

COPD annual cycle of care



The COPD annual cycle of care includes three practice appointments, one held every four months.

This document has been prepared by COORDINARE - SENSW PHN, in collaboration with the local health districts, general practitioners, respiratory team specialists, pharmacists, and allied health providers. Review of best practice literature has informed these recommendations.



Change to Participation in an annual cycle of care assists people living with COPD to better manage their condition.

The annual cycle of care appointments will include:

1. Preparation/review of management plans

- GP Management Plan
- COPD Action Plan
- Discuss Advance Care Planning

2. Health assessments

- Spirometry
- Review of medications
- Pulse Oximetry
- Vaccination status

3. Lifestyle discussions

- Physical activity
- Healthy eating
- Smoking cessation
- Emotional health

4. Referrals as indicated for

- Oxygen therapy
- Bone densitometry
- Sleep apnoea assessment
- Pharmacist home medication review

Cycle of care checklist guide for adults



When	Check
Every 4 months	
	Inhaler technique / medication check
	Smoking cessation
	Pulse oximetry
	Blood pressure
	Weight
	Physical activity education
	Offer Pulmonary Rehab if beneficial
	Symptom control assessment is home oxygen required?
Every 12 months	Above plus:
	Spirometry test to classify severity of COPD according to Z-Score results. This information will be provided by the Respiratory Scientist.
	Mild - Z-Score -1.65 to -2.4
	Moderate - Z-Score -2.5 to -3.9
	Severe - Z-Score -4 onwards
	Consider bone densitometry
	Consider Pharmacist Home Medication Review
	Vaccinations : Are the following vaccines indicated?
	Influenza
	COVID
	Pneumonia
	Shingles
	Pertussis (private vaccine)
	Sleep apnoea assessment
	Review of COPD Action Plan and GP Management Plan
	Discuss Advance Care Planning

Cycle of care



Review of medications/ Inhaler technique	Every 4 months	Check appropriate use of medications and inhaler technique.
Smoking	Every 4 months	Promote and support smoking cessation. Check maintenance of non-smoking status for patients who have previously quit smoking.
Pulse oximetry	Every 4 months	<p>Consider referral to a respiratory specialist for further assessment for long term oxygen therapy assessment if:</p> <ul style="list-style-type: none"> ● SaO₂ < 92% in room air (when COPD is stable) ● FEV1 < 30% predicted ● Cyanosis ● Polycythemia ● Peripheral oedema ● Raised JVP
Blood pressure	Every 4 months	Ideal target - < 130/80 mmHg
Healthy eating review	Every 4 months	Discuss a healthy eating plan. Obesity in patients with COPD is associated with sleep apnoea, CO ₂ retention, and cor pulmonale.
Emotional health	Every 4 months	Discuss emotional health and well-being. Discuss End of Life Care Plan/ Advanced Care Planning, as and when appropriate.
Physical activity	Every 4 months	Encourage at least 30 minutes of moderate physical activity, five or more days a week, 2-3 sessions with resistance training, and minimize time sitting.
Exercise tolerance		Offer pulmonary rehabilitation if patient has had hospital admission. 6-minute walk tolerance test.
COPD symptom control	Every 4 months	Check patient's understanding of their COPD self-management plan. Is home oxygen required?
Medication review	Every 12 months	Consider referral for a Home Medication Review by a pharmacist.
Spirometry test	Every 12 months	Assess disease progression and response to therapy.
Osteoporosis	Every 12 months	Minimise risk factors for osteoporosis and consider bone densitometry. Correct any deficiency in vitamin D status.
Vaccinations	Every 12 months	Ensure appropriate vaccinations are up to date.
Sleep apnoea	Every 12 months	Discuss sleep quality and patterns. Consider referral to a sleep apnoea clinic.
COPD Action Plan and GP Management Plan	Every 12 months	Review to ensure these plans are appropriate and up to date.
Advance Care Planning	Every 12 months	Check to see if patient has an Advance Care Plan loaded onto My Health Record – if not, discuss further.
Various Surveys	As per timelines	Assist patient to complete the necessary surveys.

More information and support



Algorithm - Managing Exacerbations

<https://lungfoundation.com.au/resources/managing-exacerbations-algorithm/>

Head to Health Hub

1800 372 000 (option 2)

Lung Foundation

<https://lungfoundation.com.au>

Healthdirect

1800 022 222

Better Living with COPD

[Better living with COPD - Lung Foundation Australia](#)

Pharmacy delivery service

<https://www.findapharmacy.com.au/our-services/delivery-services>

Support groups

<https://lungfoundation.com.au/patients-carers/support-services/peer-support/>

Sleepiness Scale

[Epworth Sleepiness Scale - Sleep Services Australia](#)
[Sleep Apnoea](#)

One-on-one peer support

<https://lungfoundation.com.au/patients-carers/support-services/peer-support/peer-connect/>

International Primary Care Respiratory Group

<https://www.ipcrg.org/desktophelpers>

Respiratory Care Nurse

1800 654 301

Quitline

13 78 48

Lungs in Action

[Lungs in Action - Lung Foundation Australia](#)

Get Healthy Service

<https://www.gethealthynsw.com.au/>

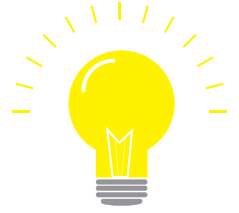
Active & Healthy

<https://www.activeandhealthy.nsw.gov.au/>

HealthPathways

[ACT and Southern NSW](#)

[Illawarra Shoalhaven](#)



Top tips

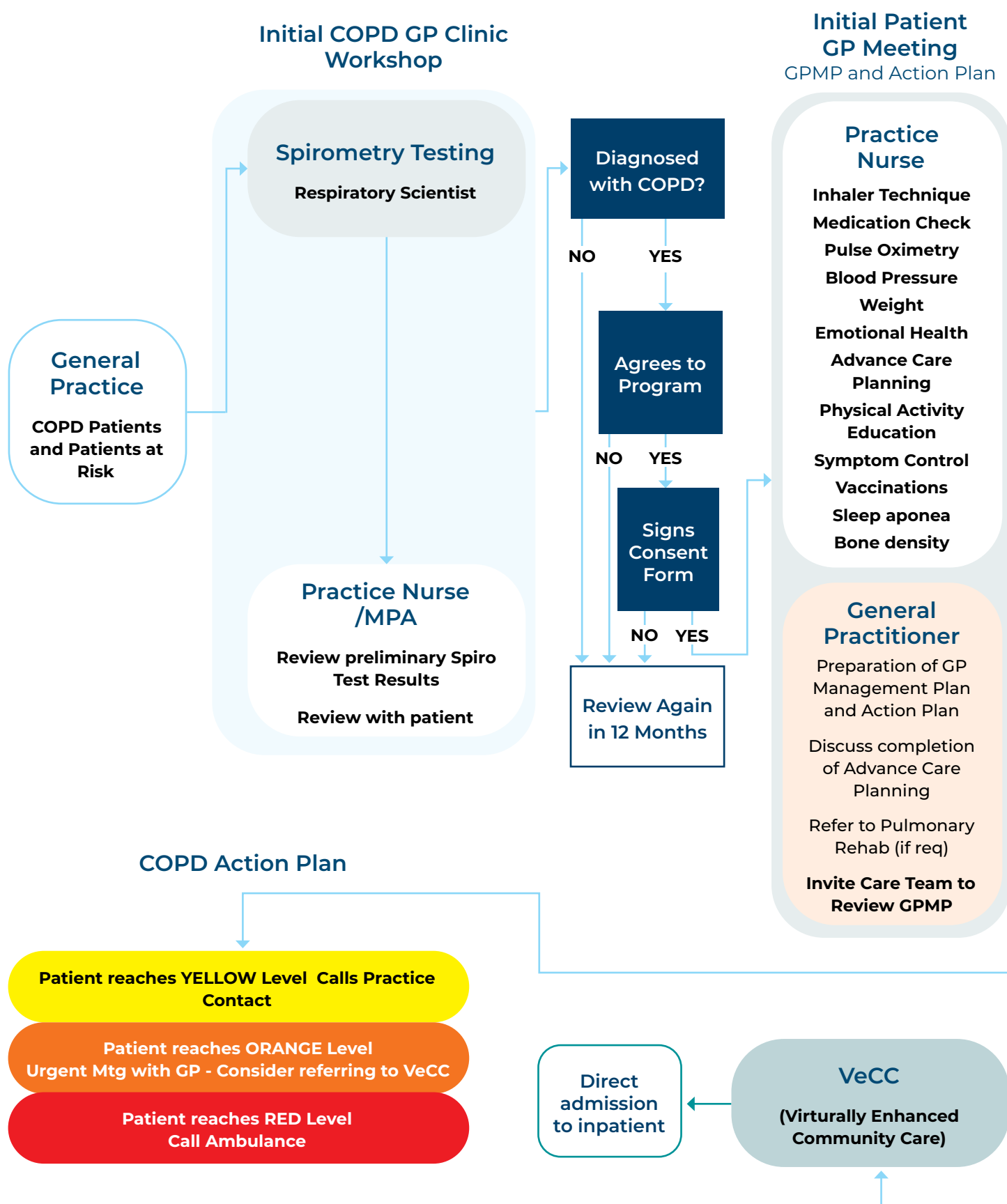
- Schedule the remaining two four monthly appointments prior to the – first appointment. These appointments are very important for assessing your patient's health and risks of COPD-related complications.
- Follow up the scheduled appointments via a phone call a week out.
- Introduce the person to their practice contact.

Notes



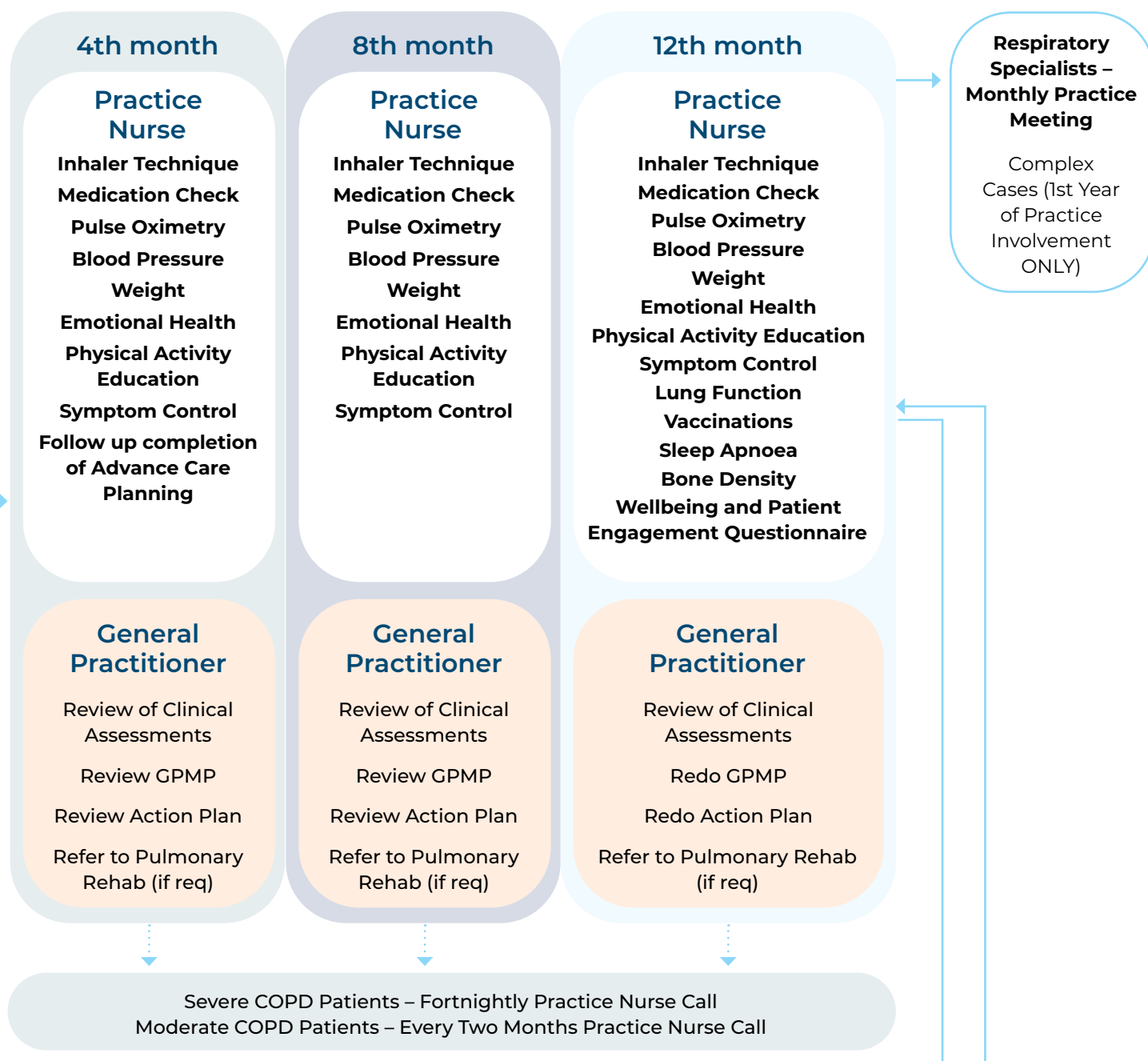
Care pathway flowchart

Early Diagnosis

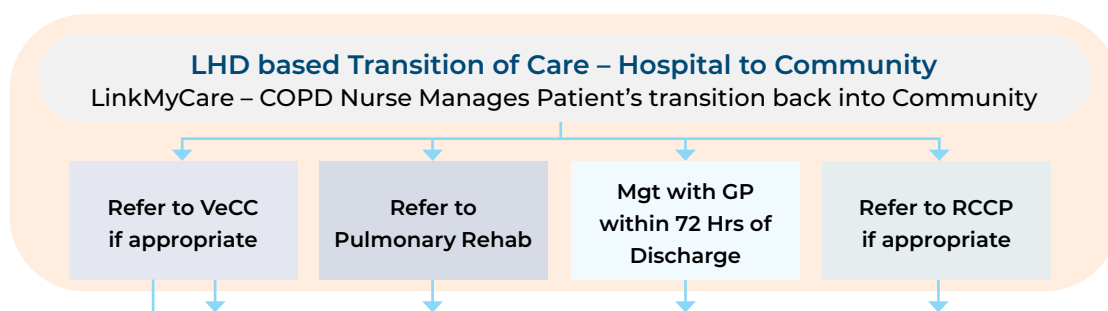


Care in the Community

Ongoing Annual Cycle of Care



Hospitalisation





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