AECOPD Daily Review Hospital at Home

Northumbria Healthcare NHS
NHS Foundation Trust

Location: Home / Hospital _____	First Name: _____ Surname: _____
Date/Time: _____ _____	Trust No:_____ DOB: _____
Days in Hospital:_____	NHS number: _____
Days at Home: _____	Address: _____

Respiratory problems Note duration and severity at first, then change over the last 24 hours subsequently
Breathlessness
Cough
Sputum Purulence
Sputum Volume
Wheeze
Other
Performance status Change over last 24 hours: Better / Similar / Worse
Comments
Difficulty with usual activities YES / NO Describe
Other symptoms or problems raising concerns
Examination: RR SpO2 FiO2 room air/ 24%/ 28%/ 35% / other BM
HR BP Temp A V P U / GCS Fasting daily weight (Kg)
Chest examination
Dependent oedema: None☐ Ankle☐ Mid-tibial☐ *knee☐ *mid-thigh☐ *sacral☐ *Fasting daily weight _____Kg

Signature:_____ Print:_____ Grade:_____ ID (NMC/GMC) _____

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Problem list and diagnosis
Any new diagnosis
ABG done (do if drop in SpO2) YES / NO Bloods done YES / NO
Acute Treatment Antibiotic Day Change if no improvement after 48 hours
Sputum sent Y / N Date sent Result MRSA status +ve / -ve
Nebulised bronchodilators YES / NO
Prednisolone day Any side effects? (check BMs)
Weight change in 24 hours
Current diuretic: None☐ Drug (dose)
Diuretic prior to admission: None☐ Drug (dose)
Oxygen YES / NO If yes, Venturi mask (most patients)☐ FiO2: %; Nasal Cannulae☐ flow rate: l/min
Target sats 88-92%
Carbocisteine YES / NO Tinzaparin YES / NO Physio review YES / NO (all patients day 3) Home exercise YES / NO
Other
Chronic Treatment Inhaler technique adequate YES / NO If persistently inadequate, consider changing inhaler
Referral required: Psychology YES / NO Nutrition YES / NO Change in care package YES / NO
Describe issues and action
Exacerbation recognition and self-management education delivered (including smoking cessation) YES / NO
Importance of activity and pulmonary rehab discussed YES / NO
Consider azithromycin, bone protection near time of discharge from Hospital at Home
Other
Provisional discharge date Follow up: Clinic Doctor / Nurse (doctor if CXR consolidation) COPD care Bundle complete YES / NO SPUDS YES / NO

Signature:_____ Print:_____ Grade:_____ ID (NMC/GMC) _____