Barns Medical Practice Service Specification Outline: The Diagnosis and Management of Chronic Obstructive Pulmonary Disease

Up-dated: November 2018 Review Date: November 2019

Introduction

Chronic Obstructive Pulmonary Disease (COPD) is characterised by airflow obstruction that is not fully reversible. It is progressive and predominantly caused by smoking. The damage results in chronic inflammation that differs from asthma. The object of correct management of COPD is to reduce mortality, reduce exacerbations and cut down hospital admissions. It also hopes to achieve optimum health benefits.

Symptoms tend to be breathlessness on exertion, chronic cough, regular sputum production, frequent winter bronchitis and wheeze. Consideration should also be given to those complaining of fatigue, effort intolerance, weight loss, ankle swelling, chest pain and haemoptysis (coughing up blood).

Diagnosis

The diagnosis should be based on signs and symptoms, history taking and supported by a breathing test called 'spirometry and reversibility'. Patients are generally over 35, smokers and with one or more of the above symptoms.

The MRC 1-5 dyspnoea score is recorded to ascertain the degree of breathlessness incurred and the CAT (COPD Assessment Test) score helps the clinician to decide the best treatment for the individual patient.
If spirometry results show a FEV1 (forced expiratory volume) less than 80% predicted and FEV1/FVC is less than 0.7 or 70% a diagnosis can be confirmed. If FEV1 is greater than 80%refer back to GP for differential diagnosis.

Global Initiative for Chronic Obstructive Lung Disease. Global strategy for Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary disease. Report 2017. Available online at http://www.goldcopd.org [Accessed 10/11/2018].

The diagnostic code for COPD #h3z should be coded priority 1 and a Problem created.

Annual Review

- A 20 minute appointment should be offered with the practice nurse and the COPD template within the consultation manager completed.
- MRC score should be recorded as well as, Pulse oximetry, CAT score and FEV1. (Consider referral to respiratory if SA02 is less than 93%).
- Check inspiratory flow with in-check dial – DPI 30-90l/min; MDI 30-60l/min
- Smoking status recorded and cessation advice given
- Inhaler technique observed /taught. Spacer devices are compatible with MDI (metered dose inhalers) and inhaled drugs can be administered via a spacer by single inhalation or tidal breathing.
- Spacers should be washed at least monthly and replaced annually.
- COPD reviews should be tailored to meet the needs of the individual patient where goal planning is discussed to identify health needs, reduce exacerbations and maximise health.
- The importance of exercise, nutrition, advanced care planning and telehealth should be discussed.
- Vaccinations for Pneumococcal and Flu should be offered.
- Self management plans should be discussed and medication in reserve organised if deemed appropriate. Thereafter an anticipatory care plan should be completed.
- If the MRC score is greater than 3, a referral to pulmonary rehab should be offered. A patient information sheet is available on Barnsnet and guidance for referral can be found on the athena website.

Treatment

- It is important that inhalers are prescribed only after patients have received adequate training in the use of the device.
- For intermittent breathlessness and exercise limitation, offer short acting bronchodilators (SABA) 1st choice is salbutamol MDI with or without spacer. Second choice is Easyhaler Salbutamol.
- If symptoms persist add either long acting b2-agonist (LABA) 0r long acting muscarinic antagonist (LAMA).
- LABA first choice is Formoterol Easyhaler . Second choice is Atimos Modulite MDI.
- LAMA first choice is Spiriva Respimat and second choice is Incruse Ellipta.
- If still having more significant symptoms and FEV1 > 50% and < 1 exacerbation in last 12 months not requiring hospital admission: stop LAMA or LABA and use combination LAMA/LABA
  First choice is Anoro ellipta and second choice is Spiolto Respimat.
- If FEV1 < 50% or 2 or more exacerbations in one year or one requiring hospital admission stop any existing LABA and use LABA/ICS. Separate LAMA can still be used.
- First choice is Relvar Ellipta second choice is Fostair.
- Long term monotherapy with inhaled corticosteroids is not recommended in COPD as it is less effective than the combination

inhaled corticosteroids. A significant proportion of patients with COPD may not benefit from ICS and clinicians should observe if the addition of this inhaler improves symptoms and reduces exacerbations. ** If no improvement is noted consider discontinuing the ICS but continue with the LAMA/LABA.

- Consider other treatments such as theophylline if inhaled therapy is ineffective. Carbocisteine could be considered with patients who have chronic cough and excessive sputum but should not be prescribed to prevent exacerbations in patients with stable COPD. The use of Carbocisteine should be reviewed after 4 weeks and if no benefit stop.
- Longterm Oxygen Therapy (LTOT) is indicated for patients with severe resting hypoxaemia. Referrals for LTOT should be made to the respiratory nurse specialists.

http://athena/adtc/DTC%20%20Clinical%20Guidelines/ADTC64A.pdf

Resources

Information leaflets on COPD can be found on the internet and patient.co.uk. Patients can be signposted to fresh-air-shire and local pharmacies if they wish additional support with smoking.
http://www.nhsaaa.net/services-index/f-fresh-air-shire.aspx
http://www.nhs.uk/conditions/chronic-obstructivepulmonarydisease/pages/introduction.aspx

NHS A&A Pulmonary Rehab Programme

Staff involved and training required

- All RGNs within the practice who have completed COPD education and are committed to regular updates.
- The HCA has now been delegated the task to carry out the spirometry procedure. She has been taught by trained staff and has been deemed competent. She must report to GP or ANP,NP or Practice Nurse if any problems are experienced with the procedure. For the procedure of spirometry, salbutamol must be prescribed prior to the procedure.

Advertising of service to patients

Patients are contacted annually via letter or text .Barns Medical Practice advertises this service on the internet and actively encourages patients to make annual review appointments.

**Current Barns Respiratory Project

Pharmacist Martina Lees and PN Sister Sophie Steele are currently reviewing COPD patients who are on steroid inhalers and deciding with the patients whether the steroid is still required. Those who are not in category D (Ayrshire & Arran Area Drug and Therapeutics Committee prescribing guidance) are undergoing a trial of steroid inhaler discontinuation (excluding mixed asthma/COPD) for 4 weeks. After the 4 weeks, the patients are reviewed and those who have found their symptoms worsen, are considered for triple inhaler therapy (ICS/LABA/LAMA); as more cost effective than

giving separate ICS/LABA and LAMA. At the moment, Trelegy ellipta (DPI) is on formulary and there is a MDI version called Trimbow; although this has not been added to formulary yet. Trelegy is licensed for moderate to severe COPD.

http://athena/adtc/DTC%20%20Clinical%20Guidelines/ADTC64A.pdf

https://www.medicinescomplete.com/#/content/bnf/471113942?hspl=trelegy#DMD34952211000001104