

This care bundle describes 5 high impact actions to ensure the best clinical outcome for patients admitted with an acute exacerbation of COPD (AECOPD). The aim is to ensure patient safety with a timely and accurate diagnosis of COPD, correct assessment of oxygenation, early response to respiratory failure and early specialist review. This bundle applies to all patients admitted to hospital with an acute deterioration of known or suspected COPD. Patients seen and assessed in A&E who are diagnosed with an acute exacerbation of COPD who are discharged without admission to hospital either with or without follow up by a community respiratory team should also be included.

Patient sticker

**COMPLETE WITHIN 24 HOURS OF ADMISSION**

**REMEMBER DISCHARGE BUNDLE**

**1. ENSURE CORRECT DIAGNOSIS OF AN ACUTE EXACERBATION OF COPD**  
*The diagnosis of an acute exacerbation of COPD starts with a clinical assessment and is supported by review of an ECG and CXR which should be done within 4 hours of admission. The patient should also have documented evidence of spirometry showing airflow obstruction*

CXR done within 4 hours of admission:       ECG done within 4 hours of admission?

Date of CXR : \_\_\_\_\_ Time CXR carried out: \_\_\_\_\_      Record of spirometry available in medical records?   
(record as no if old notes not available within 4 hours)

Signature

**2. ASSESS OXYGEN & PRESCRIBE TARGET RANGE FOR OXYGEN**  
*Early oxygen assessment is associated with improved prognosis. The provision of oxygen, when needed, follows after appropriate assessment. A target range for the oxygen saturation to be achieved (with supplemental oxygen if necessary) should be prescribed (94–98%, Patients at risk of CO2 retention: 88–92%). (BTS Emergency Oxygen Guideline)*

Physiological observations made within 1 hour of admission:       Oxygen prescribed within 1 hour of admission:

Signature

**3. RECOGNISE AND RESPOND TO RESPIRATORY ACIDOSIS**  
*The patients with highest mortality from COPD following hospital admission are those who are admitted in ventilatory failure. An arterial blood gas for all patients admitted to hospital with oxygen saturations of 94% or less (on air or controlled oxygen) is required. Early assessment for suitability for NIV is required for those with Type 2 respiratory failure and a pH of <7.35 after one hour on optimum medical therapy (controlled oxygen and nebulised therapy).*

Oxygen saturations  $\leq 94\%$  after one hour of medical therapy:       ABG carried out:

pH < 7.35 on ABG:       Patient started on NIV:

Signature

**4. ADMINISTER STEROIDS & NEBULISERS WITHIN 4 HOURS OF ADMISSION**  
*Patients medical therapy should be optimised on admission. This should follow local guidance detailed below. Consideration should be given to use of corticosteroids, nebulised bronchodilators and antibiotics (where the patient reports a deterioration in their respiratory symptoms from their stable state plus the presence of purulent sputum)*

Nebulisers administered within 4 hours of admission:       Steroids administered within 4 hours of admission:

Antibiotics administered within 4 hours of admission:       Time prescription written: \_\_\_\_\_

Signature

**5. REVIEW BY RESPIRATORY TEAM WITHIN 24 HOURS**  
*Results of the National COPD Audit 2003 suggest that deaths in hospital from COPD occur within 72 hours of admission and that death rates were lower in larger centres. Early review by a member of the respiratory specialist team may help improve patient outcomes*

Respiratory medical or nurse review within 24 hours:

Date of respiratory review: \_\_\_\_\_ Time of respiratory review: \_\_\_\_\_

Signature

**Instructions for use of bundle:**

**Data entry:** <https://audits.brit-thoracic.org.uk/>  
**Enquiries:** [carebundles@brit-thoracic.org.uk](mailto:carebundles@brit-thoracic.org.uk)