Supplementary file.1

Emergency Department (ED) electronic Integrated COPD proforma (e-ICP)
Triage to discharge

Oxygen therapy	• Maintain oxygen saturation of 88-92% (Use nasal prongs at 0.5–2.0 L/minute or a Venturi mask at 24% or 28%)
Inhaled bronchodilators	• Short acting bronchodilators, Inhaled beta-agonist (e.g., salbutamol, 400–800mcg; terbutaline, 500–100mcg) and antimuscarinic agent (ipratropium, 80mcg) can be given by pressurised metered dose inhaler and spacer, or by jet nebulisation (salbutamol, 2.5–5 mg; terbutaline, 5 mg; ipratropium, 500mcg).

Diagnostics	• In case of FEV1 < 40% predicted perform: COPD severity score, blood gas measurements, chest x- rays and electrocardiography
Arterial blood gas	• FEV1 is less than 1.0 L or less than 40% predicted, or if percutaneous oxygen saturation is less than 90% in the presence of adequate peripheral perfusion or cor- pulmonale.
Corticosteroids	• Up to two weeks therapy with prednisolone (40–50 mg daily) is adequate
Antibiotics	• Antibiotics are given for purulent sputum to cover for typical and atypical organisms
Non-Invasive Ventilation	• Indicated for increasing hypercapnia and acidosis. (Non-invasive ventilation

	by means of a mask is the preferred method)
Pulmonary rehabilitation referral criteria	• Pulmonary rehabilitation should be offered to patients with COPD following hospitalisation for an exacerbation of COPD within 2 weeks
ED discharge criteria	• Clinically stable condition with no parenteral therapy • Inhaled bronchodilators are required less than four-hourly • Oxygen delivery has ceased If previously able, the patient is ambulating safely and independently, and performing activities of daily living • The patient or caregiver understands and can administer medications • Follow-up and home care arrangements arranged

ED discharge template to General practitioner or Outpatient Patient Clinic

- Discharge summary will be linked here electronically
- Provide COPD patient information pack by Lung foundation Australia

Supplementary file.2

Emergency Department electronic Integrated COPD care proforma (e-ICP) Triage to discharge

1) Oxygen therapy	• Maintain oxygen saturation of 88-92% (Use nasal prongs at 0.5–2.0 L/minute or a Venturi mask at 24% or 28%)
2) Inhaled bronchodilators	• Short acting bronchodilators [dose interval is titrated to the response and can range hourly to six hourly] • Inhaled beta-agonist [Salbutamol MDI 100 mcg (4 to 8 puffs), Ipratropium MDI 21 mcg (4 puffs)] • Jet nebulisation (Salbutamol, 2.5–5 mg; Terbutaline, 5 mg; Ipratropium, 500mcg)
3) Diagnostics	• Modified Medical Research Council (mMRC) Dyspnoea Scale to assess severity in the absence of FeV1 • In case of FEV1 < 40% predicted perform: COPD severity score, blood gas measurements, chest x- rays and electrocardiography • ABG recommended if the VBG pH ≤7.34

4) Corticosteroids	• Oral corticosteroids for 5 days and up to 14 days (prednisolone 40–50 mg daily)
5) Antibiotics	• Antibiotics are recommended for purulent sputum only to cover for typical and atypical organisms.
6) Non-Invasive Ventilation	• NIV for increasing hypercapnia and acidosis (ABG with a PaCO2 above 45mmHg and a pH less than 7.35)
7) ED discharge criteria	• Clinically stable condition with no parenteral therapy • Inhaled bronchodilators are required less than four-hourly • Inhaler technique assessed by ED clinician or a nurse • Oxygen delivery has ceased unless patient is on home oxygen • If previously able, the patient is ambulating safely and independently, and performing activities of daily living (3–6-minute walk test recommended) • The patient can eat and sleep without significant episodes of dyspnoea

• The patient or caregiver understands and is able to administer medications

8) ED discharge template to primary care or OPC

9) Resp Nurse outpatient's clinic (OPC) referral

- Follow-up and home care arrangements (e.g.: home oxygen, homecare, Meals on Wheels, community nurse, allied health, GP, specialist)
- Discharge summary template for convenience (will be linked electronically)
- Provide COPD patient information pack by Lung foundation Australia (will be linked electronically) • All AECOPD ED discharges are highly recommended to have Respiratory CNC referral (Direct electronic referrals from ED will be linked here)