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# Pathway Pearls



## Discharge Management Plan

Taking a closer look

2018Jun14

# Learning Objectives



- Review practice recommendations
  - Review the components preparing the patient for discharge
  - Review the COPD Action Plan & when to use it
  - Describe completion of the Discharge Management Plan
  - Share site implementation strategies
  - Identify 2 Pathway Pearls to assist implementation
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# Outline



- Recommendations
- COPD: Take Action

(Carol Zemanek, RN)

- Review Pathway Discharge Management Plan
  - Group Discussion:  
How do you see it being done at your site?
  - Wrap Up
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# GOLD 2018 (p. 108)



**Table 5.7. Discharge criteria and recommendations for follow-up**

- Full review of all clinical and laboratory data.
- Check maintenance therapy and understanding.
- Reassess inhaler technique.
- Ensure understanding of withdrawal of acute medications (steroids and/or antibiotics).
- Assess need for continuing any oxygen therapy.
- Provide management plan for comorbidities and follow-up.
- Ensure follow-up arrangements: early follow-up < 4 weeks, and late follow-up < 12 weeks as indicated.
- All clinical or investigational abnormalities have been identified.

TRIBUTE

# COPD Action Plan



The research examining the efficacy of COPD education remains inconclusive, with recent work suggesting that if not properly implemented and monitored, that it may actually be harmful.

For this reason, recent guidelines support the use of COPD education only when combined with an action plan and case manager.

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# CCS Heart Failure 2017



Self-care includes knowledge, skills, and confidence about HF treatments, exercise, dietary measures, symptom-, and weight-monitoring. It also includes an action plan to address exacerbations early and determine if actions were helpful to circumvent further deterioration. This plan should facilitate rapid access, either in person, by phone, or other modes of communication or technology, to HF clinic staff for assistance (p. 1412).

# Presentation: COPD- RGH

## **Discharge Management Plan**

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**My COPD Action Plan** \_\_\_\_\_ Date \_\_\_\_\_

Physician's Copy (Patient's Name)



This is to tell me how I will take care of myself when I have a COPD flare-up.

My goals are \_\_\_\_\_

My support contacts are \_\_\_\_\_ and \_\_\_\_\_  
 (Name & Phone Number) (Name & Phone Number)

| My Symptoms             | I Feel Well  | I Feel Worse   | I Feel Much Worse <b>URGENT</b>   |
|-------------------------|--|--|---|
| I have sputum.          | My usual sputum colour is: _____   | Changes in my sputum, for at least 2 days. Yes <input type="checkbox"/> No <input type="checkbox"/>  | My symptoms are not better after taking my flare-up medicine for 48 hours.  |
| I feel short of breath. | When I do this: _____  | More short of breath than usual for at least 2 days. Yes <input type="checkbox"/> No <input type="checkbox"/>  | I am very short of breath, nervous, confused and/or drowsy, and/or I have chest pain.   |
| My Actions              | Stay Well  | Take Action  | Call For Help   |
|                         | I use my daily puffers as directed.  | If I checked 'Yes' to one or both of the above, I use my <b>prescriptions</b> for COPD flare-ups.  | I will call my support contact and/or see my doctor and/or go to the nearest emergency department.  |
|                         | If I am on oxygen, I use _____ L/min.  | I use my daily puffers as usual. If I am <b>more</b> short of breath than usual, I will take _____ puffs of _____ up to a <b>maximum</b> of _____ times per day. | <b>I will dial 911.</b>   |
| Notes:                  | I use my breathing and relaxation methods as taught to me. I pace myself to save energy.<br>If I am on oxygen, I will increase it from _____ L/min to _____ L/min. |  | <b>Important information:</b> I will tell my doctor, respiratory educator, or case manager <b>within 2 days</b> if I had to use any of my flare-up prescriptions. I will also make follow-up appointments to review my COPD Action Plan twice a year. |



**My COPD Action Plan** \_\_\_\_\_ Date \_\_\_\_\_  
Patient's Copy (Patient's Name)



This is to tell me how I will take care of myself when I have a COPD flare-up.

My goals are \_\_\_\_\_

My support contacts are \_\_\_\_\_ and \_\_\_\_\_  
(Name & Phone Number) (Name & Phone Number)

**Prescriptions for COPD flare-up (Patient to take to pharmacist as needed for symptoms)**

These prescriptions may be refilled two times each, as needed, for 1 year, to treat COPD flare-ups. Pharmacists may fax the doctor's office once any part of this prescription has been filled.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Patient Identifier (e.g. DOB, PHN)

1. (A) If **the colour** of your sputum **CHANGES**, start antibiotic \_\_\_\_\_ Dose: \_\_\_\_\_ #pills: \_\_\_\_\_  
How often \_\_\_\_\_ for #days: \_\_\_\_\_

(B) If the first antibiotic was taken for a flare-up in the **last 3 months**, use this different antibiotic instead:

Start antibiotic \_\_\_\_\_ Dose: \_\_\_\_\_ #pills: \_\_\_\_\_  
How often \_\_\_\_\_ for #days: \_\_\_\_\_

**AND / OR**

2. If you are **MORE short of breath** than usual, start prednisone \_\_\_\_\_ Dose: \_\_\_\_\_ #pills: \_\_\_\_\_  
How often: \_\_\_\_\_ for #days: \_\_\_\_\_

Once I start any of these medicines, **I will tell** my doctor, respiratory educator, or case manager within **2 days**.

\_\_\_\_\_  
Doctor's Name

\_\_\_\_\_  
Doctor's Fax

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
License

\_\_\_\_\_  
Date

# How do we do it? When do we start?

- Discharge planning starts as soon as the patient is admitted.
- We give the patient our COPD package (Living Well With COPD, My COPD Action Plan, Pulmonary Rehab Brochure as well as COPD Education and PRIHS Checklist) within 48 hours of admission.
- The checklist has many elements but we focus mainly on mobility, breathing/coughing techniques, avoiding triggers, inhaler techniques and COPD medications.
- We utilize a multidisciplinary team approach (nursing, respiratory therapy, PT/OT, pharmacy and transition services).

# How do we do it? When do we start?

- The dietician may or may not be consulted in hospital. This is determined based on the results of the malnutrition screening tool score.
- Smoking cessation is addressed on admission and through out the stay. Alberta Quits toolkit is offered to the patients as well as a referral prior to discharge.
- If the patient meets the Pulmonary rehab guidelines a referral will be made.

# How do we do it? When do we start?

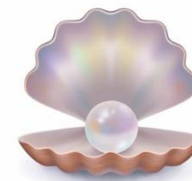
- We also offer vaccines (flu & pneumococcal) or direct the patient where to go as an outpatient to receive their vaccine.
- The LACE Score is completed by myself or the charge nurses for consistency.
- Helpful websites for patients include:
- [www.myhealth.alberta.ca](http://www.myhealth.alberta.ca)
- [www.livingwellwithcopd.com](http://www.livingwellwithcopd.com)

# Pathway Pearls: Discharge Management Plan

# Discharge Management Plan

# Documentation

# Discharge Management Plan



**COPD Discharge Management Plan**

COPD Education Resource Package (Include all handouts identified)

| Bring this Management Plan with you to your next visit  | Handout  |
|---|--|
| Nutrition Dietitian referral <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Phone  |  |
| Activity<br><input type="checkbox"/> Practice breathing and coughing techniques to help when you feel short of breath<br><input type="checkbox"/> Use body positions and energy conserving methods to help prevent feeling short of breath  | <input type="checkbox"/> COPD: Learning to Breathe Easier  |
| Medication Prescription <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Discharge medication list faxed to community pharmacy <input type="checkbox"/> No <input type="checkbox"/> Yes<br><small>(Talk to your doctor or pharmacist before taking any non-prescription or herbal medicines)</small> | <input type="checkbox"/> COPD: Avoiding Your Triggers<br><br><input type="checkbox"/> COPD Medications |
| Treatments<br><input type="checkbox"/> Be sure to use your inhaler properly.  | <input type="checkbox"/> Inhaler technique: Devices  |
| <b>Personal Assessment Checklist - Patient to complete</b>  |  |
| Please review the statements below and check the appropriate box beside each item. Please ask staff for help if you answered NO to any item   |  |
|   | <input type="checkbox"/> AlbertaQuits<br><input type="checkbox"/> Flip Into Action                     |
|   | Yes No   |
| 1. A staff member watched me use my inhalers and spacers to see if I was doing it correctly   |  |
| 2. I feel confident using my inhalers   |  |
| 3. My respiratory medicines were explained to me  |  |
| 4. I was given written information about how to manage my condition after I go home   |  |
| 5. I was offered help and information about quitting smoking/tobacco use <input type="checkbox"/> N/A   |  |
| 6. Someone has talked to me about pulmonary rehabilitation  |  |
| 7. I understand the instructions given to me  |  |
| 8. All of my questions have been answered to my satisfaction  |  |
| You may be contacted after you have been discharged to see how you are doing  |  |
| Comments  |  |
| <b>Follow-up</b>  | Location Phone number Date (yyyy-Mon-dd) Time (hh:mm)  |
| Primary Care Provider (within 2 weeks of discharge)   |  |
| Pulmonary Rehabilitation <input type="checkbox"/> Yes <input type="checkbox"/> Refused <input type="checkbox"/> N/A   |  |
| Local Health Unit for influenza and pneumococcal vaccines   |  |

**Prior to Discharge** Review results, where relevant, and ensure appropriate follow-up

|  |  |  |  |
|--|--|--|--|
| 3. Early mobilization (done within 48 hours by any discipline)   |  |  |  |
| 4. Review and optimize respiratory medication  |  |  |  |
| 5. Respiratory assessment for home oxygen requirements   |  |  |  |
| 6. Frailty screen  |  |  |  |
| 7. Cognitive screen  |  |  |  |
| 8. Transition/Discharge services assessment  |  |  |  |
| <b>At Discharge</b>  |  |  |  |
| 9. Complete discharge medication reconciliation  |  |  |  |
| 10. Complete 'LACE Index Scoring Worksheet' to identify risk of hospital readmission; circle result on Discharge Management Plan |  |  |  |
| 11. Complete, review and provide patient with 'Discharge Management Plan' (ensure adequate patient understanding)                |  |  |  |
| 12. Assess and refer to pulmonary rehabilitation IF patient agreeable, ambulatory, and meets local criteria                      |  |  |  |
| 13. Notify Primary Care Provider of patient discharge  |  |  |  |
| 14. Arrange Primary Care Provider follow-up within 2 weeks (14 days) of discharge  |  |  |  |
| 15. Provide Primary Care Provider with Discharge Summary and Discharge Management Plan   |  |  |  |
| <b>Additional Comments</b>   |  |  |  |

# Admission to Discharge Checklist

## Pathway Pearls: Discharge Management Plan

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Participants are encouraged to participate in session talks.

If you would like to email your question, please send to:

**[hfpathway@ahs.ca](mailto:hfpathway@ahs.ca)**

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