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Title: Chronic Obstructive Pulmonary Disease (COPD) in Adults (aged 16 and above) Guideline

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Contents

1 Introduction

Chronic obstructive pulmonary disease (COPD) is a common, preventable and treatable lung disease that is characterised by persistent respiratory symptoms and airflow limitation that interferes with normal breathing and respiratory function (Global Initiative for Chronic Obstructive Lung Disease (GOLD), 2022 [online]).

The disease is normally progressive in nature and is currently an incurable condition, but with the correct diagnosis and treatment, it can be managed effectively (World Health Organization (WHO), 2022 [online]). Without treatment, the symptoms of COPD tend to gradually worsen over time and can limit normal daily activities. There may also be periods when symptoms become suddenly worse, known as a flare-up or an exacerbation.

Predominantly, the characteristics of COPD include:

- Emphysema: damage to the alveoli (air sacs) in the lungs
- Chronic Bronchitis: long-term inflammation of the bronchial airways (breathing tubes) inside the lungs

COPD develops gradually over time and is usually the result of a combination of risk factors:

- Tobacco exposure from active smoking or passive exposure to second-hand smoke
- Occupational exposure to dusts, fumes, particles, chemicals etc
- Indoor air pollution such as biomass fuels (wood, crop residue, animal dung, coal)
- Early life events such as frequent/severe respiratory infections in childhood that resulted in reduced maximum lung growth
- Childhood asthma
- Alpha-1 antitrypsin deficiency (a rare genic condition)

WHO, 2022 [online]

COPD is now one of the top three causes of death worldwide (GOLD, 2022 [online]), with many people dying prematurely from the disease or its associated complications. Despite being a major cause of chronic morbidity and mortality, COPD is both preventable and treatable, although continued exposure to COPD risk factors together with an ever-increasing aged population is set to cause an enduring problem for public health globally as the number of people diagnosed with the disease is expected to further increase (Soriano et al, 2005). Many people don't realise they have the disease until they present with respiratory symptoms that lead to further investigation.

In addition, it is well documented that life expectancy of people diagnosed with a serious mental illness (SMI) is significantly less than that of the general population - with cardiovascular disease, diabetes and respiratory disease (particularly COPD and pneumonia) being the leading causes of increased mortality (Alam et al, 2016; Jaen-Moreno et al, 2021). It is therefore essential that early referral, diagnosis and continued

treatment is initiated and/or maintained together with sound encouragement of well supported smoking cessation recommendations.

TEWV NHS Foundation Trust provides care to a diverse range of service users across several specialties and localities, all of whom require varying degrees of need and support. As reiterated by NHS England, 2019 [online], care provision is variable, with some groups of people continuing to experience inequalities. TEWV NHS Foundation Trust is therefore fully committed to ensuring that patients receive care that is individualised, holistic and evidence based, and that fair and equal treatment is offered to all. No one should have a poorer service or a lesser experience because of their differences, inclusive of COPD treatment and management. It is in keeping with this principle that this guideline has been written.

This guideline reflects the Trust's strategic direction of travel, Our Journey to Change, by supporting its values and goals:

To co-create a great experience for our patients, carers and families, so you will experience:

- **Outstanding** and compassionate care, all of the time.
- **Access** to the care that is right for you.
- **Support** to achieve your goals.
- **Choice** and control.

To co-create a great experience for our colleagues, so you will be:

- **Proud**, because your work is meaningful.
- **Involved** in decisions that affect you.
- **Well led** and managed.
- That your workplace is **fit for purpose**.

To be a great partner, so we will:

- Have a **shared understanding** of the needs and the strengths of our communities
- Be **working innovatively** across organisational boundaries to improve services.
- Be **widely recognised** for what we have achieved together.

Living our values is integral to the care we deliver. We will show respect to patients and their families, by actively listening to their concerns and acting upon them. We will ensure we are always compassionate, kind and supportive. We will be open and honest in our conversations, always receptive (listening) to how much information a person may want, and in what kind of format.

This guideline also supports the Trust's strategic goals. It is important that we work closely with the person and/or their families, so that the experience can be as good as it possibly can be, working to ensure the person has as much choice and control as possible. We will work closely with our Trust colleagues, so they feel supported in working with the person and their family.

Finally, we will ensure we work in close partnership with the other agencies involved with the person, such as their GP, the voluntary and charity sector and secondary health services, to ensure seamless and compassionate care.

2 Purpose

Following this procedure will help the Trust to: -

- Standardise practice for all clinical staff for the management of COPD.
- Support medical and nursing staff through the process required to ensure that patients with COPD receive safe, effective, and appropriate care that is supported by current national guidance and best practice.
- Support people with a diagnosis of COPD to manage their condition.
- Provide people with the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professions.
- Promote the long-term management of modifiable risk factors.
- Reduce the clinical risk(s) associated with inappropriately managed long term chronic condition(s).

3 Who this procedure applies to

This guideline applies to all healthcare professionals working within TEWV NHS Foundation Trust who have a responsibility to monitor and review individuals with COPD and/or manage COPD exacerbations and associated symptoms/conditions.

All clinical staff have a responsibility to take every opportunity to advise, signpost, support and empower service users in relation to good physical healthcare including the importance of healthy lifestyle choices and potential risk factors.

Consideration has also been given to those who may be affected by this guideline to ensure that the document content aligns to the Trust's values, so that people who may be affected are treated with compassion, respect and responsibility.

Respect

- Listening
- Inclusive
- Working in partnership

Compassion

- Kind
- Supportive
- Recognising and celebrating

Responsibility

- Honest
- Learning
- Ambitious

4 Related documents

This guideline describes what you need to do to implement the 'policy section' of the Physical Health and Wellbeing Policy.

The Physical Health and Wellbeing Policy defines a clear purpose, objectives and standards relating to physical health care provision which you must read, understand, and be trained in before carrying out the procedures described in this document.

This guideline also refers to: -

- ✓ Consent to Examination or Treatment Policy
- ✓ Medication Safety Series: MSS 10 Oxygen - Administration in an Emergency
- ✓ Medicines & Smoking Procedure
- ✓ Nicotine Management Policy
- ✓ Oxygen & Other Medical Gases - Administration, Prescribing, Storage and Safety Guideline
- ✓ Patient Own Drugs (PODs): Procedure for Use
- ✓ Physical Health and Wellbeing Policy
- ✓ Procedure for Using the National Early Warning Score (NEWS) for the Early Detection and Management of the Deteriorating Patient
- ✓ Resuscitation Policy

5 Guidance

5.1 Diagnosing COPD

The diagnosis of COPD is usually made after careful consideration of signs, symptoms, associated risk factors and the presence of airflow obstruction within the lungs. Primary diagnosis relies on competent clinical judgement from an experienced clinician and requires a comprehensive history, physical examination, and the review of pulmonary function tests (PFTs) - specifically spirometry.

The National Institute for Health and Care Excellence (NICE, 2018a, last updated 2019) advocates early identification of COPD where possible. Diagnosis of COPD should be considered for any person aged 35 or over who has a risk factor (such as smoking or a history of smoking) and who present with one or more respiratory symptoms. The likelihood of developing COPD increases with the amount and/or length of time that an individual smokes. In addition, a significant proportion of people with chronic bronchitis go on to develop airflow limitation and as such, spirometry should also be considered for these individuals.

A diagnosis of COPD in younger people should still be considered if symptoms are evident or reported. Prolonged or continued symptoms should not be ignored.

5.2 Symptoms

- Exertional Breathlessness (difficulty breathing when active)
- Chronic cough
- Regular sputum/phlegm production
- Frequent winter bronchitis/chest infections
- Wheeze

When establishing a diagnosis of COPD, other signs and symptoms to consider (and to discuss with the patient) are:

- Weight loss/reduced appetite
- Reduced exercise tolerance
- Waking at night with breathlessness
- Ankle swelling (oedema)
- Generalised fatigue
- Occupational hazards
- Chest pain
- Coughing up blood (haemoptysis)

It should be noted however that chest pain and haemoptysis are relatively uncommon in COPD and such symptoms should prompt the consideration of alternative diagnoses (NICE, 2018a, last updated 2019).

5.3 Spirometry

Spirometry is the most common of the PFTs that measures lung function, specifically the amount and/or speed of air that can be inhaled and exhaled. Spirometry measures the volume of air that a patient is able to expel from the lungs after a maximal inspiration and is used to support the diagnosis of COPD by demonstrating airflow obstruction. Spirometry also differentiates between obstructive respiratory disorders (COPD and asthma) and restrictive respiratory disorders (where the size of lung capacity is reduced). Spirometry is the most effective way to assess the level of severity of COPD as this cannot be established from clinical signs and symptoms alone (British Medical Journal (BMJ), 2022a [online]).

Best practice identifies that spirometry should be performed as part of:

- Initial diagnosis

- To reconsider a diagnosis (should an individual demonstrate an unusual or exceptionally good response to treatment)
- To monitor disease progression

(NICE, 2018a, last updated 2019)

Spirometry can be performed by any healthcare worker who has undertaken appropriate training, who is competent at performing the procedure, and who has kept the necessary skills up to date. Health care professionals who care for people with COPD should have access to spirometry inclusive of competent interpretation of results (NICE, 2018a, last updated 2019). For patients requiring spirometry, an appropriate referral to a community or hospital respiratory/spirometry service is required, or via collaboration with the patient's GP. All spirometry services should be supported by suitable quality control processes (NICE, 2018a, last updated 2019).

5.4 Further Investigations

In addition to spirometry, and as part of the initial diagnosis evaluation, all patients should have the following interventions undertaken:

- Chest X-ray: to exclude other pathologies/diagnoses
- Full Blood Count: to identify anaemia or polycythaemia (an increased number of red bloods cells within the blood)
- Body Mass Index (BMI) calculation

Additional investigations can also be performed where needed. Further information can be obtained from NICE Guideline 115: Chronic Obstructive Pulmonary Disease in Over 16s: Diagnosis and Management (NICE, 2018a, last updated 2019).

5.5 Incidental Findings on Chest X-rays or CT Scans

Consider a referral for a respiratory review (inclusive of spirometry) for people with emphysema or where incidental signs of chronic airways disease are evident on a chest x-ray or CT scan. The presence of emphysema on a CT scan is a risk factor for lung cancer (NICE, 2018a, last updated 2019).

5.6 Differentiating between COPD and Asthma

COPD and asthma can often be differentiated from the history and examination findings of people presenting for the first time. The table below illustrates several clinical features that can be obtained from a comprehensive history and examination. If diagnostic uncertainty remains a review of peak flow readings (in those with a previous diagnosis of asthma),

spirometry readings, and the patient's response to bronchodilators, oral steroids and inhaled therapy should also be evaluated (NICE, 2018a, last updated 2019). Further information and guidance on asthma can be obtained from NICE Guideline Asthma: Diagnosis, Monitoring and Chronic Asthma Management (NICE, 2017, last updated 2021).

Clinical Features	COPD	Asthma
Smoker or ex-smoker	Nearly All	Possibly
Symptoms under 35yrs of age	Rare	Often
Chronic Productive Cough	Common	Uncommon
Breathlessness	Persistent and Progressive	Variable
Waking at night with breathlessness and/or wheeze	Uncommon	Common
Fluctuating or day to day variability of symptoms	Uncommon	Common

(NICE, 2018a, last update 2019)

Consider a referral for a respiratory review (inclusive of spirometry) for people with or without asthma who present with increased and/or prolonged signs and symptoms, and/or who develop chronic respiratory deterioration and/or where diagnostic uncertainty remains.

5.7 Referral for Specialist Advice

Referral for specialist advice to a community or an acute hospital respiratory service may be appropriate at all stages of COPD and not solely at the diagnostic stage or for the most severe cases. People who are referred do not necessarily need to be seen by a Respiratory Physician. There may be occasions where members of a Specialist COPD/Respiratory Team (who have appropriate training and expertise) review and/or assess the patient's needs (NICE, 2018a, lasted updated 2019).

Reasons for referral may also include:

Reason	Purpose
Diagnostic uncertainty	To confirm diagnosis and to optimise treatment
Suspected severe COPD	To confirm diagnosis and to optimise treatment
Person with COPD requests a second opinion	To confirm diagnosis and to optimise treatment
Onset of Cor pulmonale (enlarged and or failure of the right ventricle of the heart)	To confirm diagnosis and to optimise treatment

Assessment for oxygen therapy	To optimise therapy and measure blood gases
Assessment for long-term nebuliser therapy	To optimise therapy and exclude inappropriate prescriptions
Assessment for oral corticosteroid therapy	To establish the need for continued treatment or to supervise withdrawal
Assessment for pulmonary rehabilitation	To identify suitable candidates for rehabilitation
A rapid decline in FEV1	To encourage early intervention
Bullous lung disease	To identify candidates for lung volume reduction procedures
Assessment for a lung volume reduction procedure	To identify candidates for surgical or bronchoscopic lung volume reduction
Assessment for lung transplantation	To identify candidates for surgery
Dysfunctional Breathing	To confirm diagnosis, optimise pharmacotherapy and to access other therapists
Onset of symptoms under 40 years or a family history of alpha-1 antitrypsin deficiency	To identify alpha-1 antitrypsin deficiency, consider therapy and to screen family
Symptoms disproportionate to lung function deficit	To look for other explanations including cardiac impairment, pulmonary hypertension, depression and hyperventilation
Frequent chest infections	To exclude bronchiectasis
Haemoptysis (coughing up blood/blood stained mucous	To exclude carcinoma of the bronchus/lung

(NICE, 2018a, updated 2019)

5.8 Managing Stable COPD

The ultimate goal of optimal COPD management is to: prevent and control symptoms, to reduce the severity and number of exacerbations, improve quality of life, and, to reduce mortality.

Although there is a well acknowledged stepwise approach to the pharmacological treatment options available, it is important to remember that as with all treatment, care planning should be individualised, and consideration should also be given to the patient's overall general health status and other comorbid conditions. Managing stable COPD involves - reducing risk factor exposure (primarily smoking), appropriate assessment and ongoing monitoring of the disease, patient education, and also, pharmacological and non-pharmacological treatments (BMJ, 2022b [online]).

5.8.1 Smoking Cessation

Smoking cessation is the most influential factor in slowing COPD progression and in addition, reduces the risk of malignancies, coronary and cerebrovascular disease. Smoking cessation should be encouraged in all patients, in addition to guidance on avoiding occupational or environmental tobacco smoke exposures. Staff must ensure the following:

- Smoking Status Assessment - all patients must have their smoking status reviewed on admission to hospital (smoker, non-smoker, never smoker or ex-smoker). This information should be added to the patient's electronic care records and should also include an appropriate care plan inclusive of the following:

    - Pack years smoked (number of cigarettes smoked/day divided by 20 and multiplied by the number of years smoked)
    - Number of cigarettes smoked per day and the offer of brief advice
    - Identify the treatment offered/accepted, check for any contraindications and then initiate treatment - i.e. Nicotine Replacement Therapies (NRT) and/or e-Cigarettes (provided within 30-60 minutes of admission to limit nicotine withdrawal)
    - Details of any side effects to treatment and a weekly planned review date
    - Document if temporary abstinence or a full quit attempt made

For more information, please read the Trust's Nicotine Management Policy and Medicines and Smoking Procedure which are available on the Trust Intranet.

5.8.2 Ongoing Assessment and Monitoring

Ongoing monitoring and assessment for those with COPD is aimed at ensuring that the goals of treatment are being met. All patients with a diagnosis of COPD should have their diagnosis clearly documented as part of the electronic care record. Similarly, any ongoing advice, treatment interventions or referrals regarding the management and/or ongoing assessment/monitoring of the disease should also be clearly recorded, including advice and interventions on helping the individual to stop smoking. A current and full synopsis of this documentation should be included as part of any CPA review letters or as part of a comprehensive discharge summary (to be sent to the patient's GP) inclusive of review dates.

All patients with COPD should be reviewed as a minimum:

- Annually (If diagnosed with stages 1-3: mild, moderate, severe)
- Twice Annually (If diagnosed with stage 4: very severe)

Such reviews should be undertaken by a competent, experienced clinical practitioner who is familiar with the COPD review process and who is able to tailor care and intervention as appropriate to the needs of the patient (dependant on review outcome). For patients

requiring a COPD review, an appropriate referral to a community or hospital respiratory/COPD service, or via collaboration with the patient's GP may be necessary.

As part of the patient's review, clinical assessment should also consider/include:

- Spirometry - to assess lung function (results should be documented)
- Smoking status and motivation to quit
- Symptom control (including breathlessness, exercise tolerance and estimated exacerbation frequency)
- Presence of complications (stages 1-3)
- Presence of Cor pulmonale (stage 4)
- Need for long-term oxygen (stage 4)
- Nutritional status and current BMI
- Presence of depression and anxiety
- Effects of drug treatment
- Side-effects of drug treatment
- Inhaler technique
- Need for additional input/services/organisations (e.g. Social Services, Occupational Therapy)
- Need for referral for specialist advice and therapy services
- Need for pulmonary rehabilitation (stages 1-3)
- Ask and review the patient's ability to undertake their usual activities of daily living and seek Occupational Therapy and Social Services advice/review where appropriate
- Grading of breathlessness using the Medical Research Council (MRC) dyspnoea score
- Oxygen saturations SaO2 should be measured and recorded for patients with stage 4 COPD

(NICE, 2018a, updated 2019)

5.8.3 Patient Education

There are many online resources available to support people diagnosed with COPD. These include advice regarding smoking, breathing techniques, physical activity, nutritional advice, symptom monitoring and symptom trigger avoidance. Patients should only be encouraged to access reputable resources when seeking further information about their condition. Some available resources include The British Lung Foundation, NHS website, Patient.info.

All patients should be well informed about their COPD diagnosis including treatment, progression of the disease, symptoms of an exacerbation and prognosis. Further information regarding patient education can be obtained from Further information can be obtained from NICE Guideline 115: Chronic Obstructive Pulmonary Disease in Over 16s: Diagnosis and Management (NICE, 2018a, last updated 2019). It is important that the patient understands that no medicine has been shown to modify the long-term decline in lung function, and the primary goal of medication is to control symptoms and prevent complications.

5.8.4 Medications Used for Stable COPD

When caring for an individual with COPD, it is important to be familiar with the medications used to treat the disease, and also, the various means of medication delivery. Many COPD medications are commonly administered through direct inhalation into the lungs which helps to potentially reduce adverse systemic effects. The overall approach to managing stable COPD is to follow a stepwise increase in treatment, depending on the individual's symptoms, disease progression and severity.

COPD medications are not curative, but rather are aimed at:

- Reducing and/or managing symptoms
- Increasing exercise tolerance
- Improving health status and quality of life
- Reducing the risk of instability and exacerbations
- Reducing the risk of disease progression

(O'Dell et al, 2018)

Wherever possible, medication, treatment and care intervention should take into account the patient's needs and preferences. The choice of medication delivery should reflect the dose of drug needed, the person's ability to utilise the device and consideration of the resources available to ensure that the drug is being administered safely.

People with COPD should have the opportunity to make informed choices and decisions about their care and treatment and work collaboratively with healthcare professionals.

Consider referral and/or obtain specialist advice regarding specific changes to prescribed medication changes or when escalating treatment as part of an ongoing treatment plan.

5.8.5 Inhaled Therapy

As mentioned, many of the medications prescribed to manage COPD are inhaled directly into the lungs. Such medications may be inhaled via an inhaler (of which there are several types), and/or via a nebuliser/nebulised therapy.

Inhalers

There are a vast number of inhaler devices requiring various techniques of use (dependent on the actual type of inhaler). All forms of inhaler should be used in conjunction with the recommended technique to ensure that medication is delivered effectively and safely.

Despite the various inhalers available, these can usually be categorised into the following therapeutic groups:

Short-acting bronchodilators: used for the short-term relief from sudden breathlessness

- Short-acting beta-2 agonists (SABA) e.g. Salbutamol and Terbutaline
- Short-acting muscarinic antagonists (SAMA) e.g. Ipratropium

Long-acting bronchodilators: used regularly to help control breathlessness

- Long-acting beta-2 agonists (LABA) e.g. Formoterol and Salmeterol
- Long-acting beta-2 muscarinic antagonists (LAMA) e.g. Tiotropium

Inhaled Corticosteroids (ICS): used to reduce the inflammation within the airways

- e.g. Beclomethasone, Fluticasone, Budesonide

Inhaled Combination Therapy

- (Refers to inhalers that are a combination of LAMA + LABA + ICS)

Initial treatment for people with COPD is often with short or long-acting bronchodilators, with corticosteroids added in some cases. Such treatment may require the use of separate inhalers, but increasingly these medications are provided together in single inhalers (combined therapy). NICE (2018a, last updated 2019) have published the following visual summary to assist with treatment options:

Chronic Obstructive Pulmonary Disease in over 16s: Non Pharmacological Management and Use of Inhaled Therapies.

Short-acting bronchodilators should be the initial empirical treatment for the relief of breathlessness and exercise limitation.

Inhaled corticosteroids are not recommended as first-line therapy and are only recommended as part of escalation therapy or for patients with advanced stages of COPD who suffer from frequent exacerbations. Inhaled corticosteroids should be added to the patient's existing bronchodilator therapy (GOLD, 2022 [online], Odell et al, 2018).

Be aware of the increased risk of pneumonia in patients taking inhaled corticosteroids (NICE, 2018a, updated 2019).

Regarding psychological and behavioural side effects, follow the Medicines and Healthcare Products Regulatory Agency safety advice associated with inhaled corticosteroids.

All types of inhalers are frequently misused (O'Dell et al, 2018) with studies showing that many patients do not use their inhalers appropriately. Some of the more common errors are:

- Failing to exhale before inhalation (of the inhaler)

- Incorrect positioning or loading the inhaler incorrectly
- Failing to inhale deeply
- Failing to pause and hold the breath after inhalation

However, most patients are usually able to acquire and maintain good inhaler technique given adequate training and instruction by a suitably trained healthcare professional. Proper education and support improves efficient use (particularly when training sessions are repeated and technique is evaluated at regular intervals). All people with COPD should have their ability to use an inhaler assessed regularly by a competent healthcare professional (NICE, 2018a, updated 2019). As with all inhaled medications, it is important to verify patient understanding together with demonstration of proper delivery technique.

Spacer Devices

Spacers are devices that assist the inhaled medication to get into the lungs (rather than remaining in the patient's mouth or upper airway), and therefore, help to deliver the prescribed medication more effectively. Not all inhalers are suitable for use with a spacer but wherever possible, a compatible spacer should be provided. Spacers are primarily used with metred-dose inhalers.

NICE (2018a, updated 2019) recommends that spacers are used in the following way:

- The spacer should be compatible with the patient's inhaler
- The drug should be administered by single actuations of the inhaler into the spacer – inhaling after each actuation
- There should be minimal delay between inhaler actuation and inhalation
- Normal tidal breathing can be used as it is as effective as single breaths. This consists of breathing in and out slowly but deeply for 5 continuous in and out breaths (after one actuation of the inhaler)
- The above may be repeated if a second dose is required
- Spacers should be hand washed using warm water and washing-up liquid, then allowed to air dry
- Spacers should not be cleaned more than monthly as more frequent cleaning affects their performance (due to static build-up)
- All spacers should be used in accordance with individual manufacturer's guidelines

If a patient requires a spacer device for use with their prescribed inhaler, this should be recorded on their intervention plan, and on the physical health case note element of the electronic patient record. The spacer should also be documented on the Medicine Prescription and Administration Record Chart.

Nebulisers

Nebulisers are devices that convert liquid medication into a fine mist which is inhaled through a nebuliser face mask and/or mouthpiece. Nebulisers may be used for those with COPD who have distressing or disabling breathlessness despite maximal inhaler therapy. Nebulised therapy should not be prescribed without an assessment of the patient's ability

to use the device. Staff must ensure that all nebulisers and associated face masks are used in accordance with manufacturer's instructions (e.g. single use only).

Nebulised therapy should not continue to be prescribed without assessing and confirming that one or more of the following occurs:

- A reduction in symptoms
- An increase in the ability to undertake activities of daily living
- An increase in exercise capacity
- An improvement of lung function

Once the patient's condition has stabilised, the patient's prescription should be changed from nebulised therapy to a hand-held inhaler device.

(NICE, 2018a, updated 2019)

5.8.6 Oral Medication

There are numerous categories of oral medication that can be prescribed and administered to help people with COPD to control their symptoms, improve quality of life and to help to reduce further exacerbations. However, in addition to oral medication, maintenance therapy usually includes continuation of short-acting bronchodilators (as necessary) during episodes of sudden breathlessness.

Oral Corticosteroids

The long-term use of oral corticosteroids (oral steroids) is not normally recommended for people with COPD. However, for those with advanced COPD, long-term steroidal therapy may be necessary if such medication cannot be withdrawn following an exacerbation. In such cases, the prescribed dose should be kept as low as possible (NICE, 2018a, updated 2019).

People who require long-term oral corticosteroid therapy should be monitored for osteoporosis and prescribed an appropriate prophylaxis. NICE (2018a, updated 2019) recommends that prophylaxis without monitoring should be commenced for patients over 65 years of age.

In relation to the use of oral corticosteroids for the management of an exacerbation of COPD, see Section 7 of this document.

Antibiotics

Before commencing prophylactic antibiotic therapy, consider whether specialist respiratory input is required (NICE, 2018a, updated 2019). Prior to offering prophylactic antibiotics, the patient should have a sputum culture and sensitivity obtained (inclusive of tuberculosis culture) to identify other potential causes of persistent or recurrent infection that may require specific antibiotic treatment (NICE, 2018a, updated 2019).

In relation to the use of antibiotics for the management of an exacerbation of COPD, see Section 7 of this document.

Oral Theophylline/Methylxanthines

Methylxanthines such as theophylline have a modest bronchodilator effect but for some patients, may improve lung function. Theophylline should only be used after a trial of short-acting bronchodilators and long-acting bronchodilators or, for patients who are unable to use inhaled therapy. Theophylline requires close monitoring of the patient's serum levels and any interactions should also be closely monitored (NICE, 2018a, updated 2019).

The effectiveness of theophylline should be reviewed and assessed by its effectiveness regarding symptom control, activities of daily living, exercise capacity and lung function. Particular caution should be used when prescribing theophylline in older people – primarily because of the key differences in pharmacokinetics and the increased likelihood of comorbidities (where other medications are prescribed).

The dose of theophylline may need to be reduced for patients who are having an exacerbation depending on whether they are prescribed certain types of antibiotics (or other drugs known to interact).

Careful consideration should be given to patients who are prescribed theophylline and who continue to smoke. Cigarette smoking interacts with certain medications including theophylline (due to certain hydrocarbons found in cigarette smoke that stimulate specific enzymes).

For patients who smoke, an increased dose of theophylline is often prescribed due to the shortened half-life of the drug and the increased elimination.

Plasma theophylline concentrations should therefore be monitored, and patients should be advised to inform staff should they develop signs of theophylline toxicity such as palpitations or nausea.

Should a patient commence smoking cessation, the dose of theophylline may need to be reduced, again to prevent side effects and/or toxicity. Similarly, theophylline concentration should be monitored, and patients advised to inform staff if they resume smoking.

Mucolytic Therapy

Many patients with COPD (particularly those with chronic bronchitis) often produce thick sputum on a frequent basis. Consider mucolytic therapy for patients with a chronic cough productive of sputum (NICE, 2018a, updated 2019).

Mucolytic medication(s) are not associated with an increase in adverse effects and may be beneficial to those with COPD. Unfortunately, mucolytic agents only result in a small reduction in the frequency of COPD exacerbations and do not improve lung function or

quality of life (Poole et al, 2019). Do not routinely use mucolytic drugs to prevent exacerbations in patients with stable COPD (NICE, 2018a, updated 2019).

Mucolytic therapy may be helpful to those patients not already prescribed inhaled corticosteroids but only continue with such medication if there is evidence of symptomatic improvement (e.g. reduction in frequency of cough and sputum production).

5.8.7 Recommended Vaccinations

Influenza and pneumococcal vaccinations should be offered to every patient with COPD (GOLD, 2022 [online]). Influenza and pneumococcal vaccinations may help prevent exacerbations by reducing the likelihood of lower respiratory tract infections (O' Dell et al, 2018). All healthcare professionals have a responsibility in ensuring that patients with COPD have access to appropriate vaccinations. Influenza vaccine is given annually, and pneumococcal vaccinations are recommended for anyone over age 65 and for those under age 65 who a significant comorbid condition such as: chronic heart disease, lung disease, liver disease, diabetes, or alcoholism, as well as for cigarette smokers. Covid-19 vaccination is also recommended for adults in high-risk groups.

5.8.8 Physical Activity

Often people with COPD become less active to avoid getting breathless which results in a loss of fitness and confidence which in turn increases breathlessness.

Physical activity is recommended for all patients with COPD (GOLD, 2022 [online]) – although the type of activity and exercise intensity should be tailored to suit an individual's overall health status. People with COPD who exercise regularly (or keep active) often have improved breathing and less severe symptoms. Regular activity and exercise can also improve self-confidence and emotional wellbeing.

UK guidelines suggest 150mins of moderate physical activity per week to maintain health for adults, older adults and disabled adults (Department of Health & Social Care, 2019 [online]). However, some physical activity/movement is better than none and long periods of inactivity should be avoided. For someone with COPD, regular short periods of physical activity/movement with rests in between is advised.

The physical activity could take the form of chair exercises, Tai Chi, Yoga or simply walking or singing.

Advice regarding tailored patient exercise plans should be obtained from the Trust wide Physiotherapy Service. Physiotherapy staff can also advise on breathing techniques and inhaler use i.e. how and when to take inhaled medicine when doing physical activity.

5.8.9 Pulmonary Rehabilitation

Pulmonary rehabilitation is a specialised programme of exercise and education designed specifically to help people with lung conditions such as COPD (British Lung Foundation,

2022 [online]). This structured programme is provided by experienced healthcare professionals (often physiotherapists, nurse specialists and dietitians) and usually involves two or more group sessions per week for a period of 4-6 weeks.

Pulmonary rehabilitation can also help individuals manage their own condition by providing guidance particularly in relation to:

- Physical exercise
- COPD as a condition (education for the patient and for family members)
- Dietary advice
- Psychological and emotional support

The goals of pulmonary rehabilitation are ultimately: to reduce symptoms, increase quality of life, and to increase both psychological and physical participation in everyday activities. Often, pulmonary rehabilitation is offered to patients' who have had a recent exacerbation requiring treatment in an acute hospital but are still able to mobilise (and therefore have the potential for further rehabilitation). Pulmonary rehabilitation is not suitable for those patients that are immobile or limited in their mobility due to a recent cardiac event or an ongoing cardiac condition (such as angina).

Referral for pulmonary rehabilitation is made via the Specialist COPD/Respiratory Team or from within the Acute Hospital Trust.

5.8.10 Weight Management

Being overweight can increase breathlessness, and similarly, breathlessness caused by COPD can make it more difficult for patients to exercise. Patients living with overweight and obesity should be encouraged to have a healthy diet and achieve a healthier weight.

Additionally, some people with COPD find that they lose weight (often quite significantly) and therefore, eating food high in protein and of sufficient calorific intake may be important to reduce risk of further weight loss and to promote weight gain.

To ensure the appropriate dietary advice is given, please refer to TEWV Dietetic Services (where there is service provision) or ask the patient's GP to refer to local community Dietetics. Referral to Dietetics should always be discussed with the patient and their consent obtained. If a patient is assessed not to have capacity with regards to this decision, a best interest decision should be made regarding the need for a referral.

5.8.11 Long Term Oxygen Therapy and Ambulatory Oxygen Therapy

The decision for the use of long-term oxygen or ambulatory oxygen therapy will be confirmed by a Respiratory Physician or a member of a Specialist COPD/Respiratory Team (who has appropriate training and expertise). Referral for supplemental oxygen therapy should be made to a community or an acute hospital respiratory service. To ensure that everyone eligible for long-term oxygen therapy is identified, pulse oximetry should be available in all healthcare settings (NICE, 2018a, updated 2019).

There are several devices available to administer supplemental oxygen therapy. Some devices are only suitable for specific oxygen percentages and/or rate of flow (e.g. a nasal cannula should not exceed an oxygen flow rate of 4L/min). The device/method of oxygen administration (together with the percentage/rate of flow) should be clearly documented on the Medicine Prescription and Administration Record Chart or electronic prescribing system. Do not confuse oxygen masks with nebuliser masks. Patients receiving supplementary oxygen at the time of monitoring should have 2 added to their overall National Early Warning Score.

Clinicians should be aware that the inappropriate use of oxygen therapy for people with COPD may cause respiratory depression. Oxygen is a treatment for hypoxaemia (an abnormally low level of oxygen in arterial blood), not breathlessness (British Thoracic Society Emergency Oxygen Guideline Development Group, 2017). Many patients with COPD suffer from breathlessness even when in their usual 'stable' state. Oxygen has not been proven to have any consistent effect on the sensation of breathlessness (in non-hypoxaemic patients). Oxygen saturation levels must be monitored for all patients receiving oxygen therapy.

For further information, please see Oxygen & Other Medical Gases – Administration, Prescribing, Storage and Safety available via the Trust intranet.

Hypercapnia – (known also as type 2 respiratory failure or hypercarbia) is an abnormally high concentration of carbon dioxide in the blood. Some people with COPD are susceptible to hypercapnia, particularly when supplemental oxygen is administered. The risk of hypercapnia should be considered when prescribing supplemental oxygen and the percentage and/or rate of flow should be sufficient only to ensure target saturations are maintained:

(Aim for target saturations 88-92% for patients with known hypercapnic respiratory failure).

Note that the term 'supplemental oxygen' above refers to routine oxygen delivery by mask or nasal cannula. In relation to the administering of oxygen in an emergency see Section 5.9.4 of this document.

5.9 Managing an Exacerbation of COPD

5.9.1 Definition of an Exacerbation

NICE (2018a, updated 2019) defines an exacerbation of COPD as 'A sustained acute onset worsening of the person's symptoms from their usual stable state, which goes beyond their normal day-to-day variations. Commonly reported symptoms are worsening breathlessness, cough, increased sputum production and change in sputum colour. The change in these symptoms often necessitates a change in medication.' A range of factors

(including viral infections and smoking) can trigger an exacerbation of COPD and many exacerbations (including some severe exacerbations) are not caused by bacterial infections so will not respond to antibiotics.

5.9.2 Medications Used to Treat Exacerbations of COPD

Increased breathlessness is a common feature of a COPD exacerbation. This is usually managed by taking increased doses of prescribed short-acting bronchodilators. Both hand-held inhaler devices and nebulisers can be used to administer prescribed inhaled therapy during an exacerbation of COPD (NICE, 2018a, updated 2019).

Oral corticosteroids should be considered for all patients who have an exacerbation of COPD with any significant increase in breathlessness that interferes with their usual daily activities (NICE, 2018a, updated 2019). Ideally, corticosteroid therapy should be commenced early in order to obtain maximum benefits. Offer 30mg oral prednisolone daily for 5 days. Clinicians should refer to the BNF for guidance on stopping oral corticosteroid therapy. Patients should be made aware of the optimum duration of treatment and the adverse effects of prolonged therapy, with clear instructions on why, when and how to stop their corticosteroid treatment. Prophylaxis for osteoporosis should be considered for patients who require frequent courses of oral corticosteroids.

Oral antibiotics should be considered for patients with COPD where there is evidence of increased sputum purulence and/or where there is evidence of an acute exacerbation of COPD, but only after taking the following into account:

- Severity of symptoms, particularly sputum colour changes and increases in volume or thickness beyond the person's normal day-to-day variation
- Whether the patient requires a transfer to an acute hospital for treatment
- Previous exacerbation and hospital admission history, and the risk of developing complications
- Previous sputum culture and susceptibility results
- Any risk of antimicrobial resistance with repeated courses of antibiotics

Seek specialist advice for people with an acute exacerbation of COPD if:

- Symptoms do not improve after a course of antibiotics
- The patient has a bacteria that is resistant to oral antibiotics
- The patient cannot take oral medicines

For guidance on the choice of antibiotics to prescribe for patients with an exacerbation of COPD, see the following recommendations published by NICE (2018b): COPD (Acute Exacerbation): Antimicrobial Prescribing

5.9.3 Assessing the Need for Acute Hospital Treatment

The diagnosis of an exacerbation of COPD is made clinically and is not dependant on the results of tests or investigations. NICE (2018a, updated 2019) recommend the consideration of numerous factors when deciding where to treat a person with COPD (in terms of treatment provision within their home environment or within an acute hospital setting). Many of these factors can also be considered from an in-patient perspective when deciding whether a patient requires an urgent transfer to ensure appropriate treatment is given. Consider the need for acute hospital treatment for the following:

- Severe Breathlessness
- Deterioration of general physical condition
- Deterioration of the patient's usual level of activity or if the patient becomes confined to bed
- Evidence of cyanosis (bluish discolouration to the skin, mucous membranes, lips)
- Worsening peripheral oedema (accumulation of fluid in the lower limbs)
- Reduced level of consciousness
- Already receiving long-term oxygen therapy
- New acute confusion
- Rapid onset of symptoms
- Changes on a chest x-ray
- Oxygen saturations (from pulse oximetry) <90%
- Patient has significant comorbidity (such as cardiac problems/disease and/or diabetes)

Whilst the factors outlined above should certainly be taken into account when making a clinical decision regarding a patient's care, they do not override the responsibility of the registered nurse or doctor to make decisions appropriate to the needs, circumstances and presentation of the patient concerned. Always refer patients with an acute exacerbation of COPD to hospital if they have any symptoms or signs suggesting a more serious illness or condition (e.g. cardiorespiratory failure or sepsis).

When determining whether an acute hospital admission/treatment is required, sound clinical judgement should also include: a review of the patient's physiological observations (with appropriate actions undertaken as may be necessary), the wishes of the patient (wherever possible), and ideally, an awareness of the patient's usual 'stable' state. Any change to a patient's condition should be immediately reported to medical staff (whether this is within or outside of routine working hours) and this should be documented together with any instructions/advice given.

If medical review and/or medical advice is delayed (for whatever reason) and/or the patient appears to be acutely physically unwell, or appears to be in a physically deteriorating state, staff should call 9-999 for an emergency ambulance.

Remember, all physiological observations should be documented on the National Early Warning Score Chart (Royal College of Physicians, 2017) and the recommended instructions and/or escalations followed accordingly (and documented within the electronic case note).

Monitor respiratory rate and use pulse oximetry to monitor oxygen saturations as part of the patient assessment to determine potential hypoxaemia (an abnormally low level of oxygen in arterial blood). Hypoxaemia can lead to cardiac arrhythmias, renal damage and cerebral damage (BTS Emergency Oxygen Guideline Development Group, 2017). **When there is evidence of hypoxaemia, treat as an emergency (see below)**.

Some pulse oximeters can underestimate or overestimate oxygen saturation levels – especially if the saturation level is borderline. Overestimation has been reported in those with darker skin tones NICE, 2018a, updated 2019).

Staff should also be aware of the NHS England/Improvement Patient Safety Alert: Risk of Harm from Inappropriate Placement of Pulse Oximeter Probes

5.9.4 Oxygen Administration in an Emergency

Oxygen can be administered in an emergency (life threatening situation) and should not be withheld in such circumstances. If oxygen saturations are 93% or below or are below the target range specifically prescribed for the patient (such as those patients at risk of hypercapnic respiratory failure) oxygen should be administered at 15 litres per minute via a non-rebreathe mask (with reservoir bag).

Oxygen can be administered in an emergency by any member of staff who has completed and is up to date with Basic Life Support (BLS) or Immediate Life Support (ILS) training (and has therefore been trained to administer oxygen). The Ambulance Service must be called when a patient requires emergency oxygen.

Continue to monitor respiratory rate and use pulse oximetry to monitor oxygen saturations.

Further information can be obtained from: Medication Safety Series: MSS10: Oxygen Administration in an Emergency and also, from Oxygen and Other Medical Gases - Administration, Prescribing, Storage and Safety (available via the Trust intranet).

Patients receiving emergency oxygen therapy should have 2 added to their overall National Early Warning Score.

6 Terms and definitions

Term	Definition
Dietitians	Dietitians are qualified and regulated health professionals who assess, diagnose and treat dietary and nutritional problems. Dietitians use the most up-to-date public health and scientific research on food, health and disease which they translate into practical guidance to enable people to make appropriate lifestyle and food choices.
Long Term Condition	A long-term condition also known as a chronic condition is a health problem that requires ongoing management over a period of years or decades. A long-term condition is usually one that cannot be cured but can be controlled with the use of medication and/or use of other therapies.
NEWS	The National Early Warning Score is based on a simple scoring system in which a score is allocated to six physiological observations. Each individual observation generates a score. When all six scores are added together, this provides the overall NEWS which is set to trigger when a service user is acutely unwell or has abnormal physiology.
Physiotherapists	Physiotherapists consider the body as a whole, rather than just focusing on the individual aspects of an injury or illness. Some of the main approaches used by physiotherapists include: • Education and advice – physiotherapists can give general advice about things that can affect an individual's daily lives, such as posture and correct lifting or carrying techniques to help prevent injuries. • Movement, tailored exercise and physical activity advice. Exercises may be recommended to improve general health and mobility, and to strengthen specific parts of the body. • Manual therapy – where the physiotherapist uses their hands to help relieve pain and stiffness, and to encourage better movement of the body.
Reasonable Adjustments	Removing barriers that people with disabilities face or providing extra support for individuals with disabilities to enable them to access the healthcare they need. This could relate to people with learning and/or physical disabilities, sensory impairments and/or individuals who are neuro diverse, as well as people living with mental illness (e.g. offering extra time to individuals who have particular communication needs and offering information and advice in a language and format that the individual can understand).

7 How this procedure will be implemented

• This procedure will be published on the Trust's intranet and external website.
• Line managers will disseminate this procedure to all Trust employees through a line management briefing.
• Each team/ward manager will ensure that staff training needs are met in accordance with the Trust's training needs analysis
• Each healthcare professional is responsible for his or her own professional development and an individual's needs should be addressed through appraisal and training needs analysis
• Physical Health Core Skills Training (including refresher training) is available across the Trust for all mental health and learning disability registered nursing and nursing support staff.

7.1 Training Needs Analysis

Although there is no specific training required to implement this specific Guideline, staff are expected to undertake appropriate training and education pertinent to their role. This training is identified as follows:

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Registered MH/LD Nursing Staff (Inpatients): AMH, SIS, MHSOP, LD	Physical Health Core Skills Training Day (Registered Nurse: Inpatients) Face to Face	1 day	Once Only (but can be accessed as required)
Registered MH/LD Nursing Staff (Community): All Adult Services, MHSOP, LD	Physical Health Core Skills Training Day (Registered Nurse: Community) Face to Face	1 day	Once Only (but can be accessed as required)
Nursing Support Staff inc Nursing Associates (Inpatients): AMH, SIS, MHSOP, LD	Physical Health Core Skills Training Day (Non-Registered Nurse: Inpatients) Face to Face	1 day	Once Only (but can be accessed as required)

Nursing Support Staff inc Nursing Associates (Community): All Adult Services, MHSOP, LD	Physical Health Core Skills Training Day (Non-Registered Nurse: Community) Face to Face	1 day	Once Only (but can be accessed as required)
All clinical staff who undertake, document, report and respond to any interventions outlined as part of NEWS	NEWS2 Training Via ESR	1 hour	Once Only (but can be accessed as required)
Mandatory for nominated staff who do not have access to an Emergency Response Bag and equipment	Cardiopulmonary Resuscitation (CPR) & AED Face to Face	2 hours	Annual
Mandatory for nominated clinical staff who have access to the Emergency Response Bag and would be expected to participate in its use	Basic Life Support (BLS) Face to Face	3.5 hours	Annual
Mandatory for all designated medical staff, ECT nursing staff and Physical Healthcare Practitioners	Immediate Life Support (ILS) Face to Face	5 hours	Annual

8 How the implementation of this procedure will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Clinical Audit of Physical Health Assessments	Annually	Physical Health Group
2	Clinical Audit of the National Early Warning Score (NEWS) Procedure for patients 16 years of age and over	Annually	Physical Health Group

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10 Document control (external)

Date of approval	16 November 2022
Next review date	16 November 2025
This document replaces	Chronic Obstructive Pulmonary Disease (COPD) in Adults (aged 16 and above) Guideline Ref: CLIN-0084-002.v2
This document was approved by	Physical Health Group
This document was approved	16 Nov 2022
This document was ratified by	n/a
This document was ratified	n/a
An equality analysis was completed on this policy on	15 November 2022
Document type	Public
FOI Clause (Private documents only)	N/A

Change record

Version	Date	Amendment details	Status
V2	31/05/2019	Changes to wording in sections throughout document. Additional sections added throughout document. Updated hyperlinks throughout document and updated cross-referenced documents. Additional reference documents added.	Withdrawn
V2	01/07/2020	Intouch links removed and replaced with Trust policy/procedure/guideline name.	Withdrawn
V2	30 Mar 2021	Review date extended to 28 Nov 2022	Withdrawn

V3	16 Nov 2022	Full review and update with additional sections added and evidence-based references	Published

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Nursing and Governance/Physical Healthcare
Title	Chronic Obstructive Pulmonary Disease (COPD) in Adults (aged 16 and above) Guideline Ref: CLIN-0084-002.v3
Type	Guideline
Geographical area covered	Trust wide
Aims and objectives	• To standardise clinical practice in the management of Chronic Obstructive Pulmonary Disease (COPD). • To ensure that patients with COPD receive safe, effective and appropriate care that is supported by current national guidance and best practice. • To reduce the clinical risk(s) associated with inappropriately managed long term chronic condition(s).
Start date of Equality Analysis Screening	04/10/22
End date of Equality Analysis Screening	15/11/22

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	The Guideline benefits service users by standardising the processes/interventions required by staff for the management of COPD. The information contained within the Guideline is also aimed at reducing the clinical risk(s) associated with inappropriately managing long term chronic condition(s). Similarly, the information within the Guideline will help facilitate early detection and timely management of any clinical deterioration of patients with COPD and will ensure that patients receive

	safe, effective and appropriate interventions that are supported by current national guidance and best practice.
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Veterans** (includes serving armed forces personnel, reservists, veterans and their families) **NO**
Describe any negative impacts	The Guideline does not impact negatively on any of the protected characteristic groups.
Describe any positive impacts	The positive impacts of the guidance are: Patients with COPD receive safe, effective and appropriate care that is supported by current national guidance and best practice.

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	The Guideline has been updated in accordance with the Chronic Obstructive Pulmonary Disease in over 16s: Diagnosis and Management, Clinical Guideline 115 (National Institute for Health and Care Excellence (NICE), 2018, updated 2019).
Have you engaged or consulted with service users, carers, staff and other stakeholders	Yes

including people from the protected groups?	
If you answered Yes above, describe the engagement and involvement that has taken place	Draft documented sent to a number of specialisms including Pharmacy, Dietetics, Physiotherapy and Physical Healthcare Practitioners. The document will also be presented at the Physical Health Group prior to approval.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	**Training needs**
As part of this equality analysis have any training needs/service needs been identified?	Yes
Describe any training needs for Trust staff	As detailed in Section 8.1 Training Needs Analysis
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 – Approval checklist

	Title of document being reviewed:	Yes / No / Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yea	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	
	Are training needs included in the document?	Yes	
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Yes	

	Title of document being reviewed:	Yes / No / Not applicable	Comments
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	16/11/22
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
10.	**Publication**		
	Has the policy been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	