

This care bundle describes 5 high impact actions to ensure the best clinical outcome for patients admitted with an acute exacerbation of COPD (AECOPD). The aim is to reduce the number of patients who are readmitted following discharge after an AECOPD and to ensure that all aspects of the patients COPD care is considered.

Patient sticker

1. REVIEW PATIENT'S MEDICATIONS & DEMONSTRATE USE OF INHALERS

Assess during medication rounds. Observe the patient using their inhalers and refer to _____ if technique is inadequate. Ensure medications have been optimised by respiratory specialist team.

Inhaler technique checked: Medications reviewed by respiratory team before discharge?

2. PROVIDE WRITTEN SELF MANAGEMENT PLAN & EMERGENCY DRUG PACK

Prescribe COPD emergency drug pack and provide to patient at discharge. Ensure patient has a completed self management plan describing how and when to use medications provided. Provide oxygen alert card if patient is at risk of CO2 retention (referral to a community team for drug pack and plan is acceptable)

Self management plan? Given ... Already has ... Not applicable ... Emergency drug pack provided? Yes ... No ... Not applicable ...
 Oxygen alert card? Yes ... No ... Not applicable Referred to community team for pack or plan? Yes ... No ... Not applicable ...

3. ASSESS AND OFFER REFERRAL FOR SMOKING CESSATION

Ask every patient whether they are a current smoker and offer referral to smoking cessation service

Patient is a current smoker: Yes Ex-smoker Never smoked
 (To be classed as an ex-smoker, patients must have abstained for 3 months)

Referral made: Yes No Declined N/A

Has smoking cessation been recorded as discussed? Yes No

4. ASSESS FOR SUITABILITY FOR PULMONARY REHABILITATION

All patients who report walking slower than others on the level or who need to stop due to dyspnea after a mile or after less than 15 minutes walking should be assessed for and offered pulmonary rehabilitation _____

Already completed pulmonary rehabilitation? Referral made?
 Declined? Not applicable: Not Done:

5. ARRANGE FOLLOW UP CALL WITHIN 72 HOURS OF DISCHARGE

Follow up all patients at home within 72 hours in person or by phone. A call for the patient can be booked by calling _____ and faxing completed discharge bundle to: _____.

Patient has agreed to be contacted: Patients phone number: _____

Date of call given to patient: _____

ENSURE ALL ELEMENTS OF COPD SAFE DISCHARGE CHECKLIST COMPLETED

Nurse checking completion of discharge checklist (initials):

Checklist completed:

Date of admission:

Date of discharge:

PRIOR TO DISCHARGE

DAY OF DISCHARGE

Instructions for use of bundle:

Data entry: <https://audits.brit-thoracic.org.uk/>
 Enquiries: carebundles@brit-thoracic.org.uk