The Ottawa Hospital | L'Hôpital d'Ottawa

IN PATIENT 5 FLOW SHEET

CLINICAL PATHWAY

Chronic Obstructive Pulmonary Disease Exacerbation (COPD-E)

☐ **Civic** ☐ **General**

Clinical Frailty Scale (At baseline, at least 2 weeks before hospitalization)

Init.	Diagram	Frailty Scale Description	Expected Goal of Care	Consider Consulting Services	Date (yyyy/mm/dd)	Initials
	 **OR** 	**Well:** • No active disease symptoms • Active occasionally, e.g. seasonally **Managing Well:** • Medical problems **are well controlled**, BUT • **Not regularly active** beyond routine walking	• Return to independent living • Self manage breathing techniques, secretion clearance • Recognize early symptoms of COPD exacerbation	☐ Respiratory Therapy (for teaching by CRE)		
		**Vulnerable:** • Not dependent on others for help, BUT • Symptoms limit activities	• Return to independent living • Self manage breathing techniques, secretion clearance • Recognize early symptoms of COPD exacerbation	☐ Respiratory Therapy (for teaching by CRE) ☐ Physiotherapy ☐ Occupational Therapy ☐ Dietetics		
	 **OR** 	**Mildly Frail:** • More evident slowing • Need help in high order instrumental activities of daily living (finances, transportation, heavy housework, medications) • Progressive impairment of shopping, walking outside alone, meal preparation, housework **Moderately Frail:** • Need help with **all outside activities** and with **keeping house** • Often have problems with stairs • Need **help with bathing** • Minimal assistance (cueing, standby) with dressing	• Return home with additional services • Consider relocation to assisted living facility if appropriate • Self manage breathing techniques, secretion clearance • Recognize early symptoms of COPD exacerbation • Recognize need to modify activities and/or use additional equipment to maximize functional abilities	☐ Respiratory Therapy (for teaching by CRE) ☐ Physiotherapy ☐ Occupational Therapy (consider cognitive screen) ☐ Social Work ☐ Dietetics		
	 **OR** 	**Severely Frail:** • Completely dependent on others for personal care (physical or cognitive) • Stable, not at high risk of dying (within 6 months) **Very Severely Frail:** • Completely dependent, approaching the end of life • Could not recover even from a minor illness	• Strongly consider assisted living (either with services in current dwelling or by relocation to new facility) • Understands severity of illness and the limits this places on functional ability • Engage in advanced care planning discussions with the medical team and with the family physician upon discharge	☐ Physiotherapy ☐ Occupational Therapy ☐ Social Work ☐ Dietetics		
		**Teminally Ill:** • Approaching the end of life. • Applies to people with **a life expectancy less than 6 months**, who are **not otherwise evidently frail**	• Strongly consider palliative care consultation • Arrange hospice, long term care, or palliative care at home	☐ Social Work ☐ Palliative Care (MD to complete) If returning home: ☐ OT ☐ PT for services		

Patient _____ **Chart No.** _____

PHASE 1: Rescue Treatment

Start Date: **yyyy** _____ **mm** _____ **dd** _____

Critical Path

Assessment/Treatment
- Vital signs and SpO_2 q4h
- Chest and respiratory assessment q shift and prn
- Assess bowel function
- Assess for anxiety q shift (if anxiety severe, consider psychology consult)

Category Status
- Ensure category status form completed by physician - Init ____ Date _____

Activities
- Activity as tolerated
- Up in chair for meals (TID)

Nutrition
- As ordered/tolerated
- BMI = _____ kg/m_2 – Init ____ Date _____
- Consult Registered Dietitian using NUT 51 if BMI 21 or less, or patient report unintentional weight loss – Init ____ Date _____
- Provide nutrition booklet to patient, if appropriate
- Consult SLP if concerns with swallowing/aspiration - Init ____ Date _____

Smoking Cessation Interventions
- Provide patient nicotine replacement therapy as per orders (patch, gum, inhaler)

Discharge Planning
- Clinical Frailty Scale assessment (see left leaflet) - Init ____ Date _____

Patient Outcomes

Assessment/Treatment
- Vital signs within normal limits, afebrile
- Optimal saturation achieved
- Heart rate (less than 100 beats/minute at rest)
- Decreased use of respiratory accessory muscles
- Patient passing stool freely without difficulty

Category Status
- Category status completed

Activities
- Tolerating activity level eating more than 50% of each meal

Nutrition
- Tolerating diet

Smoking Cessation Interventions
- No symptoms of nicotine withdrawal (headache, nausea, irritability, anxiety)

Discharge Planning
- Appropriate referrals completed and sent (See action items of Frailty Scale Leaflet)

Patient ______________________ Chart No. ______________________

PHASE 1: Rescue Treatment (continued)

Patient progress corresponds with clinical pathway: D: 8–12 h day shift E: evening shift, if applicable N: 8–12 h night shift

Date: (yyyy/mm/dd) ____________

D ☐ Yes ☐ No Signature: ____________ Initials: ______ Time: ______ NTV – circle above, VC ______

E ☐ Yes ☐ No Signature: ____________ Initials: ______ Time: ______ NTV – circle above, VC ______

N ☐ Yes ☐ No Signature: ____________ Initials: ______ Time: ______ NTV – circle above, VC ______

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Variance Codes (VC)				
	492	Not discharged by end of pathway – continued need for acute care	**NTV**	Non-Tracked Variance
	510	Not discharged by end of pathway – non-medical reason	**OFF**	Ordered off clinical pathway

Patient _____ **Chart No.** _____

PHASE 2: Optimization Phase

Start Date: **yyyy** _____ **mm** _____ **dd** _____

Critical Path

Assessment/Treatment
- Vital signs and SpO_2 q8h
- Chest and respiratory assessment q shift and prn
- Assess for anxiety q shift (if anxiety severe, consider psychology consult)

RT to provide Patient/Family Education

Mark off once completed with patient:

☐ Provide standard COPD education - Init ____ Date _____
☐ Review inhaler device technique - Init ____ Date _____
☐ Review pursed lip breathing, deep breathing, and coughing exercises - Init ____ Date _____
☐ Review relaxation techniques and positioning to reduce dyspnea - Init ____ Date _____
☐ Write order for spirometry in the chart, if required to confirm COPD diagnosis (MD to cosign) - Init ____ Date _____
☐ Ensure that spirometry request sent to Module R prior to discharge (to be done as an inpatient, or outpatient, depending on availability) - Init ____ Date _____
☐ Write order in chart for referral to COPD outreach program if patient meets criteria and send referral - Init ____ Date _____
☐ If patient meets criteria for outpatient pulmonary rehabilitation, write order in chart to suggest referal to appropriate program (MD will send referral) - Init ____ Date _____
☐ If patient would benefit from community lung health resources after discharge from hospital (education, maintenance rehabilitation, etc.), write order in chart with referral suggestions (MD will send referral) - Init ____ Date _____
☐ Assess and qualify patient for home oxygen therapy if indicated

Smoking Cessation/Counselling
- Provide patient nicotine replacement therapy as per orders (patch, gum, inhaler)

Activity/ADL's
- Activity as tolerated
- Up in chair for meals (TID)
- Up to bathroom or commode – if able
- Ambulate in hallway – if able
- Assist and encourage with personal care

Nutrition
- As ordered/tolerated

Initiate Early Discharge Planning
- Ensure team is aware if patient is still requiring oxygen at rest, and was not on home oxygen
- Assess and review pre-admission functional status
- Ensure all applicable allied health team members consulted as per Clinical Frailty Scale

Patient Outcomes

Assessment/Treatment
- Vital signs within normal limits, afebrile
- Optimal saturation achieved
- Heart rate (less than 100 beats/minute at rest)
- Decrease in anxiety

Patient/Family Education
- Adequate use of inhaler device (including mouth care)
- Effective cough and expectoration techniques
- Patient verbally expressing feeling less anxious
- Spirometry suggested if required
- Need for home oxygen assessed
- COPD outreach and rehabilitation referrals suggested if required

Smoking Cessation/Counselling
- No symptoms of nicotine withdrawal

Activity
- Tolerating activity level
- Increasing mobility level
- Returning to baseline level of mobility

Nutrition
- Tolerating diet eating more than 50% of each meal
- Good swallowing function, no aspiration
- Improvement in weight and oral intake

Initiate Early Discharge Planning
- Patient understands limitations in level of function and need for additional home services (or assisted living) if required
- Patient and family concerns heard and relayed to allied health and physician team members
- Home oxygen assessment started, if required

Patient ______________________ Chart No. ______________________

PHASE 2: Optimization Phase (continued)

Patient progress corresponds with clinical pathway: D: 8–12 h day shift E: evening shift, if applicable N: 8–12 h night shift

Date: (yyyy/mm/dd) ______________

D ☐ Yes ☐ No Signature: ______________ Initials: ______ Time: ______ NTV – circle above, VC ______

E ☐ Yes ☐ No Signature: ______________ Initials: ______ Time: ______ NTV – circle above, VC ______

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RT Signature

Signature: ______________ Initials: ______

Variance Codes (VC)	**492**	Not discharged by end of pathway – continued need for acute care	**NTV**	Non-Tracked Variance
	510	Not discharged by end of pathway – non-medical reason	**OFF**	Ordered off clinical pathway

Patient _____ **Chart No.** _____

PHASE 3: Safe Transition

Start Date: **yyyy** _____ **mm** _____ **dd** _____

Critical Path

Assessment/Treatment
- Vital signs and SpO_2 q shift
- Chest and respiratory assessment q shift and prn
- Assess for anxiety q shift (if anxiety severe, consider inpatient psychology consult)

Activity/ADL's
- Activity as tolerated
- Up in chair for meals (TID)
- Up to bathroom or commode – if able
- Ambulate in hallway – if able
- Assist and encourage with personal care

Nutrition
- As ordered/tolerated

Medication Teaching
- Page Respiratory Pharmacist to complete medication review - Init ____ Date _____

Smoking Cessation/Counselling
- Continue nicotine replacement

Follow-up Appointments/Services
- Specialist follow-up arranged by clerks based on physician recommendations - MD Init ____ Date _____
- GP follow-up arranged within 2 – 4 weeks of discharge (ask patient to call)
- Referral to COPD community services sent (check all that apply):
  - ☐ COPD outreach team MD Init ____ Date _____
  - ☐ Lung Association Referral MD Init ____ Date _____
  - ☐ Champlain Lung Health Referral MD Init ____ Date _____
  - ☐ TOH COPD Education (PFT Lab) MD Init ____ Date _____
  - ☐ TRC Pulmonary Rehabilitation MD Init ____ Date _____
  - ☐ Montfort Pulmonary Rehabilitation MD Init ____ Date _____
  - ☐ Other _____ MD Init ____ Date _____

Patient Outcomes

Assessment/Treatment
- Vital signs within normal limits, afebrile
- Optimal saturation achieved
- Heart rate (less than 100 beats/minute at rest)
- Decrease in anxiety

Activity/ADL's
- Tolerating activity level
- Increasing mobility level
- Returning to baseline level of mobility

Nutrition
- Tolerating diet
- Good swallowing function, no aspiration

Medication Teaching
- Patient understands indication for use of long and short acting medications before discharge

Smoking Cessation/Counselling
- No symptoms of nicotine withdrawal

Follow-up Appointments/Services
- Patient receives written confirmation of appointment dates and times

Discharge Planning
- Ensure functional and psychosocial issues addressed by allied team members prior to discharge
- Home oxygen arranged if eligible

Patient ______________________________ Chart No. ______________________

PHASE 3: Safe Transition (continued)

Patient progress corresponds with clinical pathway: D: 8–12 h day shift E: evening shift, if applicable N: 8–12 h night shift

Date: (yyyy/mm/dd) ____________

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Pharmacist Signature

Signature: ____________ Initials: ______

Variance Codes (VC)	**492**	Not discharged by end of pathway – continued need for acute care	**NTV**	Non-Tracked Variance
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