Alberta Health Services

Acute Exacerbation of Chronic Obstructive Pulmonary Disease (AECOPD) Admission Adult

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown		

Select orders by placing a (✓) in the associated box

Date *(dd-Mon-yyyy)*	**Time** *(hh:mm)*

☑ **To be added to General Admission Orders**
☑ Notify Primary Care Provider on next business day
☐ O_2 Therapy - titrate to maintain SpO2 between 88-92%. Reassess daily.
☐ O_2 Therapy - titrate to maintain SpO2 between _____%
☑ Ambulate - Early Mobilization *(done within 48 hours)*

Initial Investigations *(If not done in Emergency Department or if otherwise clinically indicated)*

☐ Chest X-ray PA and Lateral *(GR Chest, 2 Projections)*
☐ Electrocardiogram
☐ Sputum bacterial culture x 1

If ordered, refer to Infection Prevention and Control (IPC) guidelines.

☐ Nasopharyngeal swab for Respiratory Virus Panel if the following criteria are met:
- Influenza-like-illness screen requirements: acute onset of NEW cough or change in an existing cough PLUS one or more of the following: fever, sore throat, arthralgia (joint pain), myalgia (muscle aches), prostration (severe exhaustion).
- No swab has been done within the previous 48 hours

☐ Complete Blood Count *(CBC)* with differential daily x 3 days then reassess
☐ INR, PTT, albumin
☐ Blood Gas Arterial *(choose one)*
  ☐ on room air
  ☐ on oxygen _____ litres per minute
☐ theophylline trough level *(consider only if signs and symptoms of toxicity)*
☐ Obtain previous spirometry/PFT reports
☐ Bedside spirometry *(consider if previous spirometry/PFT not available)*

Medications - refer to Medication Reconciliation before initiating below medications

Acute Bronchodilators *(choose one below)*

Metered Dose Inhaler *(preferred option)*
(check all that apply)

☐ salbutamol 100 mcg MDI 2 puffs inhaled every 4 hours with spacer

☐ salbutamol 100 mcg MDI 2 puffs inhaled every 1 hour PRN with spacer for shortness of breath

OR

Nebulization Therapy *(check all that apply)*
*(Formulary **restricted to patients who CANNOT** be treated with MDI with spacer.)*
If on contact droplet isolation, administer with airborne precautions as an aerosol generating medical procedure (AGMP)

☐ salbutamol 2.5 mg inhaled by nebulizer every 4 hours
☐ salbutamol 2.5 mg inhaled by nebulizer every 1 hour PRN for shortness of breath
☐ ipratropium 250 mcg inhaled by nebulizer every 4 hours

Prescriber Name *(print)*	Prescriber Signature	Designation

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Maintenance Therapy ***(please keep in mind patient's medication prior to admission)***
See reverse for available maintenance inhalers.

☐ Inhaled long-acting muscarinic antagonists (LAMA)*(drug name, strength, delivery device, dose, route, and frequency)*_____

☐ Inhaled corticosteroid/Long-acting beta-agonist (ICS-LABA) *(drug name, strength, delivery device, dose, route, and frequency)* _____

☐ Other _____

☐ Refer to Nicotine Replacement Therapy Order Set
☐ **OR** Nicotine replacement therapy *(drug name, dose, route, and frequency)*

_____

Antibiotics *(If the patient received antibiotics in the last three months, choose a different antibiotic class and tailor antibiotics based on available sputum culture results)* ***Choose one:***

Complicated COPD: FEV1 less than 50% predicted, 4 or more exacerbations per year, ischemic heart disease, chronic oral steroid.

Choose one (if applicable) →

☐ amoxicillin 875 mg/clavulanate 125 mg PO BID x 7 days
☐ cefUROXime 500 mg PO BID x 7 days
☐ levoFLOXacin 750 mg PO Daily x 5 days

Simple COPD

Choose one (if applicable) →

☐ amoxicillin 1 gram PO TID x 7 days
☐ doxycycline 200 mg PO **NOW** then doxycycline 100 mg PO BID x 7 days
☐ sulfamethoxazole 800 mg/trimethoprim 160 mg PO BID x 7 days

Alternatives for Simple COPD:

Choose one (if applicable) →

☐ AZIthromycin 500 mg PO Daily x 3 days
☐ clarithromycin XL 1gram PO daily x 7 days
☐ other _____

Corticosteroids

☐ predniSONE _____ *(recommend 40mg or 50mg PO daily)* x _____ days
(recommended for 5-10 days)
☐ Other _____

Prior to Discharge *(If indicated, when the patient is no longer febrile or acutely ill, with verbal informed consent)*

☐ Influenza vaccine 0.5 mL IM x 1
(during influenza season, if NOT already vaccinated)

☐ Pneumococcal polysaccharide vaccine 0.5 mL IM x 1 *(review vaccine history and eligibility criteria)*

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Maintenance Inhaler Therapy

Drug	Brand	Available Strengths	Delivery Device	Ordering Dose
Long-Acting Muscarinic Antagonists (LAMA)				
tiotropium	Spiriva HandiHaler	18 mcg/dose	DPI	1 puff daily
tiotropium	Spiriva Respimat	2.5 mcg/dose	SMI	2 puffs daily
aclidinium	Tudorza Genuair	400 mcg/dose	DPI	1 puff BID
glycopyrronium	Seebri Breezhaler	50 mcg/dose	DPI	1 puff daily
umeclidinium	Incruse Ellipta	62.5 mcg/dose	DPI	1 puff daily
Long-Acting Beta-Agonists (LABA)				
salmeterol	Serevent Diskus	50 mcg/dose	DPI	1 puff BID
formoterol	Oxeze Turbuhaler	6 mcg/dose	DPI	1-2 puffs BID
indacaterol	Onbrez Breezhaler	75 mcg/dose	DPI	1 puff daily
Combination LAMA-LABA *(Restricted use: see criteria 1, 2 below)*				
glycopyrronium-indacaterol	Ultibro Breezhaler	50 mcg-110 mcg/dose	DPI	1 puff daily
aclidinium-formoterol	Duaklir Genuair	400 mcg-12 mcg /dose	DPI	1 puff BID
tiotropium-olodaterol	Inspiolto Respimat	2.5 mcg-2.5 mcg/dose	SMI	2 puffs daily
umeclidinium-vilanterol	Anoro Ellipta	62.5 mcg-25 mcg/dose	DPI	1 puff daily
Combination Inhaled corticosteroid - Long-Acting beta-agonist (ICS-LABA)				
fluticasone propionate-salmeterol	Advair Diskus *Restricted use: see criteria 1,2 below*	500 mcg-50 mcg/dose 250 mcg-50 mcg/dose	DPI DPI	1 puff BID 1 puff BID
mometasone-formoterol	Zenhale	200 mcg-5 mcg/dose 100 mcg-5 mcg/dose	MDI MDI	1-2 puffs BID 1-2 puffs BID
budesonide-formoterol	Symbicort Turbuhaler *Restricted use: see criteria 1,2 below*	200 mcg-6 mcg/dose	DPI	2 puffs BID
fluticasone furoate-vilanterol	Breo Ellipta *Restricted use: see criteria 1,2 below*	100 mcg-25 mcg/dose	DPI	1 puff daily
Combination ICS-LAMA-LABA				
Fluticasone furoate-umeclidinium-vilanterol	Trelegy Ellipta *Restricted use: see criteria 3 below*	100 mcg-62.5 mcg-25 mcg/dose	DPI	1 puff daily

Source: AHS Provincial Drug Formulary

Restriction Criteria: Only use identified medication for,

1. Maintenance treatment of moderate to severe COPD (i.e.,FEV1 less than 80% predicted) **AND** inadequate response to a long-acting bronchodilator, **OR**
2. Maintenance treatment of severe COPD (i.e., FEV1 less than 50% predicted).
3. Long-term maintenance treatment of COPD, including bronchitis and/or emphysema in patients who are not controlled on optimal dual inhaled therapy (i.e. LAMA-LABA or ICS-LABA)

Legend
DPI – Dry powder inhaler
MDI – Metered dose inhaler
SMI – Soft mist inhaler

Version Date: April 14, 2021

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Additional Admission Orders

Prescriber Name *(print)*	Prescriber Signature	Designation

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Acute Exacerbation of Chronic Obstructive Pulmonary Disease (AECOPD) Admission Adult Transition to Community Care Admission to Discharge Checklist

Date *(dd-Mon-yyyy)*	**Time** *(hh:mm)*	***Completed***	***Not indicated****	***Initials***
Start at Admission				
Consultations *(For all consultations, utilize the most appropriate/available health care provider(s) at your site to deliver services)*				
Screen for Malnutrition				
Screen for Frailty				
Screen for Cognitive status				
Refer to Transition/Discharge Services if anticipated need at discharge				
Inform Respiratory Therapy of patient admission & referral for assessment of Home Oxygen requirements				
Activate COPD Education Team				
Consider involving the following healthcare providers as necessary: ■ Social Worker ■ Speech Language Pathologist for swallow assessment				
COPD Education and Self-Care Instructions – *use teach-back technique to reinforce learning*				
Ambulate – Early Mobilization *(done within 48 hours)*				
Provide and review COPD education resources with patient/caregiver ☐ Inhaler Techniques ☐ COPD Medicines ☐ COPD: Learning to Breathe Easier ☐ COPD: Avoiding your Triggers				
Patient demonstrates proper inhaler technique				
Discharge Plan				
Complete Discharge Management Plan				
Follow-up as Required				
Assess tobacco use of patient ■ Provide tobacco cessation counselling and resources where appropriate ■ Refer to tobacco cessation program where appropriate				
Notify Primary Care Provider of discharge *(include designated supportive living and home care, where appropriate)*				
Provide Primary Care Provider with Discharge Summary and AECOPD Discharge Management Plan *(Form 21045)*				

*Check 'Not Indicated' only if item would NOT benefit the patient. Identify reason by placing a (✓) in the appropriate box

☐ Recently completed
☐ End-of-life
☐ Deceased
☐ Service/assessment is unavailable
☐ Other, Specify reason(s):_____

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Acute Exacerbation of Chronic Obstructive Pulmonary Disease (AECOPD) Admission Adult Discharge Management Plan

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Bring this Management Plan with you to your next visit

Nutrition

Dietitian referral ☐ No ☐ Yes ► Phone _____

Medication

Prescription ☐ No ☐ Yes

Discharge medication list faxed to community pharmacy

☐ No ☐ Yes

(Talk to your doctor or pharmacist before taking any non-prescription or herbal medicines)

What you need to know

☐ Inhaler technique: Be sure to use your inhaler properly

☐ Review COPD patient education handouts. Be able to demonstrate:
Breathing Techniques: Pursed-lip breathing, breathing with your diaphragm, breathing while bending forward at the waist

☐ Available supports to help reduce tobacco use if appropriate.

☐ Activity: ☐ No restrictions ☐ No strenuous ☐ Gradual increase
- Practice breathing and coughing techniques to help when you feel short of breath
- Use body positions and energy conserving methods to help prevent feeling short of breath

☐ Driving: ☐ No restrictions ☐ No valid license ☐ Do not drive ☐ Do not drive for _____weeks
☐ Work: ☐ No restrictions ☐ Do not go back to work for _____weeks

Follow-up	Location	Phone number	Date *(dd-Mon-yyyy)*	Time *(hh:mm)*
Primary Care Provider *(within 14 days of discharge)*				
Pulmonary Rehabilitation ☐ Yes ☐ Refused ☐ N/A				
Obtain Influenza and/or pneumococcal vaccines at pharmacy, primary care provider or health clinic if needed				

☐ Reviewed above content with patient/family/caregiver and copy of form provided

Health Care Provider *(Last Name, First Name)*	Designation	Initial
Signature	Date *(dd-Mon-yyyy)*	