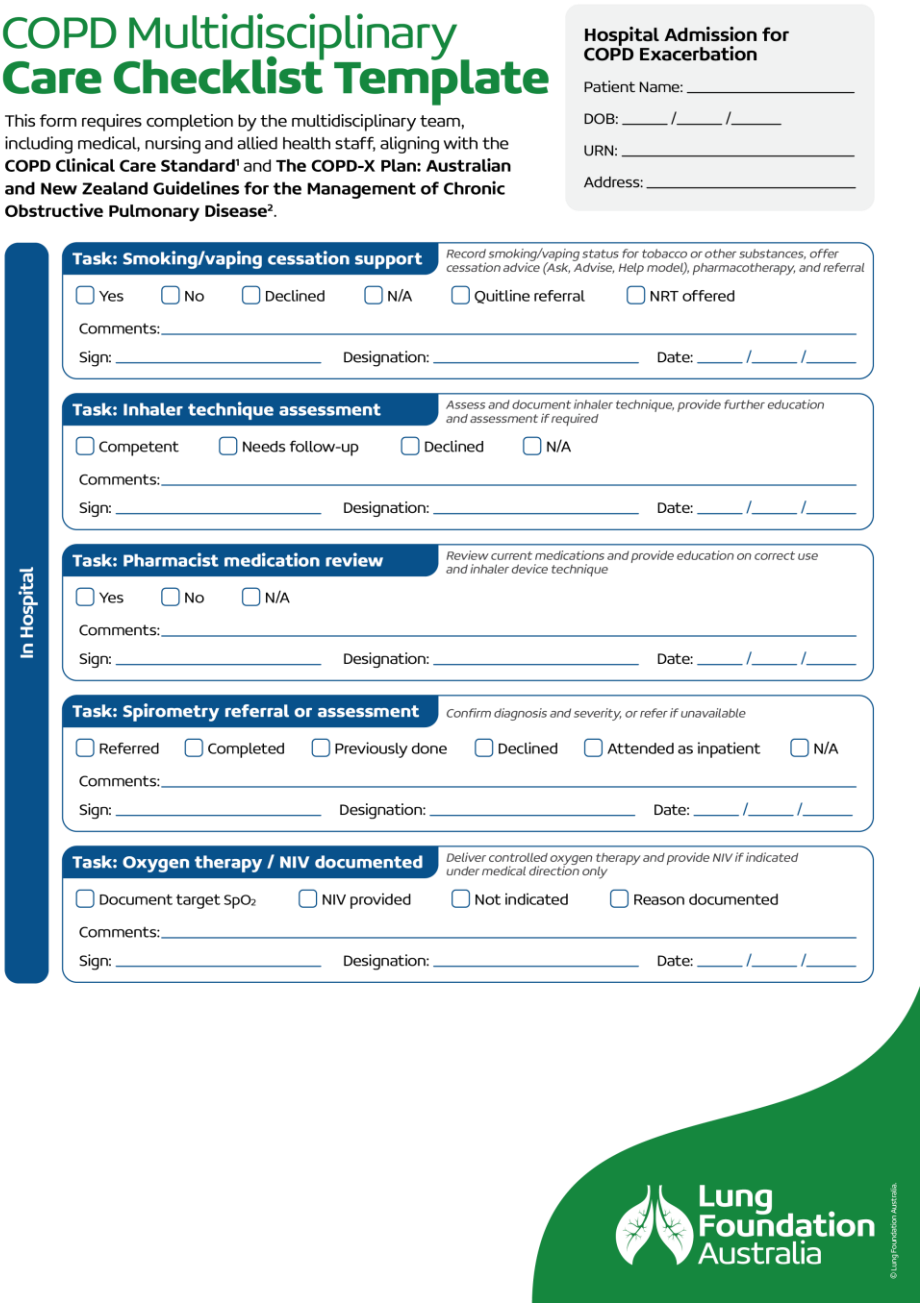
TOOLKIT DEVELOPMENT AND RELEASE

Learnings from the Nuse Ambassador collaborative informed the development of the COPD Acute Care Quality Improvement Toolkit, which includes three freely available resources designed to support consistent, scalable COPD care.

FIGURE 3. MY COPD HOSPITAL STAY CHECKLIST: WHAT TO KNOW AND ASK

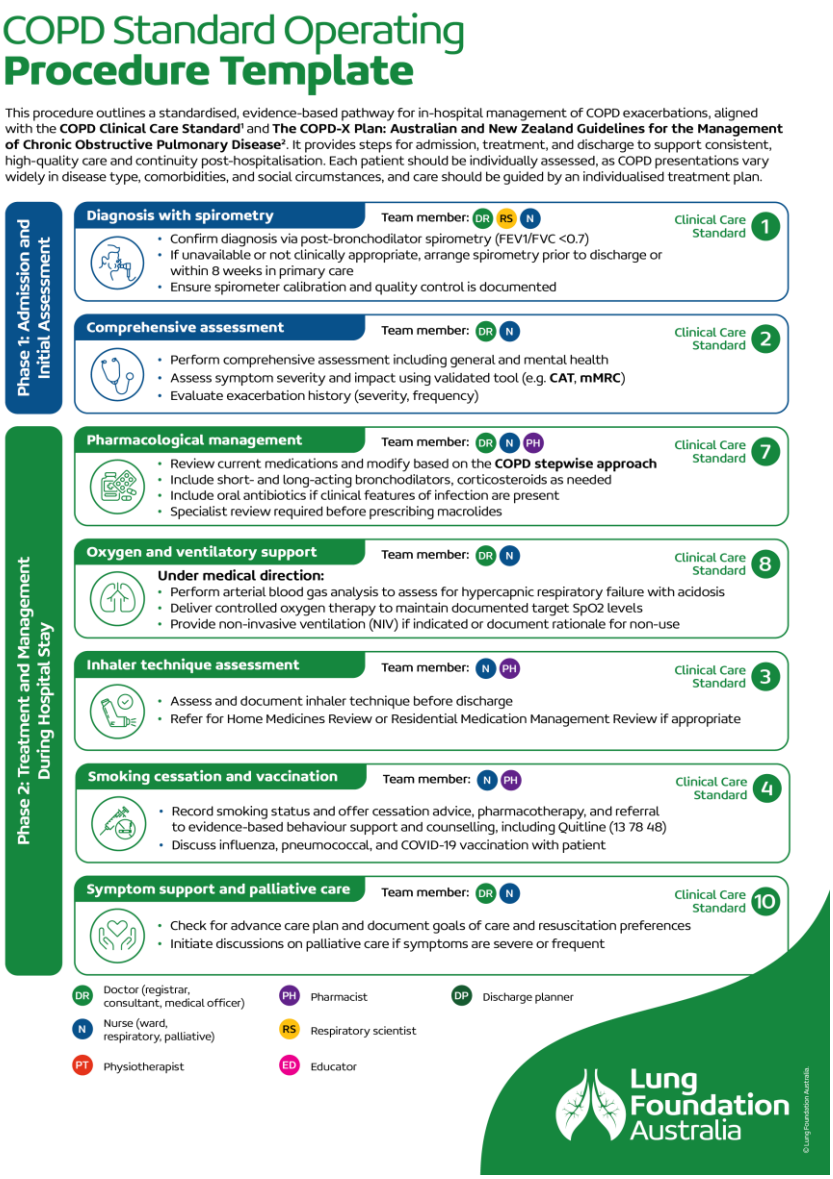
Patient activation checklist supporting engagement and discharge readiness.

FIGURE 4. COPD MULTIDISCIPLINARY CARE CHECKLIST TEMPLATE



A tested system for whole-team documentation and consistent assessment and planning.

FIGURE 5. COPD STANDARD OPERATING PROCEDURE TEMPLATE



Standardised acute-care pathway aligned with evidence-based guidelines, for adaptation at prospective hospital sites wanting to improve COPD care.

These tools and the COPD Acute Care Quality Improvement Toolkit are available for free download from the Lung Foundation Australia Resource Hub.

LEARNING

LEADERSHIP AS AN ENABLER OF REDESIGN

Executive Sponsors played a pivotal role in prioritising improvement in COPD management, removing system-level barriers, and ensuring the project was aligned with organisational priorities. Their influence reinforced the value of Nurse Ambassadors and helped embed changes into routine practice.

WORKFORCE CAPABILITY AND CULTURE

Nurse Ambassadors reported strengthened confidence in improvement science and greater confidence to coordinate change across the multidisciplinary team. Staff narratives highlighted improvements in communication, patient

engagement, and self-management support. The initiative demonstrated that investing in frontline leadership capability can positively influence culture and alignment with best-practice care.

PRACTICAL LESSONS FOR MANAGERS

Key lessons include the value of protected time for frontline leaders, the impact of cross-site learning in accelerating solutions, and the importance of accessible data for monitoring progress. Small PDSA cycles proved effective for adapting interventions to local contexts.

IMPACT FOR PRACTICE

A positive change was observed across many the quality-of-care indicators within a pilot context. Improvements included increased inhaler technique assessment, greater use and review of COPD Action Plans, a greater number of referrals to pulmonary rehabilitation, and improved hospital discharge documentation. Participating sites also reported anecdotal improvements in patient experience through better patient education and shared decision-making.

The toolkit developed through the collaborative, offers practical, adaptable resources for health services seeking to improve acute COPD care. These tools can support improved standardisation of care in the acute setting, aligned with evidence-based national standards. Broader dissemination of the toolkit and resources could enable scalability beyond the initial ten hospitals in other Victorian hospitals, or other States and Territories.

FUTURE DIRECTION

Future opportunities include testing and implementing the toolkit within additional health services, extending improvement activities to emergency departments and community settings, and establishing a COPD community of practice to foster ongoing collaboration and maintain momentum.

FUNDING

Funded by Safer Care Victoria

CONFLICTS OF INTEREST

None

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