COPD Rescue Pack Information

Background

Chronic Obstructive Pulmonary Disease (COPD) is the second most common cause of emergency admission to hospital nationally, however, there is robust evidence that many admissions are avoidable.[1] Readmissions are also a significant problem in COPD; of all emergency readmissions to hospital COPD is the 5th most common cause nationally.[1]

The NICE guideline for COPD recommends: Patients at risk of having an exacerbation of COPD (flare-up) should be given a course of antibiotic and corticosteroid tablets to keep at home for use as part of a self-management strategy.[2] This reflects good evidence that prompt therapy in exacerbations results in less lung damage, faster recovery and fewer admissions (and subsequent readmissions) to hospital.[1]

Please note, it is acknowledged that not all patients will be eligible or appropriate for the provision of antibiotic and corticosteroid for self-treatment at home, [3] and in addition, NICE advises that the appropriate use of these medications should be monitored.[2]

We are referring to this stand-by supply of antibiotic and corticosteroid tablets for a COPD exacerbation as a COPD Rescue Pack.

It is recognised locally that stand-by medications for COPD are prescribed, however, how often is unable to be determined. In the national context, despite NICE guidance, the National Audit for COPD 2008 found that only one third of people with COPD admitted as an emergency during an exacerbation had been given standby drugs.[4]

Prescribing of COPD Rescue Packs

Which patients should have Rescue Packs?
Patients who have had a COPD exacerbation should be considered for rescue medication. Consider in particular patients with a confirmed diagnosis of COPD (i.e. the presence of airflow obstruction has been confirmed by post-bronchodilator spirometry) who are

- Under the care of a Secondary care respiratory clinician

and/or

- Have had two or more exacerbations or have visited A&E/been admitted to hospital with an exacerbation of COPD.

Patients suitable for use of a rescue pack may also be appropriate for referral to pulmonary rehabilitation and this should be re-visited with the patient.

This guidance does not apply to patients on long term prophylactic antibiotics for a respiratory condition.

In line with the local Antimicrobial Guidelines[5] the first line choices of antibiotic for acute infective exacerbations of COPD are:

- Amoxicillin 500mg tds for 5 days or
- Doxycycline 200mg stat then 100mg od for 5 days in total or

The **Option 1** antibiotic choice for COPD Rescue Pack is **Amoxicillin.**

Prescriptions for the **Option 1** COPD Rescue Pack should be written as follows:

> ***Amoxicillin*** *500mg capsules x 15 Sig: COPD Rescue Pack antibiotic capsules, 1 three times daily until course complete. For COPD flare-up.*
>
> ***Prednisolone*** *5mg tablets x 30 Sig: COPD Rescue Pack steroid tablets, 6 stat and then 6 mane for 5 days For COPD flare-up.*

The **Option 2** antibiotic choice for COPD Rescue Pack is **Doxycycline**.

Prescriptions for the **Option 2** COPD Rescue Pack should be written as follows:

> ***Doxycycline*** *100mg capsules x 6 Sig: COPD Rescue Pack antibiotic capsules, 2 stat and then 1 daily until course complete. For COPD flare-up.*
>
> ***Prednisolone*** *5mg tablets x 30 Sig: COPD Rescue Pack steroid tablets, 6 stat and then 6 mane for 5 days. For COPD flare-up.*

When issuing a prescription for a Rescue Pack please use the read code *8BMW – issue of COPD rescue pack*.

Monitoring of COPD Rescue Packs

Practices should have a process in place for supply, monitoring and review of rescue medications. Using the read code 8BMW on issue will enable the use of Rescue Packs to be monitored.
Reviews should be regular and at least at every annual review or, after a maximum of 2 Rescue Pack issues.
Things to consider at review:

- Are emergency supply packs being used appropriately and is self-management still appropriate?
- Are they true exacerbations?
- Re-assess for co-morbidity, (for example malignant change) treatment adherence and inhaler technique.

- Consider pulmonary rehabilitation for those patients who may have previously declined.
- Consider bronchiectasis and check sputum for unusual organisms. (Sputum samples could be considered for symptomatic patients to exclude atypical organisms).
- Review regular medication. For patients who have had 2 or more exacerbations in 12 months consider LABA +LAMA in a combination inhaler if not already on one or ICS in addition to LABA+ LAMA if having exacerbations despite taking LABA+LAMA.
- Consider osteoporosis prophylaxis if the patient has taken ≥ 3 courses of oral prednisolone in 12 months.
- Consider whether a longer course of prednisolone is required (maximum of 14 days).

1. Department of Health. An Outcomes Strategy for COPD and Asthma: NHS Companion Document. May 2012 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216531/dh_134001.pdf
2. NICE. Chronic obstructive pulmonary disease: Management of chronic obstructive pulmonary disease in adults in primary and secondary care 2010 http://www.nice.org.uk/guidance/CG101
3. NICE. Quality Standard for Chronic Obstructive Pulmonary Disease. July 2011 http://www.nice.org.uk/guidance/QS10/chapter/Quality-statement-7-Management-of-exacerbations
4. Royal College of Physicians. The National COPD Audit 2008. Royal College of Physicians, London https://www.rcplondon.ac.uk/projects/outputs/national-copd-audit-2008
5. ELMMB Formulary http://www.elmmb.nhs.uk