



# 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 (within Inca)
- COPD Action Plan (within Inca)
- 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
<b>Every 4 months</b>	
	<a href="#">Inhaler technique / medication check</a>
	<a href="#">Smoking cessation</a>
	Pulse oximetry
	Blood pressure
	<a href="#">Weight</a>
	Emotional health - the <a href="#">K10 Survey</a>
	<a href="#">Physical activity education</a>
	<a href="#">Offer Pulmonary Rehab if beneficial</a>
	<a href="#">Symptom control assessment</a> - the <a href="#">CAT Survey</a> . Is home oxygen required?
<b>Every 12 months</b>	<b>Above plus:</b>
	<a href="#">Spirometry test</a> to classify severity of COPD according to FEV1 results
	Mild – 60-80% predicted
	Moderate - 40-59% predicted
	Severe - <40% predicted
	Consider <a href="#">bone densitometry</a>
	Consider <a href="#">Pharmacist Home Medication Review</a>
	<a href="#">Vaccinations</a> : Are the following vaccines indicated?
	Influenza
	COVID
	Pneumonia
	Shingles
	Pertussis (private vaccine)
	<a href="#">Sleep apnoea</a> assessment
	Review of <a href="#">COPD Action Plan</a> and GP Management Plan
	Discuss <a href="#">Advance Care Planning</a>

# Cycle of care



<b>Review of medications/ Inhaler technique</b>	Every 4 months	Check appropriate use of medications and inhaler technique.
<b>Smoking</b>	Every 4 months	Promote and support smoking cessation. Check maintenance of non-smoking status for patients who have previously quit smoking.
<b>Pulse oximetry</b>	Every 4 months	Consider referral to a respiratory specialist for further assessment for long term oxygen therapy assessment if: <ul style="list-style-type: none"> <li>● SaO<sub>2</sub> &lt; 92% in room air (when COPD is stable)</li> <li>● FEV<sub>1</sub> &lt; 30% predicted</li> <li>● Cyanosis</li> <li>● Polycythemia</li> <li>● Peripheral oedema</li> <li>● Raised JVP</li> </ul>
<b>Blood pressure</b>	Every 4 months	Ideal target - < 130/80 mmHg
<b>Healthy eating review</b>	Every 4 months	Discuss a healthy eating plan. Obesity in patients with COPD is associated with sleep apnoea, CO <sub>2</sub> retention, and cor pulmonale.
<b>Emotional health</b>	Every 4 months	Discuss emotional health and well-being. Patient should complete a Quality-of-Life survey. Discuss End of Life Care Plan/Advanced Care Planning, as and when appropriate.
<b>Physical activity</b>	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.
<b>Exercise tolerance</b>		Offer pulmonary rehabilitation if patient has had hospital admission.  6-minute walk tolerance test.
<b>COPD symptom control</b>	Every 4 months	Check patient's understanding of their COPD self-management plan. Is home oxygen required?
<b>Medication review</b>	Every 12 months	Consider referral for a Home Medication Review by a pharmacist.
<b>Spirometry test</b>	Every 12 months	Assess disease progression and response to therapy.
<b>Osteoporosis</b>	Every 12 months	Minimise risk factors for osteoporosis and consider bone densitometry. Correct any deficiency in vitamin D status.
<b>Vaccinations</b>	Every 12 months	Ensure appropriate vaccinations are up to date.
<b>Sleep apnoea</b>	Every 12 months	Discuss sleep quality and patterns. Consider referral to a sleep apnoea clinic.
<b>COPD Action Plan and GP Management Plan</b>	Every 12 months	Review to ensure these plans are appropriate and up to date.
<b>Advance Care Planning</b>	Every 12 months	Check to see if patient has an Advance Care Plan loaded onto My Health Record – if not, discuss further.

# More information and support



## Algorithm - Managing Exacerbations

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

## Lung Foundation

<https://lungfoundation.com.au>

## Better Living with COPD

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

## Support groups

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

## One-on-one peer support

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

## Respiratory Care Nurse

1800 654 301

## Lungs in Action

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

## Active & Healthy

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

## Head to Health Hub

1800 372 000 (option 2)

## Healthdirect

1800 022 222

## Pharmacy delivery service

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

## Sleepiness Scale

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

## International Primary Care Respiratory Group

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

## Quitline

13 78 48

## Get Healthy Service

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

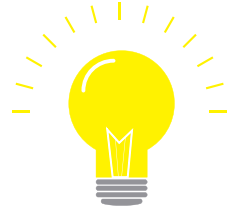
## HealthPathways

### [ACT and Southern NSW](#)

**Username:** together  
**Password:** forhealth

### [Illawarra Shoalhaven](#)

**Username:** connected  
**Password:** 2pathways



## 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.

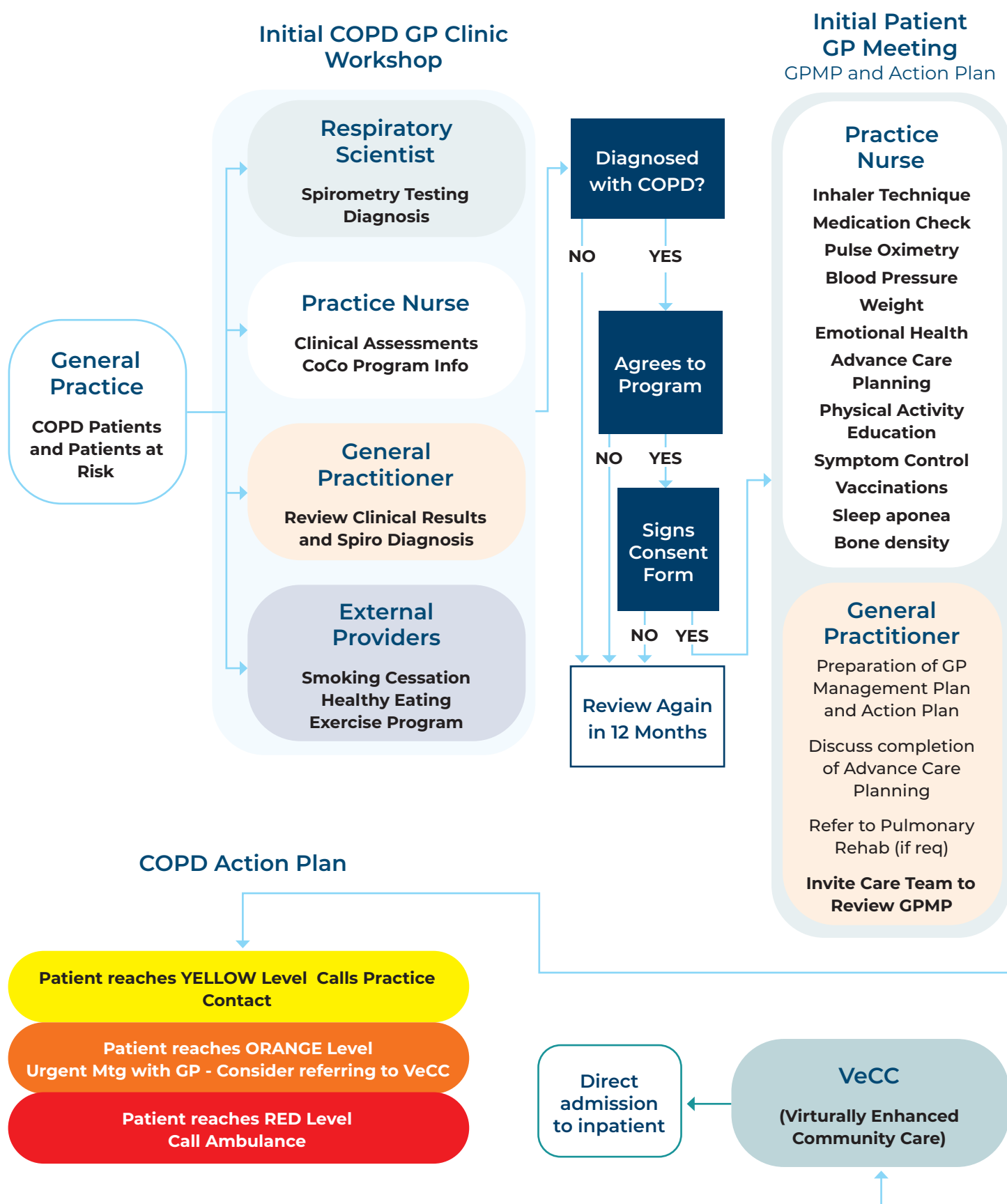
## Notes





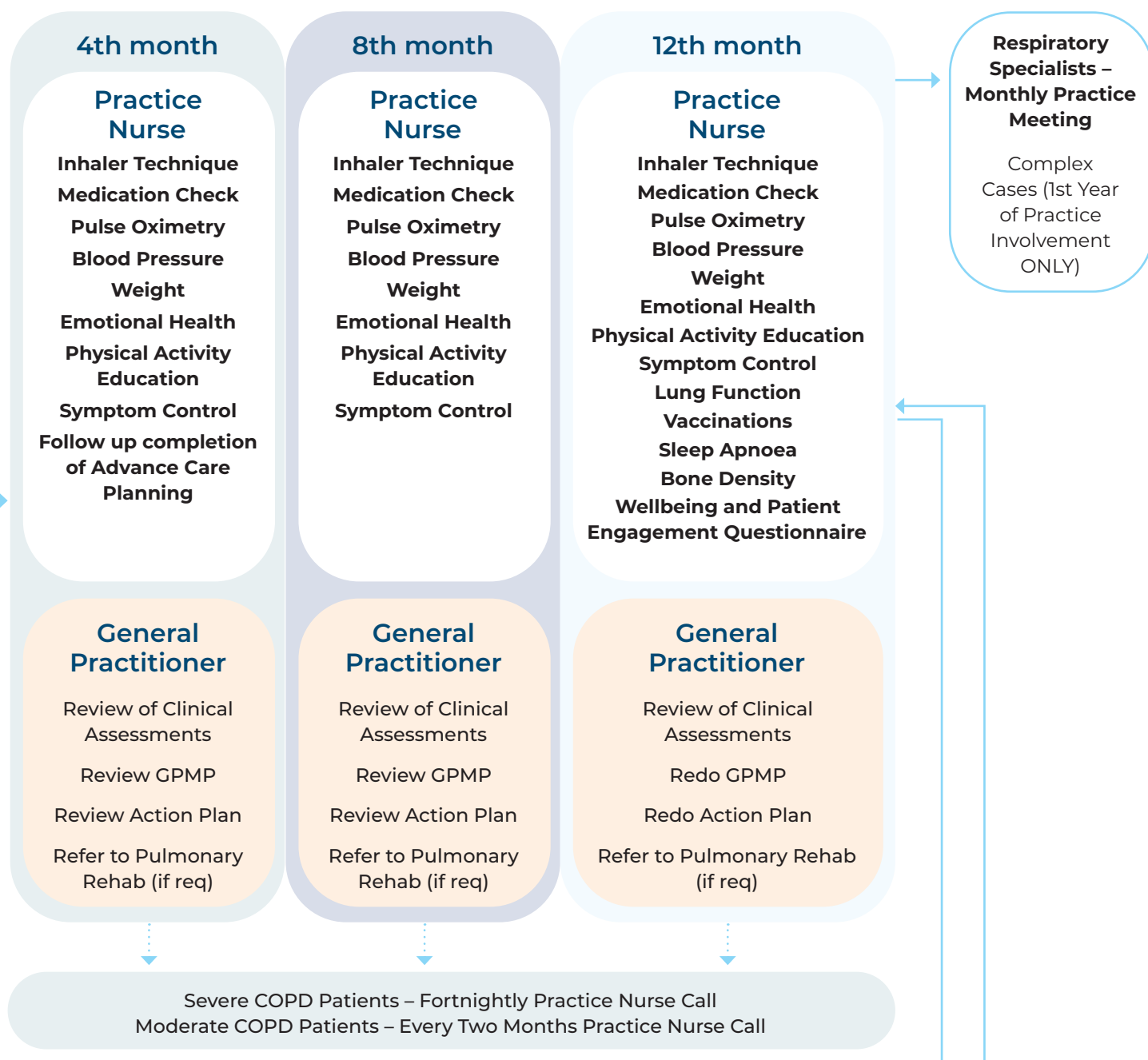
# Care pathway flowchart

## Early Diagnosis

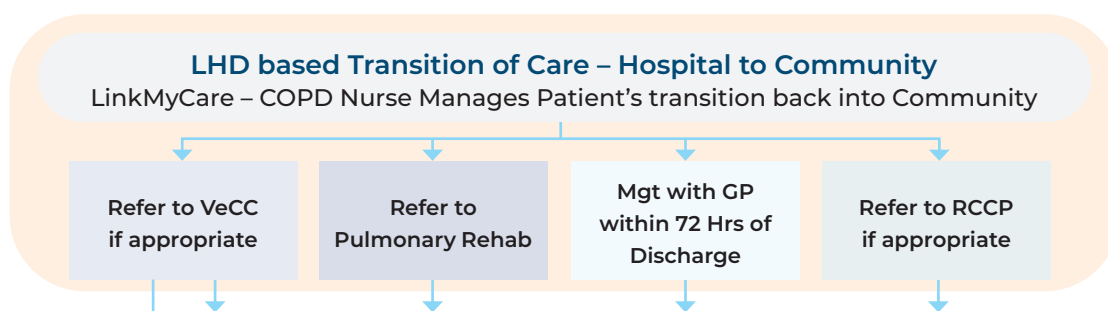


## Care in the Community

### Ongoing Annual Cycle of Care



### Hospitalisation





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