Clinical Conditions & Symptom Management: Chronic Obstructive Pulmonary Disease—COPD

VNAA Best Practices for Home Health
Definition Of COPD

• Chronic Obstructive Pulmonary Disease (COPD), a common, treatable although incurable disease, is characterized by persistent airflow limitation that is usually progressive and associated with an enhanced chronic inflammatory response in the airways and the lung to noxious particles or gases. (GOLD, 2014)
Why COPD

• COPD is the fourth leading cause of death in the U.S. (CDC, 2011a)
• The incidence of COPD is climbing as the population ages.
• 24 million Americans are estimated to have COPD (Hersh, 2010)
• Common comorbidity for home care patients
Definition Of Best Practices

1) All patients with COPD should be assessed for risk of hospitalization
2) Both non-pharmacological and pharmacological interventions should be addressed in a program that is also formally taught to staff.
3) Utilize evidence-based disease management program including teaching tools
4) Focus should be on helping patients develop self-care competencies
Interventions - Intake

Obtain the following information as part of the intake process:

1) H&P and/or hospital discharge summary
2) Stage of COPD – Mild, Moderate, Severe, Very Severe
3) Known risk indicators for re-hospitalization
4) Discharge/current medication list
5) Ordered treatments including any lab tests
6) Teach-back readiness and any teaching tools used by referral source
7) Staff concerns regarding discharge and safety
8) Extent of family involvement; identified caregiver; patient representative
Intake - Continued

Call/speak to patient on day of d/c from a facility to ask about:

1) Who is helping you at home?
2) Has your breathing changed since you got home?
3) Were all of your prescribed medications obtained? Any questions about them?
4) Was cost an issue if didn't obtain all of them?
5) Do you have a working thermometer in the house?
6) Have you used your inhaler/nebulizer since coming home? Any problems? Do you have/use a spacer?
7) Do you feel safe and/or do you need a visit today/this evening?
8) Provide agency name and contact information
Front-loading Contact Schedule

- SN – Recommend 2-3 visits in a row – assess, intervene, refocus. Utilize same RN for visits when possible to assure consistency of care.
- REHAB – 1-3 visits a week starting 1-3 days after initial RN visit
- HHA – to assist with personal care when needed
- MSW – especially if pt unable to afford medications
- Implement tele-health/telephonic communications by 2nd visit if appropriate
- See pt 5-7 visits the first week
Start Of Care Interventions/Actions

• Admit within 24 hours
• OASIS, total clinical assessment AND complete respiratory assessment including SPO2, dyspnea, standardized tests (BORG<CCQ<CAT), breath sounds, use of accessory muscles, nasal flaring, weight, cough, sputum, activity tolerance, mental status, smoking history, O2 use, ability to use inhaler, nebulizer, manage O2 therapy, Complete respiratory assessment at each visit.
• Refer to MSW for community resources/psych RN for anxiety and depression
Start Of Care - 2

- Complete medication reconciliation using VERIFY CLARIFY RECONCILE
- Assess educational needs regarding medications and use of inhalers, nebulizers, O2 equipment
- Assess immunization status (M1014/1050)
- Check that medications ordered are in home and process exists for obtaining medications including ability to pay for them.
- Introduce Stoplight Method for symptom self management
Start Of Care - 3

• Provide on-call number, MD contact number and use of 911
• Assess for tele-health appropriateness
• Refer to PT for exercise, activity tolerance
• Refer to OT for energy conservation
• Schedule PCP follow-up appointment within 7 days
• Identify 1-2 smart goals
Self Management Areas For Teaching And Ongoing Care

- SMOKING CESSATION
- REDUCING/CONTROLLING SYMPTOMS
- NUTRITIONAL NEEDS
- EMOTIONAL HEALTH
- EXERCISE
- OXYGEN THERAPY AND EQUIPMENT
- BREATHING AIDES
- CO-MORBIDITIES
- HANDLING EXACERBATIONS
Smoking Cessation

- Ask patients at each visit about tobacco use
- Using empathetic communication skills, urge patients to quit
- Provide referral to local program that includes tobacco dependence counseling and social support
- Obtain orders for nicotine replacement products and/or medications that help with physiological addiction
- Consider recommendation for an antidepressant
- Counsel patient that since tobacco dependence is a chronic disease, relapse is common and he/she should not be discouraged
Reducing Symptoms: Self-management

- Teach patient to use a dyspnea rating scale and log levels daily
- Teach pursed lip and diaphragmatic breathing
- Encourage proper positioning
- Teach controlled coughing and/or trial with an incentive spirometer to help clear airways
- Teach energy conservation techniques
- Identify environmental triggers of dyspnea and develop strategies to avoid them
- Teach clinical signs of a bacterial infection
- Explore methods to help improve sleep quality
Nutritional Needs

- Ask patient to keep a log of food and fluid intake. Review on each visit
- Discuss ways to improve intake of protein and calories
- Help patient plan for small, frequent meals high in protein
- High-caloric nutritional supplements may be indicated
- Avoid gas forming foods
- Refer to dietician for help with dietary requirements if needed
- Suggest use of breathing medication one hour before
Exercise

- Work with patients to set exercise goals and overcome barriers
- Refer to PT and/or OT so an individualized routine can be developed
- Many patients need to start off very slowly
- Encourage patient to keep an exercise log and review at each visit
- Suggest new technology such as FITBIT that tracks steps taken to provide positive reinforcement
- Use the 3 minute walk if 6 minute walk is overwhelming. See description in the Blueprint
Oxygen Therapy and Equipment

- O2 safety should be discussed especially if patient or caregiver smokes
- Discuss patient O2 requirements with DME company and assure pt/caregiver know how to contact the company
- Assess need for humidification and request order if needed
- Teach patient how to clean and maintain O2 equipment
Emotional Health

- Help patients/caregivers verbalize feelings
- Identify healthy coping behaviors such as meditation, listening to music, breathing and relaxation techniques.
- Encourage patients to share feelings
- If positive for depression, notify physician and make appropriate referrals.
Breathing Aides – Nebulizers And Inhalers

- Assess proper use of inhalers. Recommend a SPACER prescription to assure delivery of full dose.
- Assess proper inhaler technique and use of rescue/controller inhaler.
- Review proper storage as many inhalers become compromised if exposed to moisture or light.
- Nebulizers may be easier to use for some patients.
- Nebulizers are recommended if the patient is unable to understand or physically use an inhaler.
- Teach patient to clean nebulizer after every use and allow to air dry.
Self Monitoring Of Co-morbidities

- HF – see VNAA HF Blueprint for detailed discussion
- Hypertension – teach importance of monitoring and maintaining BP at goal.
- Osteoporosis – Discuss avoidance of recurring courses of systemic corticosteroids for COPD exacerbations
- Anxiety and Depression – screen for and encourage pt to seek treatment if present
- Infections – monitor for signs and symptoms of infection
- Diabetes – teach importance of keeping Hemoglobin A1c at goal
Prevention/Treatment Of Exacerbations

- Monitor frequency, severity and likely causes of any exacerbations
- Mark on calendar each time a PRN inhaler is used
- Recognize other signs of exacerbations including worsening dyspnea, chest congestion, sleep disturbance and feelings of weakness, fatigue, fear or anxiety
- Discuss importance of early recognition to initiate prompt treatment
- Teach staff to identify severity of exacerbations
- Promote oral hygiene and periodontal health to prevent infection
- Increase exercise to help prevent complications of immobility
Exacerbations - 2

- Address nutritional needs for increased protein
- Assure adequate oxygenation and secretion clearance. Avoid cough suppressants
- Avoid persons with respiratory infections
- Wash hands frequently
- Avoid gastroesophageal reflux disease
- Avoid second hand smoke and other environmental pollutants
Exacerbations - 3

- Yearly flu vaccination, ideally by October
- Pneumonia vaccine – both PCV13 and PPSV23 should be administered routinely in series to all adults 65 and older
- PPSV23 should be given 6-12 months after a dose of PCV13
- For those who previously received PPSV23, a dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose (CDC, Sept 19, 2014)
Medication Management

- Teach nursing staff to be cautious with anticholinergics if patient has an asthma component.
- Teach proper use of long acting (LABA's) versus short acting (SABA's) beta-2 agonists.
- Opioids can be recommended for patients who are poorly controlled.
- Assess understanding of medication actions and side effects and adherence.
- Refer to occupational therapy (OT) or speech therapy (ST) if cognitive skills are an issue.
Medication Management - 2

- Help patient identify a plan to consistently follow the medication schedule and obtain refills
- Assess for need to obtain devices such as pill boxes to help with medication adherence
- If on multiple inhalers, instruct use of inhaler that opens the airways (short acting beta-2 agonist (SABA's) first before an inhaled corticosteroid (ICS)
- Determine if patient is prescribed a dry powder inhaler
- Assure patient understands which medications should be taken regularly and which are used only PRN
Palliative Care And Hospice

- Discuss advanced care planning, palliative care and end-of-life-care options
- Revisit advanced care planning discussions periodically
- Use a simple, structured approach to facilitate these conversations
- Patients/families should be made aware that by making informed choices ahead of time, these choices will be consistent with the patient's goals and values
- Patients with severe and very severe COPD should be offered a formal palliative care consult if available in the community
Hospice

- Recommend and refer to hospice care if patient meets Medicare eligibility guidelines

- Guidelines include:
  - Disabling dyspnea at rest that is poorly or unresponsive to bronchodilators
  - Increasing visits to the ER or hospitalizations for pulmonary disease
  - Hypoxemia at rest on room air
  - Heart failure secondary to COPD
  - Unintentional progressive weight loss
  - Resting tachycardia
Pulmonary Rehab Post Discharge

- Discuss advantages (especially for younger patients) of pulmonary rehabilitation programs post discharge from home care
- Make referrals/recommendations as needed
Discharge/Transition Planning

Considerations should include:

- Pulmonary rehab program
- Elder services – adult day care, transportation, meals on wheels
- Private pay services for ADL's and IADL's
- Referrals for other community services for long term services and support
- Continuance of tele-health
- Referral to hospice and palliative care when appropriate
- Hand off of up-to-date medication list and discharge
Tools

- CAT – COPD Assessment Test – measure of health status impairment in COPD
- CCQ – COPD Control Questionnaire – a self-administered questionnaire to measure clinical control in patients with COPD
- GDS – Geriatric Depression Scale – asks patients to answer yes/no to a series of questions
- IHI – Institute for Healthcare Improvement re-hospitalization risk assessment – categorizes patients into Low, Moderate or High risk
- MODIFIED BORG SCALE – uses descriptive terms to measure dyspnea with activity
- MACH10 – Missouri Alliance for Home Care – falls risk assessment – is a standardized assessment consisting of ten elements used to identify areas of falls risk
Tools - 2

• PHQ2 – Patient Health Questionnaire 2 – Utilized in OASIS (M1730) to screen for depression
• PHQ9 – Expanded version of the PHQ that probes for specific possible symptoms
• PROMIS – Patient Reported Outcome Measurement Information System – measures health outcomes from the patient perspective ([www.nihpromis.org](http://www.nihpromis.org))
• RDOS – Respiratory Distress Observation Scale – used to evaluate dyspnea in patients who can not self report
• Visual Analog Scale 0 used by patients to self-report dyspnea on a scale of 0-10
Helpful Hints

- Assessment of COPD is based on level of symptoms, risk of exacerbations, severity of spirometry results and co-morbidities
- Spirometric classification is divided into four grades: Mild, Moderate, Severe & Very Severe
- Fatigue, weight loss and anorexia are common in patients with severe and very severe COPD and are poor prognostic signs
- Smoking cessation is the intervention with the greatest ability to influence the natural history of COPD (GOLD, 2014)
- For a comprehensive approach to help patients quit smoking see the 2008 U.S. Department of Health and Human Services guidelines, Treating Tobacco Use and Dependence, found at www.ncbi.nlm.nih.gov/books/NBK12193
Helpful Hints - 2

- Drug therapy for COPD is used to reduce symptoms, frequency and severity of exacerbations and improve health status and exercise tolerance.
- 24 hr (long-acting) medication products are often preferable but are cost prohibitive for some patients.
- Pulmonary rehabilitation programs have been shown to have many benefits.
- Long-term O2 therapy (greater than 15 hrs/day) has been shown to increase survival in pts with severe resting hypoxemia (SPO2 at or below 88%).
- Medicare coverage guidelines require a SPO2 at or below 88%.
- Although used to treat exacerbations, CPAP isn't indicated in the routine, long-term management of COPD (AJN, 2012).
Patient Teaching Tools

- PORCHLIGHT VNA. Living with lung disease. Strategies for breathing easier. A handbook for patients with chronic obstructive pulmonary disease (COPD)

References

References - 2


Questions?