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## Chapter 1 : WHO | WHO Strategy for prevention and control of Chronic Respiratory Diseases

*What you need to know to Chair a CoPI with Six to Sixteen Year olds 8. Implementing CoPI in Primary and Secondary Schools 9. CoPI, Citizenship, Moral virtue and Academic Performance with Primary and Secondary children*

On what are the nutrient standards based? What are the key differences between the nutrient standards for school lunches and those set out in Hungry for Success? The nutrient standards for school lunches differ in a few respects from Hungry for Success. A single set of nutrient standards for primary school pupils 2. A different basis to the setting of nutrient standards for secondary school pupils 3. Changes to the minimum levels of micronutrients 4. The addition of a standard for zinc 5. A phased approach to the standard for sodium 1. A single set of nutrient standards for primary schools Under Hungry for Success there were two sets of nutrient standards for primary school pupils 5 to 6 years and 7 to 10 years. There is now a combined nutrient standard for primary school pupils to facilitate easier menu planning. It is recognised that there will be a wide range of nutritional needs and appetites within the new age range. Catering staff will need to use their skills, knowledge and judgement to provide appropriately sized portions for individual pupils. It is important to remember that the food and drinks on offer on the school lunch menu over a school week must average out to meet the nutrient standards. The addition of a standard for zinc This standard has been added due to public health concerns about the low intakes of zinc amongst children. A phased approach to the sodium standard The standard for sodium has been eased slightly compared to the standard set previously under Hungry for Success. Useful information to support the achievement of the nutrient standards for school lunches A guidance manual 7 is available to inform catering providers and local authorities on how to conduct a nutrient analysis of a school menu to determine compliance with the nutrient standards Table 1. This guide will ensure that a consistent approach is adopted across Scotland to calculate the nutrient content of an average school lunch. A nutritional software specification guide 7 for the analysis of school menus has been developed and is available for local authorities to assist in the purchase of suitable nutritional analysis software programmes. The purpose of this guide is to assist local authorities achieve the nutrient standards through the procurement of lower sodium, fat, saturated fat and sugar products. Information on the nutrients shown in Table 1, as well as examples of the appropriate food and drink sources of each these nutrients, are provided in Annex 1.

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## Chapter 2 : Implement mandatory Kannada rule within a month: KDA to Bengaluru schools | The News Mirror

*Get this from a library! Transforming thinking: philosophical inquiry in the primary and secondary classroom. [Catherine C McCall] -- Essential reading for anyone who seeks to prepare active citizens for the 21st century, this book considers Philosophical Inquiry, an empowering teaching method.*

Editor who approved publication: Chronic obstructive pulmonary disease COPD is common but largely underdiagnosed. Case-finding initiatives have been evaluated in primary care, but few studies have explored the views of service providers on implementing them in practice. To explore the views of primary health care providers on case finding for COPD. A total of 20 semi-structured interviews were conducted from March to September among general practitioners, nurses, and managers from practices participating in a large COPD case-finding trial based in primary care in the West Midlands, UK. Interviews were transcribed and analyzed using the framework method. Participants felt that case finding improves patient care but also acknowledged potential harms to providers increase in workload and to patients overdiagnosis. Insufficient resources, poor knowledge of COPD, and limited access to diagnostic services were viewed as barriers to diagnosis, while provision of community respiratory services, including COPD specialist nurses, and support from secondary care were thought to be facilitators. Participants also expressed a need for more education on COPD for both patients and clinicians. Care providers believe that early detection of COPD improves patient care but also has accompanying harms. Barriers to diagnosing COPD, such as insufficient expertise in primary care and limited access to diagnostic services in the community, should be explored and addressed. The knowledge and attitudes of the public about COPD and its symptoms should also be investigated to inform future education and awareness-raising strategies. Patients reported receiving the diagnosis from other sources and were frustrated by delayed diagnosis. Another study by the same authors randomly assigned eight practices to deliver either optimized usual care or opportunistic assessment with spirometry for ever smokers aged over 35 years who routinely attend primary care. They felt that organized follow-up, especially with spirometry, was essential but would increase an already high workload and increase costs for patients. Some also questioned the value of diagnosing COPD in the absence of a cure. Since these studies were published, much has been done nationally and internationally to emphasize the importance of undiagnosed COPD 9 and provide education and guidance on its diagnosis and management. In all, 54 general practices were recently enrolled in a large pragmatic cluster randomized controlled trial in the West Midlands, UK, comparing the effectiveness and cost-effectiveness of targeted case finding for COPD against routine care. Method Study design Semi-structured interviews were undertaken with primary care service providers by the lead investigator SH. Interviews were conducted from March to September and were audio recorded and transcribed verbatim. Memos were made shortly after each interview to summarize key points and reflections. Eligible participants were posted an invitation letter as well as up to two reminders. Sample size We aimed to recruit five to ten participants of each profession across at least five general practices with a minimum sample size of Eventual sample size was determined by the reaching of theoretical saturation ie, no new concepts arising from the data. Repeat interviews were not conducted, and transcripts were not returned to participants for comment. Table 1 Topic prompt Abbreviation: COPD, chronic obstructive pulmonary disease. Analysis Interviews were analyzed using the framework method. Two transcripts considered to be particularly rich and informative were independently coded by three of the authors SH, REJ, and PA and compared to create an initial coding framework. Coding of all subsequent transcripts was performed by the lead investigator and built on this framework. A framework matrix was then constructed, tabulating quotes by their associated codes and participant type. Emergent themes were then discussed and finalized by three authors. The analysis was performed using NVivo version All identifiable data were held on an encrypted database. Results Practice and participant characteristics A total of care providers were invited to participate, of which 20 participants ten GPs, seven practice nurses, and three practice managers from 16 practices were interviewed Tables 2 and 3.

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Practices had a range of patient list sizes with most having 5–10, patients and the majority serving relatively socioeconomically deprived populations. Approximately one-third of practices had been in the case-finding arm of the trial, and all practices had been involved in recruiting patients for a large COPD cohort study the Birmingham COPD Study. Participants had been in practice on average for 13 or more years. Table 2 Practice characteristics Note: IMD is a measure of socioeconomic deprivation based on postcodes. Table 3 Participant characteristics Abbreviation: Views on case finding Participants were generally of the opinion that early detection of COPD was beneficial for both patients and health services. Several participants felt that early detection improved smoking cessation, helped instigate positive changes to other lifestyle behaviors eg, exercise, and improved quality of life and disease prognosis by enabling earlier access to care. Some also felt that it would be cost saving for health services in the long term. Others discussed using a more active approach such as screening at smoking cessation clinics. A wide range of factors were considered to be important triggers for considering COPD, such as smoking status and a history of asthma. Participants also highlighted the potential of clinical information systems to help identify and flag high-risk patients. Also looking at computer data, we can set up searches on our computers, but it depends on how active people are at putting the information on the computer, then we can pull that information. Some handheld flow meters were reported to feedback lung age, which was highlighted by several participants as being useful for promoting smoking cessation. Handheld flow meters were also described as quick and easy to use within a consultation. I think the key thing is not to make the diagnosis on the handheld stuff. Ease of use, provision of technical support, integration with existing clinical information systems, and the generation of automated prompts on electronic health records were seen as important factors for their implementation. One single-handed GP also commented on the need to refer patients to secondary care for medicolegal protection. Participants felt that primary care services were already stretched to capacity managing patients with established COPD and a lack of additional funding and resources would prohibit the implementation of case finding. Challenges to providing spirometry included costs of equipment and training, quality assurance, and availability of appropriately trained staff. I think there was a phase where people were just doing spirometry willy-nilly without necessarily having the right equipment, the training to use it properly. I think there has been a lot of improvement, particularly over the last couple of years with the accreditation. These included poor attendance in primary care and late presentation with advanced disease. Patients were perceived to sometimes try to cope with symptoms for as long as possible without consulting the health services until suffering an acute exacerbation. Some felt that patients often underrecognized the significance of their symptoms or were not always forthcoming about them or their smoking habits. They also felt that communicating information about COPD was challenging. I think there is a linguistic barrier; increasing numbers of patients are from ethnic minorities and getting them up and looking at them, and actually understanding where their exposure has been. Particular importance was attributed to spirometry training and acquiring a diploma in COPD, which several participating nurses had already achieved. Participants also discussed the importance of sharing diagnostic services between practices, which was especially important for smaller practices with limited service capacity. This included communicating the symptoms of COPD, disseminating information at a community level, and use of social marketing and mass publicity. Most participants felt that patients accepted their diagnosis and worked with their clinicians to improve their lifestyle behaviors, particularly in relation to smoking. Patients were perceived to sometimes even be relieved by the diagnosis, since this allows them to attribute a cause to their chronic symptoms. Some felt that patients were occasionally very reluctant to accept the diagnosis, particularly when they had no wish to give up smoking. I think it frightens patients as well because they look at the worst case scenario and associations with oxygen [GP 2] Discussion Main findings Case finding for COPD is to some extent already occurring in primary care, and some health care providers believe that this will benefit patient care at the expense of applying high workload and cost pressures on the health service as well as risking overdiagnosis and creating anxiety among patients Figure 1. Primary care providers are opportunistically diagnosing patients when presented with a suggestive clinical history, while others are keen to undertake

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active case finding using a range of approaches. Figure 1 Summary of themes discussed by participants. However, some important barriers to case finding were identified – limited service capacity, insufficient expertise on COPD and interpretation of spirometry, and restricted but improving access to diagnostic services. Effective communication of the diagnosis is thus an important component of patient care. Relationship to other studies Like Walters et al, 7 , 8 our study found that additional workload and resource requirements associated with case finding, as well as poor knowledge and confidence with spirometry interpretation, are likely to be barriers to diagnosing COPD in primary care. However, unlike their study, our participants did not express views of therapeutic nihilism. Instead, they largely felt that early intervention was likely to improve patient outcomes. Patients with COPD participating in a qualitative study in Sweden that explored their perspectives on receiving a diagnosis suggested that they would prefer the diagnosis to be given at an early stage. A recent analysis of a large primary care database by Jones et al showed that opportunities to diagnose COPD in primary care are frequently missed. The importance of support from secondary care was also highlighted by participants. Strengths and limitations We sampled a variety of stakeholders to acquire a range of both clinical and nonclinical perspectives. Participants were from a number of practices with a wide range of characteristics, including those who had participated in both the case finding and routine care arms of the TargetCOPD trial. Transcripts were not returned to participants for validation of the themes, and the interpretation of the transcripts could have been influenced by the prior beliefs of the authors who are all involved in the evaluation of COPD case finding. Similarly, participating health care providers may possibly have been more engaged in the management of COPD than non-participants, and their views may have been biased toward proactive COPD diagnosis and treatment. The findings of this study should therefore be interpreted in this light. Implications for policy, practice, and research Improving the diagnosis of COPD in primary care will likely require investment in community respiratory services and training of health professionals on COPD and performance and interpretation of spirometry. Further research should explore public perceptions of COPD, including awareness of symptoms. Greater awareness may improve the likelihood that patients with undiagnosed disease access the appropriate services. The benefits and harms of case finding highlighted in this study should be evaluated empirically in the long-term follow-up of case-finding trials. The findings of this study should also be compared to the views of patients, and the issues and implications surrounding the receipt of a diagnosis should be explored, addressing both the benefits and harms. The acceptability and feasibility of case-finding strategies should be qualitatively evaluated among care providers and patients alongside clinical trials evaluating their effectiveness. Conclusion The diagnosis of COPD in primary care may be improved by increasing access to community respiratory services and investing in the training of health professionals on COPD and spirometry. The benefits and harms of case finding should be empirically assessed in longitudinal studies to evaluate the overall effectiveness of detecting COPD early. Finally, the knowledge and attitudes of the public about COPD and its symptoms should be investigated to inform future education and awareness-raising initiatives and help those with undiagnosed disease access the appropriate care. SH recruited the participants, conducted the interviews, and coded the transcripts. PA and REJ coded two transcripts to validate the initial coding framework. All authors contributed toward data analysis, drafting, and critically revising the paper and agree to be accountable for all aspects of the work. The authors report no other conflicts of interest in this work.

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## Chapter 3 : [Full text] Case finding for COPD in primary care: a qualitative study of the view | COPD

*Secondary and tertiary prevention Early detection of occupational asthma is vital to prevent further progression and to ensure cost-effective management. Programmes for early detection of COPD have been suggested but their cost-effectiveness have yet to be fully evaluated.*

Ready to take the next step? Request information to learn more about this program and receive your free career guide. Request Info The Role of the Nurse in Preventative Health Care Preventative health care has become an increasingly popular area of the health care sector. Using a variety of methods to educate populations and avoid illnesses, this type of health care works to improve the overall wellness of Americans. Preventative health care informs populations, promotes healthy lifestyles and provides early treatment for illnesses. In the industry, the emergence of health care reform and an increased number of individuals suffering from chronic conditions has led to an amplified role for nurses in disease prevention. Preventative Health Care Nurses in preventative health care are tasked with improving the health of patients through evidence-based recommendations while encouraging individuals to receive preventative services such as screenings, counseling and precautionary medications. Through public health education, nurses can inspire a larger group of people to engage in healthy lifestyles and ultimately live longer lives. Preventative health care nurses encourage: Nurses promote regular activity preferably 30 minutes of exercise at least five days a week to combat heart conditions, high blood pressure and other diseases such as stroke, diabetes and arthritis. Exercise also encourages weight management. Preventative care includes maintaining and controlling weight with exercise and healthy eating habits to prevent diseases such as obesity, cardiovascular disease and osteoarthritis. Avoidance of smoking and drug abuse: Aside from the addiction threat associated with smoking and drug use, there is the risk of lung cancer, emphysema and other forms of cancer. Education about the effects of alcohol consumption, as well as early screening for diseases such as liver disease, stroke or high blood pressure, can significantly increase the chances of illness prevention. Control of existing diseases: Nurses involved with preventative health care work to identify existing conditions in the early stages. Preventative care encompasses a wide range of techniques to identify, educate, prevent and treat diseases in populations. There are three types of prevention that nurses take part in on a regular basis depending on their position in health care facilities or organizations: Primary Prevention The U. Preventative Services Task Force USPSTF describes primary prevention as the measures taken to provide individuals with knowledge to prevent the onset of a targeted condition. In this type of prevention, nurses play the part of educators that offer information and counseling to communities and populations that encourage positive health behaviors. From providing immunizations to reinforcing the use of seat belts, programs are designed to avoid suffering and illness in patients, as well as avoid any type of cost supplementary to disease treatment. Primary prevention is typically the most economical method of health care. Secondary Prevention Secondary prevention, a form of early disease detection, identifies individuals with high risk factors or preclinical diseases through screenings and regular care to prevent the onset of disease. Regular screenings, conducted by a preventative health care nurse, are the most common method of secondary prevention and can dramatically diminish the development of certain illnesses. Tertiary Prevention The third tier of prevention, tertiary prevention, is slightly different. This method involves the treatment of existing diseases in patients. At this point of care, nurses are tasked with helping individuals execute a care plan and make any additional behavior modifications necessary to improve conditions. As the primary and secondary methods have been unsuccessful, this stage encompasses methods of minimizing negative effects and preventing future complications. Examples of Disease Prevention Traditionally, health care systems were focused on cures for diseases. Nurses and other health care professionals are constantly working to prevent such illnesses through a variety of approaches. Heart Disease As the leading cause of death in the United States , heart disease is the focus of many health care professionals. There are many prevention programs in place and most employ the following methods of

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educating the public on ways to prevent heart-related illnesses, including: Encourage and conduct patients to engage in regular blood pressure and cholesterol checks to prevent or control high or dangerous levels. Educate populations on the symptoms of heart disease and heart attacks. Improve emergency response to increase survival rates. Organizations like the American Heart Association have developed guidelines and best practice methods for the treatment and prevention of heart disease. These strategies, used by health care professionals, work to educate and prevent cardiovascular diseases and have the ability to lower health care costs and improve overall patient care. Similar to the three types of prevention, there are four components health care professionals use for COPD management: Access and monitor Manage stable COPD Manage potential relapse or worsening of disease Health care professionals put an emphasis on primary prevention in cases of COPD, as it can be caused by exposure to indoor and outdoor air pollutants. After determining the susceptibility of an individual to COPD, nurses and professionals can determine the best route of treatment or prevention. Related Benedictine Programs As health care evolves, nurses continue to play a vital role in patient care and disease prevention. With a range of approaches to disease prevention, nurses have the ability to catch problems before they begin, educate patients on ways to minimize or eliminate risk factors, and ultimately implement change for the better. By pursuing an online MSN degree at Benedictine University, individuals acquire the latest knowledge and methods used by skilled nurses today.

## Chapter 4 : The Role of the Nurse in Preventative Health Care

*regarding chronic obstructive pulmonary disease (COPD) prevention. he process included identifying public health gaps and generating a set of goals that would define the unique role and contributions of public health in the prevention and control of COPD. his workgroup.*

Key learning points Aims and objectives To see if implementing a Chronic Obstructive Pulmonary Disease COPD discharge care bundle for all patients admitted with COPD to the respiratory ward would improve patient experience and reduce readmission rates. There were 4 main objectives in carrying out this project. Firstly, we wanted to improve the discharge process for patients admitted with an exacerbation of COPD by reducing variation in care. Further, we wanted to improve patient experience, empower self management and achieve earlier community supported discharge and follow up. Reasons for implementing your project COPD is a condition characterized by lung tissue damage and progressive airflow obstruction, and is primarily caused by smoking. It can result in shortness of breath, chronic cough, and acute exacerbations with can require hospitalisation. COPD accounts for 30, deaths per yr in England and Wales and is the 4th main cause of mortality worldwide. It accounts for 1 in 8 of all hospital admissions in the UK. Hounslow suffers from a lack of community support for COPD patients including lack of pulmonary rehabilitation and community oxygen monitoring services. In addition, there are fewer community matrons in Hounslow to support these patients compared with neighbouring Primary Care Trusts, and there is no intermediate respiratory care team in Hounslow. The aim was to see if the care bundle approach would improve patient experience and reduce readmission rates, as well as reduce variation in care and achieve compliance with National guidelines. We also compared our readmission data with our local CQIN readmission targets set by Hounslow commissioners. A care bundle was completed for all COPD patients, and this consisted of 4 evidence based interventions known to improve patient outcomes. Elements of the bundle included giving a COPD information booklet to each patient, offering smoking cessation advice, ensuring patients could use their inhalers correctly, and providing a clinic appointment for 4 weeks prior to discharge. In addition, all patients received a telephone call 3 days post discharge, if they gave consent. To help with sustainability, there were regular teaching sessions on the respiratory ward, as well as drop in inhaler technique and smoking cessation workshops. Education about the bundle was included as part of the nurse induction and appraisal process. Data on compliance with the bundle elements was kept on a bespoke web tool. A baseline audit of 50 patients was carried out to assess the quality of care given to COPD patients by medical teams across the hospital by retrospective analysis of case notes. Secondary outcome measures included 90 day reduction in mortality following discharge, length of stay, and resource saving. Eighty-five percent of patients who replied said that they found the bundle useful or very useful. No reduction in length of stay or reduction in 90 day mortality was demonstrated. Ward staff felt that their education and skills around caring for COPD patients had improved and they also felt that the bundle had made their work easier. Key learning points Introduction of the COPD discharge care bundle can improve patient and staff experience, and may help to reduce readmissions and thus provide resource savings. There were no additional staff or resource implications during this project. The bundle did not prove time consuming for nursing or medical staff. In fact, it took about 10 minutes to discuss smoking cessation, give the patient a self management booklet, and demonstrate correct inhaler technique. The 3 day post discharge phone took 20 minutes and was carried out using a set proforma. Implementing the bundle provided on going education for nursing staff who felt this was a beneficial intervention in delivering high quality care. Problems encountered in implementing the bundle have included recent changes in hospital infrastructure and reduction in nurse and administrative staff numbers in order to save resources. This has meant that roles previously carried out by staff on the respiratory ward which were important in ensuring implementation of the bundle have had to be taken over by existing staff members. Frequent changes in the bed model in the last year at our hospital involving the Medical Admissions Unit MAU , has meant that the bundle could not be rolled out to the MAU

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due to changing priorities on this ward and rapid turnover of staff. Regular education, raising awareness campaigns and team meetings are important in sustaining the service improvement, especially at times of resource savings and cutbacks affecting the NHS.

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## Chapter 5 : Transforming Thinking : Catherine C. McCall :

*Implementing CoPI in primary and secondary schools CoPI, citizenship, moral virtue and academic performance with primary and secondary schoolchildren Afterword: the past, the present and the future?*

National surveillance systems should primarily focus on monitoring the following, bearing in mind the importance of developing and implementing simple methodologies for providing objective measures of trends: Standard indicators should be adopted. These may include lung function measurements, disease progression, absenteeism from school or work, and hospitalisations. Elements of health care structure that can also be monitored to evaluate the quality of care include drug availability, cost and quality, existence of local guidelines and policies, and level of training of health professionals. Primary prevention Primary prevention of CRDs requires the reduction or avoidance of personal exposure to common risk factors, to be started during pregnancy and childhood. Avoidance of direct and indirect exposure to tobacco smoke is of primary importance not only for healthier lungs, but as a preventative measure for the other 3 priority NCDs cardiovascular disease, cancer, and diabetes identified in the Global Strategy for NCD prevention and control. Other shared risk factors that should be addressed include low birth weight, poor nutrition, acute respiratory infections of early childhood, indoor and outdoor air pollutants, and occupational risk factors. For primary prevention to be effective, other sectors within a community must be actively engaged. Additionally, the population must be fully informed about what constitutes a healthy lifestyle, such as healthy nutritional habits, regular exercise and avoidance of tobacco, airway irritants and allergens. For asthma, primary prevention implies the prevention of sensitization to factors that might subsequently induce disease. In addition to those mentioned, there is increasing evidence that allergic sensitization, which is the most common precursor to the development of asthma, can occur antenatally. As such, current knowledge on primary prevention requires emphasis on the health, nutrition and environment of the pregnant woman and newborn child. However, more research is needed before effective strategies for primary prevention of asthma can be established. Secondary and tertiary prevention Early detection of occupational asthma is vital to prevent further progression and to ensure cost-effective management. Programmes for early detection of COPD have been suggested but their cost-effectiveness have yet to be fully evaluated. Although long term decline in lung function may not be reversible, effective management including smoking cessation, pulmonary rehabilitation and reduction of personal exposure to noxious particles and gases can reduce symptoms, improve quality of life, and increase physical fitness. Further, evidence indicates influenza vaccination is a cost-effective intervention for patients with COPD. Asthma, although not curable, is a treatable disease with preventable morbidity. It is also a known risk factor for COPD. Secondary and tertiary prevention involves avoidance of allergens and non-specific triggers. Optimal pharmacological treatment, including the use of anti-inflammatory medication, has been shown to be cost-effective in controlling asthma, preventing the development of chronic symptoms, and reducing mortality.

## Chapter 6 : Asthma Policy For Schools | American Lung Association

*Preventative health care has become an increasingly popular area of the health care sector. Using a variety of methods to educate populations and avoid illnesses, this type of health care works to improve the overall wellness of Americans.*