Addressograph

Patient NHS No……
Patient Name……

COPD - Education for Patients and Carers Integrated Care Pathway

Date ICP completed:……

Is the patient following another Integrated Care Pathway[s]……..Yes / No

If yes, record which other Integrated Care Pathway[s] is in use:

……

Inclusion Criteria
Establish patient has formal diagnosis of Chronic Obstructive Pulmonary Disease [COPD] this must include lung function testing, the document is to be completed by a Respiratory Nurse Specialist.

Exclusion Criteria
Patients who have not gained a formal diagnosis of COPD via the above means should not be put on this ICP. If the patient does not consent to this ICP then they will be excluded.

This Integrated Care Pathway is intended as a guide to care only and does not replace clinical judgement.

Integrated Care Pathway Document Information

Document Number: 006
Version control: V04, October 2004 **PILOT**
Review Date: January 2005
Document created by: ULHT, WLPCT, ELPCT, LSWtPCT
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How to use an Integrated Care Pathway [ICP]

- Firstly if you are going to write in the ICP you need to state your name, job title and give a sample signature and initials. See below.
- Ensure each page is marked with the patient's unique identifier i.e. NHS number
- If you are recording an event that is predicted by the ICP, then just initial against that predicted activity or intervention in the column provided.
- If your intervention is not in line with the ICP, you must record this as a variance on the Additional Information / Variance pages. Variance will allow the ICP to reflect the patient's experience.
- The Additional Information / Variance pages are also for you to write free text about problems identified and the care given to the patient. These records should always be timed and dated. If your entry relates to an activity or intervention within the ICP, record the activity number against your entry.
- **The grey shaded areas act as a prompt where you may wish to record further information as a variance.**
- All ICPs are chronological so you should be able to track the care very easily.

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Patient NHS No……
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Signature Record

All members of staff who are using this Integrated Care Pathway should use **black ink** and complete this section. You can then use initials when recording care.

	Print Name	Job Title	Bleep No or Ext	Signature	Initials
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

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Patient NHS No……
Patient Name……

Communication		Yes Initials	No Initials	Date	Time	Variance and action taken
1	Does the patient have any communication difficulties?					
2	Does the patient have any hearing difficulties?					
3	Does the patient have any visual difficulties?					
4	Does the patient have any mental or physical difficulties. If applicable undertake Mini Mental / Exit 25 test & state score:					

Diagnosis information		Yes Initials	No Initials	Date	Time	Variance and action taken
5	Health Care Professional gives information to the patient regards their diagnosis					
6	Patient given information leaflet to support diagnosis					
7	Does the patient understand their diagnosis of COPD					
8	Explain the anatomy & physiology for the patient in relation to COPD					
9	Explain to the patient possible causes for their COPD					

Smoking		Yes Initials	No Initials	Date	Time	Variance and action taken
10	Has the patient previously smoked?					How many years? How many per day? When did they stop? Total pack years:
11	Explain how the their disease will progress using Fletcher and Peto graph					☐ N/A
12	Assess the patients motivation to stop smoking					☐ N/A
13	Patient given information regards stopping smoking (Leaflet)					☐ N/A
14	a. Patient identifies to the Health Care Professional that they wish to stop smoking					☐ N/A
	b. If Yes - Refer patient to Phoenix Service / Smoking cessation counsellor Date of referral:					☐ N/A

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Patient NHS No……
Patient Name……

Pharmacotherapy education		Yes Initials	No Initials	Date	Time	Variance and action taken
Patient with existing inhaler						
15	Has patient had inhaler technique checked previously					
16	HCP reassess inhaler technique using questions 20-26					
17	a. Does the patient have a problem with their inhaler technique					
	b. If Yes - Correct the patient's technique or					
	c. Change device or mode of delivery for the patient					☐ N/A
18	If patient already has a device where possible continue with this device					
19	Patient unable to use inhaler, inform the patient on alternative therapies					☐ N/A
Patient who requires an inhaler						
20	Can the patient suck and blow?					
21	Does the patient have sufficient inspiratory effort ?					
22	Can the patient hold breath for a few seconds?					
23	Is the patient co-ordinated enough to use a specific inhaler device					
24	Identify device that the patient feels comfortable with using					
25	Can the patient load appropriate device correctly?					
26	Can the patient care for the device?					
All patients who require an inhaler						
27	Can the patient identify when the device is empty?					
28	Patient given advice on full / empty device					
29	Patient given information regards short and long acting drugs and inhaled steroids/ oral steroids					
30	Give patient leaflet on Steroid information					
31	Patient given advice regards nebulizers and their disease **(If appropriate)**					☐ N/A
32	Give patient leaflet on Nebulizers information					

Addressograph

Patient NHS No……
Patient Name……

Pharmacotherapy Education Cont'd		Yes Initials	No Initials	Date	Time	Variance and action taken
33	Patient given advice on how the therapy will work					
34	Patient given advice on when they should take their medication					
35	Patient advised to have regular reviews of their condition					
36	Patient given advice regards annual flu vaccination					
37	Patient given advice regards pneumococcal vaccination					
Patient who feels they may require oxygen therapy						
38	Educate the patient regards oxygen therapy and that breathlessness does not always equal requirement for oxygen.					
39	Give patient oxygen leaflet					
40	Information given to the patient regards needing assessment for oxygen therapy					
Patient with SpO2 ≤ 92% + / or FEV_1 < 1.5 litres						
41	a. Is patient saturation < 92%?					
	b. If Yes - Patient referred to secondary care for oxygen therapy assessment & advice given. Date of referral:					

Symptom Management and self management of an exacerbation		Yes Initials	No Initials	Date	Time	Variance and action taken
42	Patient identifies symptoms when well					
43	Patient identifies symptoms of breathlessness including in terms of exercise tolerance					
44	Patient identifies normal cough & or sputum production ☐ Volume of sputum identified ☐ Colour of sputum identified ☐ Tenacity of sputum					
HCP identifies what patient should do if symptoms become abnormal						
45	Patient understands the significance of change in colour of sputum					
46	Patient advised on the need to obtain a course of antibiotics from GP if sputum colour changes					

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Symptom Management and self management of an exacerbation Cont'd		Yes Initials	No Initials	Date	Time	Variance and action taken
47	Patient understands the significance of increased breathlessness or increased volume of sputum					
48	Patient given advice to increase reliever medication to improve symptoms (Leaflet)					
49	Advise patient to obtain course of steroid therapy from GP or commence own steroid medication as prescribed					
50	Advise patient to contact GP / HCP if symptoms don't improve within 48 hrs					

General symptom management		Yes Initials	No Initials	Date	Time	Variance and action taken
51	The patient understands increased breathlessness					
52	Patient states their trigger factors					
53	Patient understands how to manage the trigger factors					
54	The patient understands suitable positions to ease breathlessness					
55	Patient given advice on relaxed sitting ☐ Forward lean sitting (elbows on table) ☐ Forward lean standing without prop ☐ Long sitting in bed with pillow or support ☐ High side lying					
56	Patient given leaflet to advise on positions					
57	Patient given advice to attempt to control breathing					
58	Patient with oxygen given advice to use oxygen as prescribed					☐ N/A
59	If no improvement advise patient to use reliever medication as prescribed					
60	If patient cannot gain relief advised to contact HCP, GP, PN, specialist nurse					

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Chest Clearance education		Yes Initials	No Initials	Date	Time	Variance and action taken
61	Patient identifies that they have difficulty in clearing sputum					
62	Refer the patient to the Physiotherapist [PT] for chest clearance education Date of referral:					
63	Patient is informed about normal mucus production					
64	Patient given information why some patients produce excess mucus					
65	Patient given information on why it is important to clear excess mucus					
66	Patient given information why some patients find difficulty in clearing secretions (PT only)					
67	Patient given advice on how to clear mucus (PT only)					

Nutrition education / information		Yes Initials	No Initials	Date	Time	Variance and action taken
68	a. Patient given general advice on the importance of balanced nutrition in lung health					
	b. Patient given information leaflet on general nutritional advice					
	c. Refer patient to dietitian Date of referral:					
Patient who is overweight						
69	Advise patient regards losing weight without reducing nutritional input in the diet					☐ N/A
70	Advise the patient on extra weight energy, increase expenditure and work of breathing					☐ N/A
71	Inform patient regards possible referral to dietitian					☐ N/A
Patient who is underweight						
72	Educate patient on why they may be underweight					☐ N/A
73	Advise patient to manage dietary intake					☐ N/A
74	Advise patient on small meals little and often and supplements					☐ N/A
75	In an exacerbation advise the patient to keep calorific intake up					☐ N/A
76	Inform patient regards possible referral to dietitian					☐ N/A

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Travel education / information		Yes Initials	No Initials	Date	Time	Variance and action taken
77	Advise patient regards preparing to travel and the need for a sufficient supply of medication					☐ N/A
78	Advise patient on the importance of obtaining travel insurance					☐ N/A
79	Advise the patient on vaccinations in advance if required					☐ N/A
80	Advise patient to discuss with their GP possibility for flying and the possible requirement of oxygen therapy					☐ N/A
81	a. If patient is an oxygen user then education regards oxygen in-flight is required					☐ N/A
	b. Refer patient to in-flight oxygen assessment clinic Pilgrim Hospital Referral date:					☐ N/A
82	If patient takes nebulized therapy advise patient regards contacting airlines, the need for travel adapters & preparation					☐ N/A
83	Advise the patient regards the information available at the British Lung Foundation on travelling					

Exercise education / information		Yes Initials	No Initials	Date	Time	Variance and action taken
84	Advise patient on the importance of taking regular physical exercise ☐ Cardiovascular system ☐ Respiratory system ☐ Musculoskeletal benefits ☐ Physical Function / ADLs					
85	Patient identifies their current exercise ability / tolerance					
86	Identify with patient why they are not exercising & cause					
87	Advise patient on risks of not exercising					
88	Patient given advice on how to exercise within the limits of their breathlessness					
89	a. Patient educated on benefits of pulmonary rehab.					
	b. Patient advised on possible referral to pulmonary rehab.					
	c. Patient is referred to pulmonary rehab Referral date:					☐ N/A

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Relaxation education / information		Yes Initials	No Initials	Date	Time	Variance and action taken
90	Patient / carer given information about the importance of relaxation					
91	Advise patient regards taking time out to relax during the day					
92	Patient identifies what they find is relaxing					
93	Patient given advice on type of relaxation					

Energy conservation / pacing education / information		Yes Initials	No Initials	Date	Time	Variance and action taken
94	Patient / carer given information on energy conservation, British Lung Foundation Leaflet					
95	Refer patient to Social Services for further home support Date of referral:					
96	Patient given advice on planning day to day activities					
97	Patient given advice not to rush					
98	Patient given advice on taking breaks					
99	Patient given advice on breaking up tasks if necessary					
100	Patient given advice on lifestyle adaptation					
101	Patient given advice on different approach to lifestyle					
102	Patient identifies what time of day is best for them					
103	Patient identifies a need for equipment					
104	Refer patient to the Occupational Therapist [OT]					
105	Patient given advice on household adaptation [OT only]					
106	Patient / carer given advice regards equipment available & how to access it [OT only]					☐ N/A

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Psychological needs of patient / carer		Yes Initials	No Initials	Date	Time	Variance and action taken
107	Patient identifies psychological problems due to their illness					☐ N/A
108	a. Identify the reasons why the patient may have psychological problems due to their illness / affecting illness ☐ Loss of role / unemployment ☐ Loss of self esteem ☐ Loss of pride ☐ Loss of sexual function ☐ Feelings of increased pressure / stress / anger ☐ Depression + / - anxiety, denial, fear					☐ N/A
	b. If Yes - HAD score is undertaken Result:					☐ N/A
109	Patient given advice regards local help groups, British Lung Foundation					☐ N/A
110	Patient given advice regards availability of support services relevant to them					
111	Refer patient to psychiatric / psychological services					☐ N/A

Managing surgery education / information		Yes Initials	No Initials	Date	Time	Variance and action taken
If surgery required - Advice for patient on pre-admission preparation						
112	Advise patient to take pharmacotherapy inhalers & devices into hospital with them					☐ N/A
113	Advise patient they will be seen by a pre-assessment nurse & an anaesthetist (ensure anaesthetist is aware of diagnosis)					☐ N/A
114	Advise patient they will not always be offered a general anaesthetic due to their condition					☐ N/A
115	Advise patient with regards types of regional block e.g. spinal / local anaesthetics					☐ N/A
Advice for patient during admission						
116	Advise patient to continue to take usual inhalers					☐ N/A
117	Advise patient that they should inform a member of staff quickly if chest is “not as it usually is”					☐ N/A

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Patient NHS No……
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Managing surgery education / information Cont'd		Yes Initials	No Initials	Date	Time	Variance and action taken
Advice for patient post surgery						
118	Inform patient regards importance of early mobilisation post operation					☐ N/A
119	Inform patient of risk of chest infection if bed bound					☐ N/A

Benefits information		Yes Initials	No Initials	Date	Time	Variance and action taken
120	a. Patient / carer is given advice on how to find out about benefits available					☐ N/A
	b. Refer patient to social worker / other Date:					☐ N/A

Sex education / information		Yes Initials	No Initials	Date	Time	Variance and action taken
121	Is sex important to the patient?					☐ N/A
122	Advise patient to talk to their partner					☐ N/A
123	Information given to prepare patient in readiness for sex					☐ N/A
124	Advise patient on the importance of the use of O2 / inhalers prior and or during sex					☐ N/A
125	Advise patient on consideration of sexual positions					
126	Patient given sexual advice leaflet					☐ N/A

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Additional Information / Variance				
No.	**Identify the problem, cause of problem and action taken**	Initials	Date	Time