Tailored Intervention for People with COPD and Co-morbidities by Pharmacists and Consultant Physicians

Baseline Date: _____	Completed by: _____

COVID Vaccinated?	Yes ❑ / No ❑	If yes, how many?	1st ❑ / 2nd ❑
Temp:	_____ ˚C	Pulse:	_____
O_2 Sats:	_____ %	Anosmia:	Yes ❑ No ❑
New, dry cough <7 days and continuous?	Yes ❑ No ❑	Respiratory Rate (RR) breaths per minute:	_____
Have you been self-isolating in the past 7 days?			Yes ❑ No ❑
Have you been in contact with anyone with COVID symptoms in the past 7 days?			Yes ❑ No ❑
Has there been any change in your breathlessness in the past 7 days?			Yes ❑ No ❑
If COVID symptoms or if Temp >38°C and RR >25 breaths per minute, and HR>110bpm → phone GP/ambulance			

1 DEMOGRAPHICS

Patient Name:	_____	Patient CHI No:	_____
Gender:	Male ❑ / Female ❑ / Other ❑	Age of Patient at interview date:	_____
Patient's Home Address (incl. postcode):	_____ _____ _____	Next of Kin: Name/Relationship: Contact Tel No:	 _____ _____

Home Information

Telecare	Yes ❑	No ❑	Community Alarm?	Yes ❑	No ❑
Stair Lift?	Yes ❑	No ❑	Heating	Yes ❑	No ❑
Internal Stairs?	Yes ❑	No ❑	External Stairs?	Yes ❑	No ❑
Bedroom Location:	_____		Bathroom Location:	_____	

Ethnicity

A. White Scottish ❑ Other White British ❑	White Irish ❑ Any Other White Background ❑	B. Mixed or Multiple Ethnic Groups ❑	
C. Asian, Asian Scottish or Asian British ❑		D. African, Caribbean or Black ❑	
E. Other Ethnic Group (Arab/Other, state) ❑			

1 DEMOGRAPHICS (continued)

GP, Pharmacy & Social Care

GP Name: _____ GP Contact Tel No: _____	GP Address: _____ _____ _____

Pharmacy Name: _____ Pharmacy Contact Tel No: _____	Pharmacy Address: _____ _____ _____
Is your medication delivered by the pharmacy? Yes ❑ No ❑ Sometimes ❑	

Social Care package in place? Yes ❑ No ❑	Social Care Contact Name and Address: _____ _____ _____
Current Package of Care: (e.g. 4x7, 2x7 …): _____	Any other teams/folk helping you? _____
Are you receiving any benefits? Yes ❑ No ❑	If yes, description: _____

2 LIFESTYLE

Smoking History

Current tobacco smoker? Yes ❑ No ❑	If no, ever smoked? Yes ❑ No ❑ Explain _____
If yes, age started:	No of years as smoker:
No of cigarettes/day:	No of Rollups/day (half ounce = 15g tobacco = 20 cigarettes):
Ex-Smoker? Yes ❑ No ❑ Date Stopped: _____	Any known triggers for restarting? _____
Previous quit attempts? Yes ❑ No ❑	If yes, date(s):
Any support in place for quit attempts? Yes ❑ No ❑	Would you consider stopping smoking now? Yes ❑ No ❑ Don't know ❑
Do you know where to access smoking cessation services? Yes ❑ No ❑ Don't know ❑	Would you like to be referred to smoking cessation services? Yes ❑ No ❑ Don't know ❑
Any other substances smoked? Yes ❑ No ❑	Details:

2 LIFESTYLE (continued)

Alcohol

Past drinking behaviour:	_____	When?	_____
Currently: do you drink alcohol?	Yes ❑ No ❑	What type(s):	_____
How much in a typical week?	_____	How many days of the week do you drink alcohol?	_____ days
How many units per day do you drink?	_____	Looking to reduce/stop?	Yes ❑ No ❑
Require any referral for help?	Yes ❑ No ❑	1 unit = standard 76ml glass of wine Standard 25ml glass of whiskey Standard 250ml beer 4% Standard 218ml cider ABV times volume divided by 1000 gives units	

Diet – What do you eat in a typical day?

Breakfast:	Lunch:	Dinner:

Exercise

What is your typical daily exercise? …			
None	❑	Low (e.g. collecting prescription, watering the grass, stoating about the house)	❑
Medium (e.g. walking, weeding, digging)	❑	High (e.g. gym work or running)	❑
How many days would you exercise in a week?			____ days

3 RESPIRATORY HISTORY

Diagnoses (patient reported):	_____				
From Portal/EMIS/GP notes:	COPD ❑	COPD/asthma ❑	Bronchiectasis ❑	ILD ❑	Antitrypsin ❑
How has your breathlessness been in the past year compared to the year before?	Same as before ❑	Less bothersome ❑	Slightly worse ❑	Significantly worse ❑	
Do you have a self-management plan / rescue pack of medication in the house?	Yes ❑ No ❑	How many rescue packs (steroids and/or antibiotics) have you used for your breathing in the past 12 months?	_____		

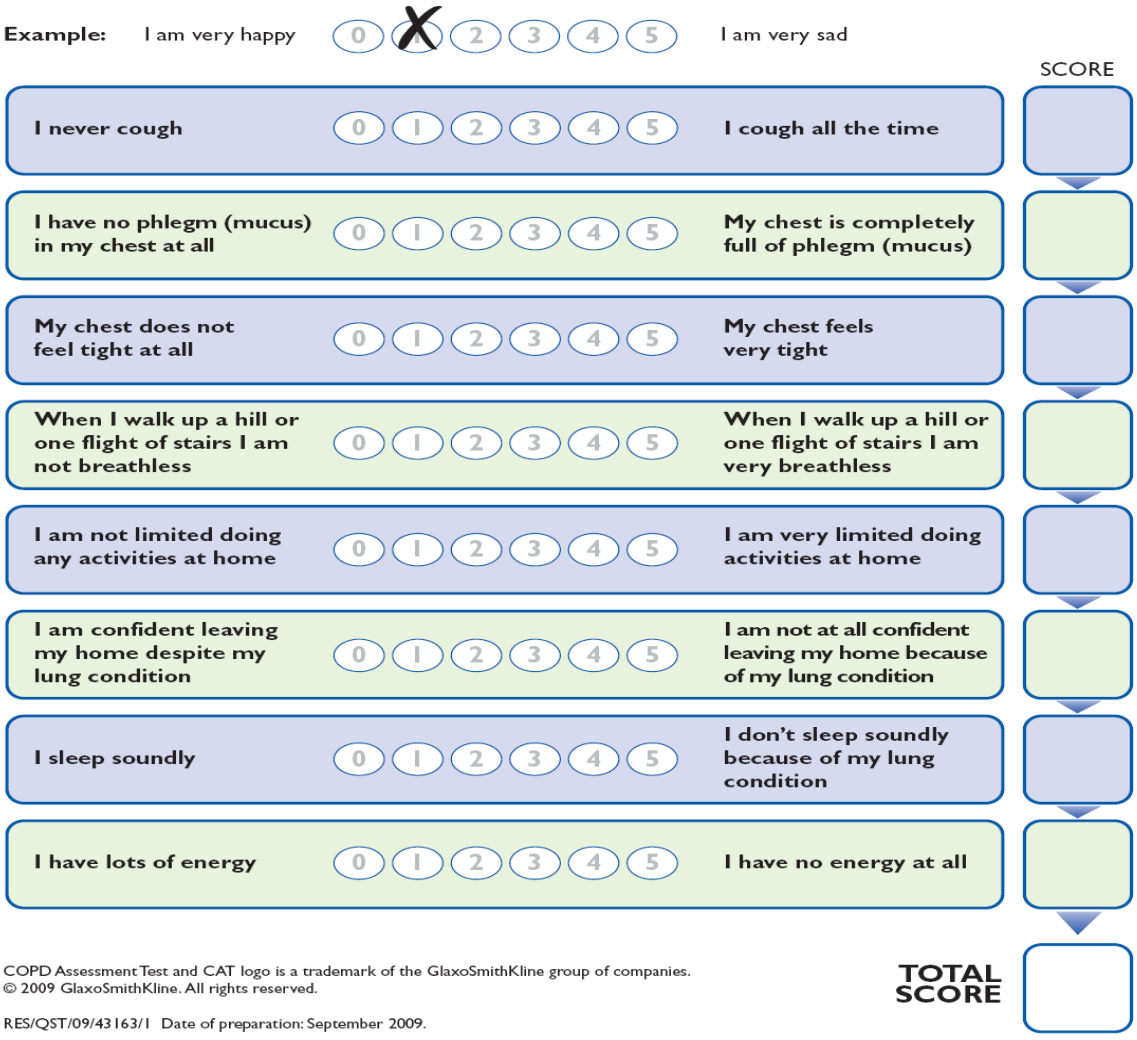
3 RESPIRATORY HISTORY (continued)

How many hospitalisations for breathing have you had in the past 12 months?				
What is the usual colour of your spit / phlegm?				
What is the usual consistency of your spit/phlegm:	Liquid ❑	Frothy ❑	Glue like ❑	Porridge like ❑
Have you attended pulmonary rehab in the past?			Yes ❑	No ❑
If yes, when? _____				

What statement best describes your level of breathlessness?

Breathlessness only with strenuous exercise	0
Breathlessness when hurrying or walking up a slight hill	+1
Walk slower than people of the same age because of breathlessness or has to stop for breath when walking at own pace	+2
Stops for breath after walking 100 yards (91m) or after a few minutes	+3
Too breathless to leave house or breathless when dressing	+4
MRC Score:	

CAT Score *(mark an X in the box that best describes you currently)*



RES/QST/09/43163/1 Date of preparation: September 2009.

3 RESPIRATORY HISTORY (continued)

Is your chest ever wheezy?	Yes ❑ / No ❑	If yes, when?
Do you ever get seasonal or allergic rhinitis / hay fever?	Yes ❑ / No ❑	If yes, when?
Do you ever get a night time cough?	Yes ❑ / No ❑	
Do you have a productive cough?	Yes ❑ / No ❑	If yes, when?
Do you ever get night sweats/fevers?	Yes ❑ / No ❑	If yes, when?
Have you ever coughed up blood?	Yes ❑ / No ❑	If yes, when?
Do you ever suffer from reflux, heartburn?	Yes ❑ / No ❑	If yes, when?
Have you had chest pain recently?	Yes ❑ / No ❑	If yes, how recent?
Have you had an exacerbation (rescue pack) in the past 12 months?	Yes ❑ / No ❑	<2 _____ / >2 _____

4 BONE HEALTH

Have you had any falls in the past?	Yes ❑ / No ❑	If yes, when and how many?
Have you had any fractures in the past?	Yes ❑ / No ❑	If yes, when and how many? What kind of fractures?
Is there any family history of hip fracture?	Yes ❑ / No ❑	If yes, who?
Do you have rheumatoid arthritis?	Yes ❑ / No ❑	
Have you ever had prednisolone for $\geq$3 months at $\geq$7.5mg/day?	Yes ❑ / No ❑	

5 NON-RESPIRATORY CURRENT MEDICAL ISSUES

Patient reported:	From case notes (EMIS MH, EMIS GP, Portal, own GP):

6 CURRENT PRESCRIBED MEDICINES

Patient reported		**From GP, EMIS, Portal, Case Notes / Community Pharmacy**			**Received > 80% in 3 months**	**Medication taken?**
Name and strength	**Dose and frequency**	**Name and strength**	**Dose and frequency**	**Date started**	**Y/N – If no, why not?**	
					Y/N – If no, why not?	
					Y/N – If no, why not?	
					Y/N – If no, why not?	
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					Y/N – If no, why not?	

7 HEALTH MEASURES

Height (cm):	Weight (kg):	BMI:	
Compared with one year ago, has your weight changed? Yes ❑ / No ❑		If yes lost weight? ❑ / gained weight? ❑	_____ lbs or kg
Blood Pressure (mmHg):		RR breaths per minute:	
Heart Rate (bpm):		Pulse, beats per minute:	
Oxygen Saturation (%):		Sp02(%) at rest:	
Grip Strength (kg)[1]:		Temperature °C:	
FEV1 % using copd 6:		FEB1/fvc <0.78: Yes ❑ / No ❑	
Vaccinations:			
Flu/pneumococcal vaccine within the past year? Yes ❑ / No ❑			
Inhaler technique check			
Over the past two weeks, how often have you felt tired or had little energy? *(mark on scale, 0 = ? / 10 = ?)*	0 1 2 3 4 5 6 7 8 9 10		

8 DIAGNOSES: MENTAL HEALTH

Any mental health problems:

Patient reported:		From case notes (EMIS MH, EMIS GP, Portal, own GP):	
Lost interest in things you used to enjoy? Yes ❑ / No ❑		Persistent low mood? Yes ❑ / No ❑	
Any problems/feelings of:	Sleep (increase or decrease) Yes ❑ / No ❑	Any problems/feelings of:	Activity (increase or decrease) Yes ❑ / No ❑
Guilt/Worthlessness ❑	Appetite Changes ❑	Fatigue ❑	Concentration Poor ❑
For how long? _____	Suicide attempts? Yes ❑ / No ❑	If yes, number of attempts _____	How long ago? _____
How are you feeling in yourself today? Same as usual ❑ Worse than usual ❑		If worse, why? Is there any reason for this?	

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop/control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3

4. Feeling down, depressed or hopeless	0	1	2	3

9 QUALITY OF LIFE

We would like to know how good or bad your health is TODAY
100 means the best health you can imagine. 0 means the worst health you can imagine

Under each heading, please tick the ONE box that best describes your health TODAY.

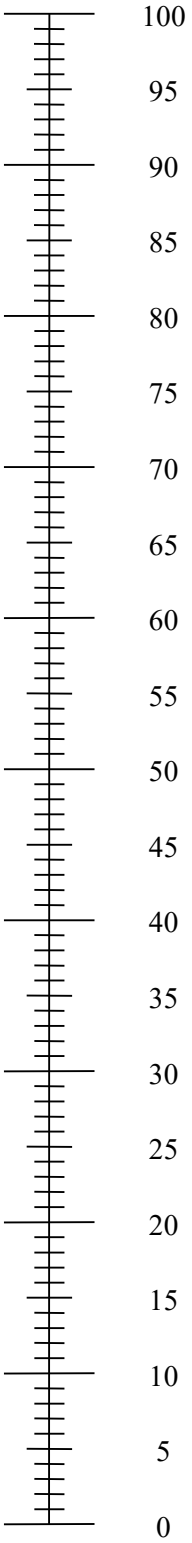
MOBILITY
- I have no problems in walking about ❑
- I have slight problems in walking about ❑
- I have moderate problems in walking about ❑
- I have severe problems in walking about ❑
- I am unable to walk about ❑

SELF-CARE
- I have no problems washing or dressing myself ❑
- I have slight problems washing or dressing myself ❑
- I have moderate problems washing or dressing myself ❑
- I have severe problems washing or dressing myself ❑
- I am unable to wash or dress myself ❑

USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*
- I have no problems doing my usual activities ❑
- I have slight problems doing my usual activities ❑
- I have moderate problems doing my usual activities ❑
- I have severe problems doing my usual activities ❑
- I am unable to do my usual activities ❑

PAIN / DISCOMFORT
- I have no pain or discomfort ❑
- I have slight pain or discomfort ❑
- I have moderate pain or discomfort ❑
- I have severe pain or discomfort ❑
- I have extreme pain or discomfort ❑

ANXIETY / DEPRESSION
- I am not anxious or depressed ❑
- I am slightly anxious or depressed ❑
- I am moderately anxious or depressed ❑
- I am severely anxious or depressed ❑
- I am extremely anxious or depressed ❑



Your Health Number Today is: _____

How do you think you could improve this number? _____

10 EXPERIENCE WITH TREATMENT + SELF-MANAGEMENT

These questions ask about prescription and non-prescription medicines that you are taking. If you are not taking AHY medicines, please skip the questions below and go onto the next page. For each item, please mark an"X" in the box that best describes how you feel or what is true for you.

10.1 Medicines

Over the past **4 weeks**, how easy or difficult has it been for you to …

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult
Organize your medicines?	❑	❑	❑	❑	❑
Take more than one medicine every day?	❑	❑	❑	❑	❑
Take your medicines several times each day?	❑	❑	❑	❑	❑
Get more of your medicines before they run out?	❑	❑	❑	❑	❑
Adjust your medicines (including the amount, type, or time when you take it)?	❑	❑	❑	❑	❑
Take your medicines as directed?	❑	❑	❑	❑	❑
Plan your daily activities around your medicine schedule?	❑	❑	❑	❑	❑

Over the past **4 weeks**, how bothered have you been by …

	Not at all bothered	A little bothered	Somewhat bothered	Quite bothered	Very bothered
How much you have to rely on your medicine(s)?	❑	❑	❑	❑	❑
Side effects of your medicine(s)?	❑	❑	❑	❑	❑

10.2 Medical Information

Over the past **4 weeks**, how easy or difficult has it been for you to …

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult	Does not apply to me
Learn about your health problem?	❑	❑	❑	❑	❑	❑
Learn what foods you should eat to stay healthy?	❑	❑	❑	❑	❑	❑
Find information on the medications you have to take?	❑	❑	❑	❑	❑	❑
Understand any changes to your treatment plan?	❑	❑	❑	❑	❑	❑
Understand the reasons why you are taking some medicines?	❑	❑	❑	❑	❑	❑
Find sources of medical information you trust?	❑	❑	❑	❑	❑	❑
Understand advice from different healthcare providers?	❑	❑	❑	❑	❑	❑

10.3 Appointments

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult
Make or keep your medical appointments?	❑	❑	❑	❑	❑
Keep track of your medical appointments?	❑	❑	❑	❑	❑
Make or keep appointments with <u>different</u> healthcare teams?	❑	❑	❑	❑	❑
Find the time to get to your medical appointments?	❑	❑	❑	❑	❑
Find the energy to get to your medical appointments?	❑	❑	❑	❑	❑
Find transportation to get you to your medical appointments?	❑	❑	❑	❑	❑

10.4 Keeping tabs on your health

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult	Does not apply to me
Keep tabs on your health behaviors, for example, the foods you eat, or medicines you take, exercise, sleep pattern?	❑	❑	❑	❑	❑	❑
Keep tabs on your health condition, for example, weighing yourself, or checking your blood sugar, checking sputum colour, breathlessness?	❑	❑	❑	❑	❑	❑

10.5 Exercise

Thinking about exercise, how much do you agree or disagree with the following statements? …

	Strongly agree	Agree	Disagree	Strongly disagree
It is difficult for me to find the time to exercise.	❑	❑	❑	❑
It is difficult for me to follow my healthcare provider's recommendations about exercise.	❑	❑	❑	❑
It is difficult for me to get motivated to exercise.	❑	❑	❑	❑
Physical pain or discomfort limits my ability to exercise.	❑	❑	❑	❑

10.6 Relationships with Other People

Over the past **four weeks**, how bothered have you been by …

	Not at all bothered	A little bothered	Somewhat bothered	Quite bothered	Very bothered
Feeling dependent on other people for your healthcare needs?	❑	❑	❑	❑	❑
Other people reminding you to do things for your health like organize appointments?	❑	❑	❑	❑	❑
Your healthcare needs creating tension in your relationships with other people?	❑	❑	❑	❑	❑
Other people not understanding your health situation?	❑	❑	❑	❑	❑

10.7 Difficulty with Health Services

	Strongly agree	Agree	Disagree	Strongly disagree	Does not apply to me
I have problems with different healthcare teams not communicating with each other about my medical care	❑	❑	❑	❑	❑
I have to see too many different specialists for my health problems(s) or illness(es)	❑	❑	❑	❑	❑
I have problems filling out forms related to my healthcare	❑	❑	❑	❑	❑
I have problems getting appointments at times that are convenient for me	❑	❑	❑	❑	❑
I have problems getting appointments with a specialist	❑	❑	❑	❑	❑
I have to wait too long at my medical appointments	❑	❑	❑	❑	❑
I have to wait too long at the pharmacy for my medicine					

10.8 Medical Equipment e.g. dosette boxes, wound dressings, inhalers, walking aids, bath aids …

Do you currently use any medical equipment or devices? Yes ❑ / No ❑ **If no, skip the questions below and go to the next section?*

Over the past **four weeks**, how easy or difficult has it been for you to …

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult
Obtain your equipment	❑	❑	❑	❑	❑
Use your medical equipment or device?	❑	❑	❑	❑	❑
Keep your medical equipment or device working correctly?	❑	❑	❑	❑	❑

10.9 Managing Your Health refers to all of those things that you have to do to stay health, e.g. taking medicine, going to appointments, exercise.

In the past **four weeks**, how much has being able to manage your health interfered with your …

	Not at all	Wee bit	Somewhat	Quite a bit	Very much
Family responsibilities?	❑	❑	❑	❑	❑
Daily activities?	❑	❑	❑	❑	❑
Hobbies?	❑	❑	❑	❑	❑
Ability to spend time with family and friends?	❑	❑	❑	❑	❑
Ability to travel?	❑	❑	❑	❑	❑

In the past **four weeks**, how often did managing your health make you feel …

	Never	Rarely	Sometimes	Often	Always
Angry?	❑	❑	❑	❑	❑
Preoccupied?	❑	❑	❑	❑	❑
Depressed?	❑	❑	❑	❑	❑
Worn out?	❑	❑	❑	❑	❑
Frustrated?	❑	❑	❑	❑	❑

DATA FROM CASE NOTES, AFTER INTERVIEW …

Healthcare contacts in past 12 months

Primary Care	**Number of Contacts** (S = Scheduled / U = Unscheduled)	**Dates and Durations**
GP		
Pharmacist		
Nurse		
Nurse - COPD Annual Review		
Out of Hours		
Mental Health	**Number of Contacts** (S = Scheduled / U = Unscheduled)	**Dates and Durations**
MH Nurse		
Hospital	**Number of Contacts** (S = Scheduled / U = Unscheduled)	**Dates and Durations**
A&E Visits (without admission) due to respiratory causes		
Emergency admissions due to respiratory causes		
Outpatient consultant appointment scheduled		

BLOODS (most recent, in past year)

Type	Normal or not – if not, what?	Date
K		
Na		
Urea		
Cr		
Egfr		
LFTs		
ALT		
AST		
Alb		
ALP		
Eosinophils		
FBC		
Folate		
B12		
CRP		
Ca		

DIAGNOSTICS (most recent, in past year)

Type	Normal or not – if not, what?	Date
Sputum Results		
Chest X-Ray		
ECG		
CT Scan		

Thanks and voucher given? £5 gift card at each researcher visit.	❑
Time taken for interview	_____ hr(s) _____ mins
Phone for randomisation (The Robertson Centre: _____)	❑
Allocation	ACTIVE ❑ CONTROL ❑

Requested access to look up of clinical notes	❑
Add Alert to EMIS Web	❑

Baseline Form passed back to office:	Date: _____
Data entered onto spreadsheet:	Date: _____ / By Whom: _____
Checked on:	Date: _____ / By Whom: _____

Planned date of 3 months follow-up:	Date: _____