## AIMS OF THE NURSE-LED COPD CLINIC
- To promote independence and achieve best quality of life through psychological care, education and referral to the multi-disciplinary team.
- To monitor patient’s disease progression and alter treatment within agreed National Guidelines.

## OBJECTIVES OF THE NURSE-LED COPD CLINIC
- To provide review, assessment and symptom control.
- To provide advice, education and information and assist informed decision making.
- To improve the patient’s understanding of their disease and encourage self management.
- Provide link to respiratory healthcare team.
- To provide seamless care.
- To improve patient follow up.
- To improve patient access.
- To increase consultation time.
- To monitor patient’s disease progression and alter treatment within agreed national guidelines.
- To improve respiratory review clinic waiting times.
- To improve patient quality of life.
- Provide link to respiratory healthcare team.
- To improve patient follow up.
- To improve patient access.
- To increase consultation time.
- To monitor patient’s disease progression and alter treatment within agreed national guidelines.
- To improve respiratory review clinic waiting times.
- To improve patient quality of life.
- Provide link to respiratory healthcare team.

## CLINICAL COMPETENCIES REQUIRED
- Arterial Blood Gas Sampling and Analysis.
- Chest auscultation.
- Chest inspection.
- Chest palpation.
- Chest percussion.
- Expert knowledge of respiratory system disease process and management.

## EXCLUSION CRITERION
- Patients requiring review by respiratory consultant:
  - Asthma
  - Restrictive lung disease
  - Pulmonary hypertension
  - Unstable cor-pulmonale
  - Co-existing disease/co-morbidity
  - Unstable cardiac disease (if not under review by cardiologist)
  - Acute/Chronic renal failure
  - Cancer

## CLINIC PROTOCOL
- Referral as per referral criterion.
- Appointments sent to patient via respiratory secretary.
- Informal consent given by patient.
- Introduction to Nurse Specialists at first visit and care discussed with patient.
- Assessment of symptoms and impact on quality of life at each visit.
- Brief education according to patient needs. Printed information will be given.
- Review allergies and discuss common side-effects of medications. Disease management and/or therapies altered, when necessary in agreement with patient.
- Ensure that patient understands importance of concordance with medications and treatment changes.
- Immediate communication with Respiratory medical staff if clinical condition has deteriorated significantly and/or requiring hospital admission.
- Investigations will be based on clinical need.
- Review date will be based on clinical condition.
- Details of clinic visit will be documented in case notes.
- A typed letter will be sent to the GP after each visit.
- Patients will be encouraged to self refer to community social services where appropriate.

## DISCHARGE PROTOCOL
- Patients with stable disease
- Controlled symptoms
- Optimal pharmacology for symptom control
- No oral corticosteroid therapy or hospital admissions for 3 months
- Patients with end-stage disease who are being/will be reviewed by CLDNS
- On discharge patients will be given an individual self-management plan, which will include recognition and treatment of early warning signs of exacerbation.
- Discharged patients will be referred to General Practitioner/Practice Nurse. A typed discharge summary and copy of spirometry results will be sent.