Wirral Health & Care Commissioning

Making a Difference in COPD - Top Tips January 2019 and Rescue Pack Information

1. Diagnose COPD Early

Picking up new cases of COPD early, slows decline and improves morbidity. Actively think of and test for COPD in anybody who has smoked after the age of 35, including illicit drug smoking, who has one or more of: chronic cough, breathlessness on exertion, winter bronchitis, regular sputum production, or wheeze. After CAT (see link at end) and MRC score, baseline bloods, CXR, and pro-BNP if heart failure suspected, confirm the diagnosis with post bronchodilator spirometry and start treatment.

In addition, EMIS automatically generates a report of possible COPD patients which can be found in Population Reporting, GP Contract - QOF, COPD, COPD supplementary searches (monthly).

2. Educate the Patient and Optimise Treatment - use COPD service and Pulmonary Rehabilitation

Refer newly diagnosed patients, or those whose control is sub-optimal, to the COPD service (on WROCS form) for education of their condition and optimisation of treatment. Make a separate referral to Pulmonary Rehabilitation (on WROCS form) for people with MRC 3 or worse, or who have just been in hospital with an exacerbation of COPD. Be very positive about PR for patients - it really does improve quality of life!

3. COPD Rescue Packs

Rescue packs (short course of steroids and antibiotics kept at home by the patient "in case") can keep people out of hospital by allowing them to start treatment early in an exacerbation, but not everyone is suitable and the patient first has to be trained in their use. You can download and keep a copy of the new Clinician COPD Rescue Pack Guidance attached to this bulletin, which runs through how and when to use rescue packs, and give the patient a copy of the leaflet Patient COPD Rescue Pack Leaflet, also attached.

Clinician COPD Rescue Pack Guidance leaflet click here
Patient COPD Rescue Pack leaflet click here

4. Triple inhalers

Most COPD patients who are already taking both a LABA+ICS and a LAMA inhaler will benefit from changing to a triple inhaler, containing LABA, LAMA and ICS in one. The choices are Trimbow, a MDI taken 2 puffs twice daily, and Trelegy Ellipta, a dry powder inhaler, one puff once daily. A triple inhaler costs less than 2 separate ones and compliance is much better, with subsequent improvement in symptoms. Before changing, at the patient's COPD review, check compliance with both existing inhalers then see which device the patient can best use (use In-Check Dial Device if possible) and make the switch. Review after a month to address any issues.

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CCG Medicines Management Committee approved date – Feb 2019
Review date – August 2022

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5. Promote Stopping Smoking
Mention stopping smoking to every patient who smokes, at every consultation. Studies show that the constant drip method of persuasion by healthcare professionals really works in stopping smoking. Offer referral to a stop smoking adviser - patient can ring 0151 541 5656 or text ABL to 06777.

6. Be alert to lung cancer
The COPD group is at high risk for lung cancer. Sudden deterioration in symptoms, increased frequency of exacerbations, weight loss, or haematoptysis should prompt a chest Xray, and CT scan if high suspicion even if CXR is negative (a significant proportion of lung cancers do not show on CXR).

7. Is it definitely COPD?
Make sure all the existing COPD patients on the register have had the diagnosis confirmed by spirometry with reversibility. As a region we are lower than we should be in this area and some patients' diagnoses may need questioning - it could be a different lung condition needing different treatment.

8. Home treatment of Exacerbations
After you have assessed a patient who is exacerbating and are happy for them to be treated at home, if the patient needs nebulisers, or oxygen monitoring, refer to the District Nurse Team or Community Matron. The Rapid Response Team via SPA can also support if a package of care or appliances are needed to enable to patient to stay home. Please note the COPD service does not provide an acute service for COPD patients in an exacerbation, and also Respiratory Physiotherapy is not available in primary care despite it still being on some WROCS forms (this is being addressed).

9. End of Life Recognition
COPD is a terminal illness but it can be hard to recognise the move to end of life. Consider DNACPR and moving to palliative care in patients with very severe COPD, 3 or more hospital admissions in a year, on long term oxygen therapy or who have had to have non-invasive ventilation. There is a useful algorithm in the links below.

Useful links:
Pan Mersey prescribing guidelines for COPD
https://www.panmerseyapc.nhs.uk/media/1835/copd_201607_g17_v0303.pdf
NICE 2018 COPD guidelines diagnosis and management
https://www.nice.org.uk/guidance/ng115/chapter/Recommendations
CAT (patient COPD symptoms) score tool
http://www.catestonline.org/images/pdfs/CATest.pdf
Smoking cessation adviser ABL at 0151 541 5656 or text ABL to 6777
Algorithm for Assessment for Palliative Care in COPD
https://www.pcrs-uk.org/palliative-care-assessment-copd