# Long Term Conditions Care Pathways

# Summary of key implementation messages: COPD

## Introduction

- New NICE guidance was published summer 2010. Care pathways reflect this guidance and by implementing practices will ensure compliance.
- Advice and training on care pathways can be provided by the community specialist respiratory nurse, Joy Parrington (joyparrington@nhs.net)

## Stable patient in primary care

- Practices to update stratification of all patients into Mild, Moderate, Severe, Very Severe using the new NICE guidelines (GOLD criteria)
- Practices to ensure creation of a patient care plan to include patient's own goals, self-management plan (e.g. COPD and me) as to how to achieve these goals, and appropriate treatment and referrals to support delivery (including community matron, specialist smoking cessation for hard-to-quit patients, pulmonary rehabilitation for MRC 3-5 and following exacerbation)
- All patients to receive at least an annual programmed structured primary care review. 'Very Severe' patients under GOLD criteria to be reviewed twice a year.
- Where a house-bound patient is unable to get to their GP practice, the GP practice to co-ordinate the review at home with support from the practice nurse / community matron / specialist community respiratory nurse / or other, as appropriate.
- Evidence suggests that many prescriptions for short-burst oxygen therapy are not clinically effective. Patients should only be considered for oxygen therapy where a patient's SpO2 is <92%, measured on air on 2 separate occasions at least 2 weeks apart (in the absence of exacerbation).

## Exacerbation in primary care

- When patients present with an exacerbation, the aim is where possible to manage the patient safely at home. Support may be required from community matrons / case managers, fast response team or community specialist respiratory nurse.
- For patients treated at home, presence and compliance with the patient's self management plan to be checked and treatment options considered.
- Patients to receive a post exacerbation review of care plan in primary care within 2-4 weeks of exacerbation where indicated (e.g. where there are concerns about treatment compliance, second exacerbation in 12 months for severe / very severe patients, changes were made to medication other than antibiotics and oral corticosteroids, low SpO2 during initial assessment)

## Telehealth

- Pathways have been designed to suggest use of telehealth technology at appropriate points, e.g. as an aid to delivering the patients care plan, or following exacerbation in primary or secondary care
- Practices to review their list of COPD patients to identify suitable potential patients who might benefit from the technology and refer.