Clinical Care Path – COPD

WEEK 1 - COMPREHENSIVE HOME VISIT ASSESSMENT	*Yes*	*N/A*
Complete Initial Nursing Assessment – Refer to Comprehensive Cardio/Respiratory Assessment for details		
Review patient's main concerns with current heath/symptoms: ESTABLISH GOALS		
Recommend Influenza (annually) and/or Pneumovax (Initial/confirm) vaccines and provide resources		
If hospital referral, recommend follow up with PCP within 7 days, assist with process if necessary		
Complete initial Medication Reconciliation (BPMH) Look for medications related to COPD (rescue & maintenance inhalers)		
Liaise with PCP, Respirologist, COPD Clinic as needed		
Assess for referral to NP/Pharmacy and RT (as per criteria)		
Liaise with Community Care Coordinator about service plan and/or patient's clinical status via telephone or in-person		
Provide Contact Information to patient and/or caregiver and Review DIVERT-CARE telephone support line process		
If patient has a visiting nurse or attends Nursing Clinic, arrange for joint visit for week two		
Send Primary Care update form using SBAR and request physician copy of COPD action plan to be completed by primary care		

Week 1 - Patient/Caregiver Education		
Initiate teaching. Use Patient Activation Measure (PAM) and assess teach back ability on the following:		
• Brief overview of medication related to COPD Medication Indication and review use of inhalers and ensure patient/caregiver can teach back (if patient is not taking appropriate inhalers or is having difficulty with teach back consider Pharmacy/NP referral)		
• Review and teach back breathlessness techniques		
• Provide the following Handouts to review prior to next visit:		
• Managing COPD		
• COPD Brochure		
• Managing COPD Flare Ups		
• Smoking Cessation (if applicable)		
WEEK 2 - HOME VISIT	**YES**	**N/A**
If patient has visiting nursing or attends Nursing Clinic, confirm arrangements for joint visit		
Complete Nursing Reassessment – Refer to Comprehensive Cardio/Respiratory Assessment for details		
Inquire re: outcome of PCP assessment - are there changes in treatment plan or medications?		
Inquire re: outcome of Meds Check assessment/Pharmacist Review		
Reconcile any new, discontinued medications and/or dose changes. Provide patient with copy of BPMH		
Send Primary care update form using SBAR as needed		

Week 2 - Patient/Caregiver Education		
• Review and assess comprehension through teach back from visit one: Re-enforce teaching of how to use inhalers and strategies for breathlessness		
• Initiate COPD action plan teaching and start patient copy of action plan. Complete page 1 & 2 with patient		
• Review handouts provided at first visit and complete teach back		
WEEK 3 - TELEPHONE ASSESSMENT	**YES**	**N/A**
Follow-up with PCP to determine if COPD action plan (physician copy) has been completed. If not, consider referral to NP/Pharmacy to assist with completion		
Complete telephone assessment - refer to COPD TELEPHONE assessment for details		
Reconcile any new, discontinued medications and/or dosage changes		
Send Primary Care update using SBAR form as needed		
WEEK 4 - HOME VISIT	**YES**	**N/A**
Complete Nursing Reassessment – Refer to Comprehensive Cardio/Respiratory Assessment for details		
Review and complete the COPD action plan with the patient (total package with physician instructions for COPD flare ups)		
Review medications and reconcile any changes and update patient copy of medications		
Inquire re: outcome of PCP assessment-are there changes in treatment plan or medications		
Send Primary Care update using SBAR form as		

needed		
Week 4 - Patient/Caregiver Education		
• Review and assess comprehension through teach back from visits one and two		
• Review action plan and what to do if experiencing symptoms (preventing flare ups)		
• Review use of COPD medications (inhalers, antibiotics, steroids and other medication)		
• Review smoking cessation if applicable. Assist with linking to community resources		
WEEK 5 - No Intervention	**YES**	**N/A**
WEEK 6 - TELEPHONE ASSESSMENT	**YES**	**N/A**
Follow-up with PCP to determine if COPD action plan (physician copy) has been completed. If not, may consider referral to NP/Pharmacy to assist with completion		
Complete telephone assessment - refer to COPD TELEPHONE assessment for details		
Reconcile any new, discontinued medications and/or dosage changes		
Send Primary Care update using SBAR form as needed		
WEEK 7 - No Intervention	**YES**	**N/A**

WEEK 8 - HOME VISIT (Last Home Visit)	YES	N/A
Complete Nursing Reassessment – Refer to Comprehensive Cardio/Respiratory Assessment for details		
Review medications and Reconcile any changes and update patient copy of medication list if applicable		
Review and complete the COPD action plan with the patient (total package with physician instructions for COPD flare ups)		
Review with patient and caregiver: communication resources and planning for medical appointments		
Week 9 & 10 – No Intervention	**YES**	**N/A**
WEEK 11 – TELEPHONE ASSESSMENT	**YES**	**N/A**
Follow up with PCP to determine if COPD action plan (physician copy) has been completed. If not, may consider referral to NP/Pharmacy to assist with completion		
Complete telephone assessment - refer to COPD TELEPHONE assessment for details		
Reconcile any new, discontinued medications and/or dosage changes		
Send Primary Care update using SBAR form as needed		
WEEKS 12, 13, 14 – NO INTERVENTION	**YES**	**N/A**

WEEK 15 – TELEPHONE ASSESSMENT	YES	N/A
Follow up with PCP to determine if COPD action plan (physician copy) has been completed. If not, may consider referral to NP/Pharmacy to assist with completion		
Complete telephone assessment - refer to COPD TELEPHONE assessment for details		
Reconcile any new, discontinued medications and/or dosage changes		
Send Primary Care DISCHARGE UPDATE using SBAR form		
******If the patient and/or caregiver are having difficulty with teach back at any time during the 15-week process, consider referral to the Nurse Practitioner******		