COPD Clinical Pathway

Site Applicability

Providence Health Care Acute Care Inpatient Units using the Cerner Electronic Health Record

Pathway Patient Goals

1. Acute Care Length of Stay 7 days – Acute Phase 1-2 days, Transition Phase 2-3 days, Pre-Discharge Phase 1 to 2 days
2. Coordinated evidence based care and discharge planning delivered by an interdisciplinary team
3. Pre-discharge teaching completed by target date

Inclusion Criteria

1. Provider order for pathway (required)
2. All patients admitted with COPD

Instructions

1. Review pathway once per shift for patient care goals and expected outcomes
2. Do not document on this pathway, complete documentation in the Electronic Health Record or paper chart as per policy

COPD: Care Pathway

DAY 1 - DAY OF ADMISSION Acute Phase	
Care Category/Tasks & Activities	**Expected Outcomes**
Fall Risk	• Falls Risk Assessment Screen completed and care plan in place, if appropriate.
Cognition	• Alert and Oriented x 3 (person, place, time) • Delirium (CAM) screen negative – no evidence of delirium
Assessment	• Comprehensive Nursing Assessment completed as per all flow sheet criteria • Vital signs within patient normal limits • Heart Rate less than 100 BPM at rest, or as per Prescriber's Order • If patient febrile, temperature is decreasing • Baseline Admission Screening /Risk Assessments completed: o Violence risk o Delirium risk o Alcohol/Drug Screen o Smoking o Dysphagia o Falls o Advance Care planning • Completed VTE risk assessment and prophylaxis
Respiratory Function	• Deep breathing and coughing hourly for patients with a productive cough • SpO_2 88 to 92% (or as prescribed) on oxygen therapy or room air, at rest and on exertion • Respiratory Rate less than 30 breaths per minute, at rest • Patient reports less shortness of breath compared to time of admission • Breath sounds assessment completed and noted in the patient record
Elimination	• Patient's regular bowel pattern documented
Nutrition / Hydration	• Mouth care every 2 hours + PRN • Intake and output noted • Weight on admission taken and documented in the patient record

	• If patient is not known to be a diabetic but is on corticosteroids, monitor capillary glucose • Diet as tolerated, or as per Prescriber's Order
Skin/Dressings/Drains	• Baseline Braden Scale documented • Skin integrity intact or documented
Diagnostics	• Ordered investigations are completed and results available (e.g. Lab work, radiology)
Mobility	• Functional mobility assessment completed and documented. • Activity as tolerated – provided oxygen as required to maintain SpO_2 88 to 92% (or as prescribed)
Medications	• Administer medications as per Prescriber's Order • Nicotine Replacement Therapy Orders initiated, if applicable Vaccines up to date or administered as per Prescriber's Order
Consults	• Referrals sent / completed as per Prescriber's Order, e.g.PT, RT
Teaching & Discharge Planning	• Referral to Respiratory Patient Educator sent • If patient / family have no access to financial or community support on discharge, refer to social worker.

DAY 2 - Acute Phase (usually 1 to 2 days)	
Care Category/Tasks & Activities	**Expected Outcomes**
Fall Risk	• Falls Risk Assessment Screen completed and care plan in place, if appropriate.
Cognition	• Alert and Oriented x 3 (person, place, time) • Delirium (CAM) screen negative – no evidence of delirium
Assessment	• Comprehensive Nursing Assessment completed as per medicine physical assessment guideline • Vital signs within patient normal limits • ***Moving to Transition Phase – temperature will be normal*** • Heart Rate less than 100 BPM at rest, or as per Prescriber's Order • If patient febrile, temperature is decreasing • Completed VTE risk assessment and prophylaxis • SpO_2 88 to 92% (or as prescribed) on oxygen therapy or room air, at rest and on exertion • Respiratory Rate less than 30 breaths per minute, at rest • Patient reports less shortness of breath compared to time of admission • Breath sounds assessment completed and noted in the patient record ***Moving to Transition Phase*** *– patient will subjectively report shortness of breath back to baseline level* *– patient will report improvement in sputum production back to baseline* ***If patient improving, encourage bed exercises, independent transfer, and ambulation (with oxygen via nasal prongs as required)***
Elimination	• Patient's regular bowel pattern documented
Nutrition / Hydration	• Mouth care every 2 hours + PRN • Intake and output noted • Weight in AM if patient has congestive heart failure • If patient is not known to be a diabetic but is on corticosteroids,

	monitor capillary glucose • Diet as tolerated, or as per Prescriber's Order
Skin/Dressings/Drains	• Skin integrity intact or documented
Mobility	• Activity as tolerated – provided oxygen as required to maintain SpO_2 88 to 92% (or as prescribed)
Medications	• Administer medications as per Prescriber's Order • Nicotine Replacement Therapy Orders initiated, if applicable • Vaccines up to date or administered as per Prescriber's Order
Consults	• Referrals sent / completed as per Prescriber's Order
Teaching & Discharge Planning	• If patient / family have no access to financial or community support on discharge, refer to social worker. • Review with patient: 1. Pursed lip breathing 2. Relaxation positioning 3. Effective coughing techniques if patient has sputum production 4. Patient/family information re: plan of care • Motivational counseling, chronic health teaching, psycho/social support to family • ***If patient improving, review :*** 1. Inhaler technique 2. Smoking cessation strategies • ***If patient improving:*** Advocate for transition from nebulizers to inhaled medication

DAY 3 - Acute Phase (usually 1 to 2 days)	
Care Category/Tasks & Activities	**Expected Outcomes**
Fall Risk	• Falls Risk Assessment Screen completed and care plan in place, if appropriate.
Cognition	• Alert and Oriented x 3 (person, place, time) • Delirium (CAM) screen negative – no evidence of delirium
Assessment	• Vital signs within patient normal limits ***Moving to Transition Phase*** o ***temperature will be normal*** o ***patient will report improvement in sputum production back to baseline*** • If patient febrile, temperature is decreasing • SpO_2 88 to 92% (or as prescribed) on oxygen therapy or room air, at rest and on exertion • Respiratory Rate less than 30 breaths per minute, at rest • Heart Rate less than 100 BPM at rest, or as per Prescriber's Order ***Moving to Transition Phase – patient will subjectively report shortness of breath back to baseline level*** • Breath sounds assessment completed and noted in the patient's record ***If patient improving, encourage bed exercises, independent transfer, and ambulation (with oxygen as required)***
Elimination	• Patient's regular bowel pattern documented
Nutrition / Hydration	• Mouth care every 2 hours + PRN • Intake and output noted • Patient tolerating recommended diet
Skin/Dressings/Drains	• Skin integrity intact or documented
Mobility	• Bed exercises, independent transfer, and ambulation as tolerated -provided oxygen as tolerated to maintain SpO_2 88 to 92% (or as prescribed) • Mobility improved as compared to Acute Phase (days 1, 2)

Medications	• Administer medications as per Prescriber's Order • Vaccines up to date or administered as per Prescriber's Order • Patient transitioned to maintenance inhaled medication
Consults	• Referrals sent / completed as per Prescriber's Order
Teaching & Discharge Planning	Review with patient: • Pursed lip breathing • Relaxation positioning • Effective coughing techniques (if patient has sputum production) • Energy conservation techniques • Patient / family information given re: plan of care • Smoking cessation strategies discussed with patient (where applicable) • Motivational counseling, chronic health teaching, psycho/social support to family / patient • Inhaler technique reviewed and demonstrated by patient

DAY 4 – 5- Transition phase	
Care Category/Tasks & Activities	**Expected Outcomes**
Cognition	• Alert and Oriented x 3 (person, place, time) • Delirium (CAM) screen negative – no evidence of delirium
Assessment	o Vital signs within patient normal limits o If patient febrile, temperature is decreasing o Heart Rate less than 100 BPM at rest, or as per Prescriber's Order ***Moving to Pre-Discharge Phase*** o SpO_2 88 to 92% (or as prescribed) on oxygen therapy or room air, at rest and on exertion o patient will subjectively report shortness of breath back to baseline level o Breath sounds assessment completed and noted in the patient record o Patient will report improvement in sputum production back to baseline ***If patient improving, encourage bed exercises, independent transfer, and ambulation (with oxygen via nasal prongs as required)***
Elimination	• Patient's regular bowel pattern documented
Nutrition / Hydration	• Patient tolerating recommended diet • Intake and output noted in the patient record
Skin/Dressings/Drains	• Skin integrity intact or documented
Mobility	• Bed exercises, independent transfer, and ambulation as tolerated- provided oxygen as tolerated to maintain SpO_2 88 to 92% (or as prescribed) • Mobility improved as compared to Acute Phase • ***Moving to Pre-Discharge Phase – patient able to do baseline ADL or acceptable for discharge***
Medications	• Administer medications as per Prescriber's Order • Vaccines up to date or administered as per Prescriber's Order • Patient transitioned to maintenance inhaled medication

Consults	• Referrals sent / completed as per Prescriber's Order
Teaching & Discharge Planning	Review with patient: • Pursed lip breathing • Relaxation positioning • Effective coughing techniques (if patient has sputum production) • Energy conservation techniques reviewed • Patient / family information given re: plan of care • Smoking cessation strategies discussed with patient (where applicable) • Motivational counseling, chronic health teaching, psycho/social support to family / patient • Inhaler technique reviewed and demonstrated by patient If patient is meeting all of the indicators in the COPD Care Documentation Pathway, patient may be able to be discharged early. If this is the case, discharge planning also includes: COPD Discharge Plan completed and given to patient Home Oxygen Assessment if warranted (to be done within 72 hours prior to discharge) Community resource information and on-going support for family arranged GP notified of discharge QuitNow referral faxed on day of discharge (if patient agrees to program)

DAY 6 – pre-discharge phase	
Care Category/Tasks & Activities	**Expected Outcomes**
Cognition	• Alert and Oriented x 3 (person, place, time) • Delirium (CAM) screen negative – no evidence of delirium
Assessment	• Vital signs within patient normal limits • Heart Rate less than 100 BPM at rest, or as per Prescriber's Order • Breath sounds assessment completed and noted in the patient record • Minimal sputum production or back to baseline level ***If patient improving, encourage bed exercises, independent transfer, and ambulation (with oxygen via nasal prongs as required)***
Elimination	• Patient's regular bowel pattern documented
Nutrition / Hydration	• Patient tolerating recommended diet • Intake and output noted in the patient record
Skin/Dressings/Drains	• Skin integrity intact
Mobility	• Activity as tolerated • Patient able to do baseline ADL or acceptable for discharge
Medications	• Administer medications as per Prescriber's Order • Patient transitioned to maintenance inhaled medication • Pneumococcal vaccine up to date • Influenza vaccine up to date
Teaching & Discharge Planning	Review with patient: • Pursed lip breathing • Relaxation positioning • Effective coughing techniques (if patient has sputum production) • Energy conservation techniques reviewed • Patient / family information given re: plan of care • Exercise and strength building • Patient / family information given re: plan of care • Smoking cessation strategies discussed with patient (where applicable) Motivational counseling, chronic health teaching, psycho/social support to family / patient

	COPD Discharge Plan reviewed with patient / family Patient provided with smoking cessation material (if current smoker) Inhaler technique reviewed; patient technique checked Patient is meeting indicators for expected discharge on day 7. If not, CNL aware. COPD Discharge Plan completed and given to patient Community resource information and on-going support for family arranged GP notified of discharge If patient agrees to QuitNow program, fax QuitNow referral form on day of discharge Home Oxygen Assessment if warranted (to be done within 72 hours prior to discharge)

DAY 7 – expected day of discharge	
Care Category/Tasks & Activities	**Expected Outcomes**
Cognition	• Alert and Oriented x 3 (person, place, time) • Delirium (CAM) screen negative – no evidence of delirium
Assessment	• Vital signs within patient normal limits • Heart Rate less than 100 BPM at rest, or as per Prescriber's Order • SpO_2 88 to 92% (or as prescribed) on oxygen therapy or room air, at rest and on exertion ***Moving to Discharge Phase –*** *patient will subjectively report shortness of breath back to baseline level* • Breath sounds assessment completed and noted in the patient record Minimal sputum production or back to baseline level ***If patient improving, encourage bed exercises, independent transfer, and ambulation (with oxygen via nasal prongs as required)***
Nutrition / Hydration	• Patient tolerating recommended diet
Skin/Dressings/Drains	• Skin integrity intact
Mobility	• Complete ADLs unassisted or home supports in place
Teaching & Discharge Planning	• Patient is expected to discharge today • Patient will not be discharged today; reason for extended length of stay charted in the patient record. Continue to follow pathway pre-discharge phase • COPD Discharge Plan completed and given to patient/family • Pneumococcal and Influenza vaccine up to date • Community resource information and on-going support for family arranged • GP notified of discharge • If patient agrees to QuitNow program, fax QuitNow referral form on day of discharge • Home Oxygen arranged (where required)

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