

Barns Medical Practice Service Specification outline: The diagnosis and management of Chronic Obstructive Pulmonary disease

Developed June 2017 Review Date June 2019

Introduction

Chronic Obstructive Pulmonary Disease (COPD) is characterised by airflow obstruction that is not fully reversible. It is progressive and predominantly by smoking. The damage is a result of 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 or 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.

Reference: <https://www.nice.org.uk/guidance/cg101>

<https://www.mylungsmylife.org/topics/group-1/symptoms-ofcopd/copdassessment-test-cat>

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

Annual Review

1. A 20 minute appointment should be offered with the practice nurse and the COPD template within the consultation manager completed.
2. MRC score should be recorded as well as, Pulse oximetry, CAT score and FEV1.

(Consider referral to respiratory if FEV is less than 93%).

Check inspiratory flow with in-check dial – DPI 30-90l/min; MDI 30-60l/min

3. Smoking status recorded and cessation advice given
4. 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 of tidal breathing. Spacers should be washed at least monthly and replaced annually.
5. 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.
6. Vaccinations for pneumococcal and Flu should be offered.
7. Self management plans should be discussed and medication in reserve organised if deemed appropriate. Thereafter an anticipatory care plan should be completed.
8. 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.

<http://athena/pdu/respiratory/Documents/pulmonary%20Rehab%20Guidance%20for%20ReferrersFeb%202015.pdf>

Treatment

1. It is important that inhalers are prescribed only after patients have received adequate training in the use of the device.
2. For intermittent breathlessness and exercise limitation, offer short acting bronchodilators or SABA 1st choice is salbutamol MDI with or without spacer or easyhaler. Second choice is Bricanyl turbohaler.
3. If symptoms persist add either long acting b2-agonist (LABA) Or long acting muscarinic antagonist (LAMA).

LABA first choice is Atimos modulite or formoterol easyhaler . Second choice is serevent either evohaler or accuhaler.

LAMA first choice is incrise ellipta and second choice is Eklira genuair and third choice is spiriva as handihaler of respimat.

4. 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 Duakir genuair

5. If FEV1 < 50% or 2 or more exacerbations in one year or one requiring hospital admission stop any existing LAMA and use LAMA/ICS (inhaled corticosteroid). Separate LAMA can still be used.

First choice is Relvar ellipta second choice is Fostair and symbicort is third.

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.

6. 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 is primarily prescribed to delay the onset of pulmonary hypertension and cor pulmonale and any patient assessed as potentially needing oxygen should be referred to the respiratory nurse specialists.

References

1. COPD Quick Guide: pharmacological Management Area drug and Therapeutic

Committee NHS Ayrshire and Arran available on Athena website
2. Gold 2017 Global Strategy for the diagnosis, management and prevention of COPD available online at <https://www.goldcopd.org/gold-2017-global-strategy-diagnosismanagement-prevention-copd/> accessed 04/06/2017

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-obstructive-pulmonarydisease/pages/introduction.aspx>

NHS A&A Pulmonary Rehab Programme

Staff involved and training required

1. All RGNs within the practice who have completed COPD education and are committed to regular updates.
2. 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 with the procedure and 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.