NHS Kirklees and NHS Wakefield District

GP asthma monitoring annual review for adults Wakefield version

History

• Number of exacerbations since last seen in clinic	• Atopy – triggers identified	• Consider need for blood tests e.g. IgE, RAST
• Accident and Emergency attendance since last seen in clinic	• Family history of respiratory disease recorded	• Identify and treat factors worsening control, eg oesophageal reflux, rhinitis
• Emergency asthma admission since last seen in clinic	• Is there any suggestion of occupational asthma?	• Flu vaccination recorded in last 12 months
• Nebulised bronchodilators required since last seen in clinic	• Stop smoking advice given	• Pneumonia vaccination recorded
• Last oral steroid use	• Referral to stop smoking service	• Peak flow meter at home - ensure technique satisfactory
• Work days lost since last seen in clinic	• Smoking status recorded	

Royal College of Physicians - 3 Questions

1. Have you had difficulty sleeping because of your asthma symptoms (including cough)?
2. Have you had your usual asthma symptoms during the day (cough, wheeze, chest tightness)?
3. Has your asthma interfered with your usual activities (work / sex / housework / exercise)?

Spirometry

- Is there a record of reversibility?
- At each visit record FEV1, FVC, % predicted, FEV1/FVC

PEFR*

If spirometry not available use patients own peak flow meter where possible to record

- PEFR, Predicted PEFR, Best PEFR (as actual and % predicted)

Assessment/examination

Height, Weight, Body mass index, Blood pressure, Inhaler technique

Medication review

Discuss and record current medication and step of SIGN/BTS guidance	Consider referral to Stop Smoking service	Drug side-effects (current) and potential risks (e.g. steroid-induced osteoporosis)
Assess asthma control using RCP 3 questions - Step up/down of treatment as needed in response to assessment. Consider a decrease in inhaled steroid dose by 25-50% every 3 months	Assess inhaler technique: Is device appropriate? Is there a need for spacer /spacer replacement (how long in use)?	Consider risks of drug interactions (e.g. ibuprofen, theophylline).
Assess SABA* use / overuse (record reliever-free days and number of puffs used/day)	Assess concordance/ understanding	Assess and record use of OTC */ herbal medications

Asthma care plan

Assess patient's understanding of how to recognise worsening asthma (including symptoms & PEFR) & what action to take	Assess and address patients needs for education
Assess understanding of action to take in an emergency	Consider referral to Expert Patients Programme
Agree interval for asthma follow-up	Self management/action plan updated, care plan completed

* OTC – Over the Counter, * PEFR – Peak Expiratory Flow Rate, * SABA – Short-acting beta2-agonist

Group responsible for development: NHS Kirklees in collaboration with NHS Wakefield District, Mid Yorkshire NHS Hospitals Trust and Calderdale and Huddersfield Hospital Foundation Trust (Kirklees Sector).

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Routine review in primary care

The Sign/BTS Asthma Guidelines 2009 state there is strong evidence that proactive clinical review of people with asthma improves clinical outcomes, with those reviews that include discussion and use of a written self management plan being of greatest benefit.

Proactive reviews are associated with reduced exacerbation and days lost from normal activity, as opposed to unstructured or opportunistic review. Outcomes are similar whether reviews are conducted by a Practice Nurse or GP with the best outcomes achieved by those clinicians with asthma management training.

Identification of patients at high risk is recommended. Telephone review has been shown to be a suitable option for those patients who fail to attend for routine reviews.

Routine management of Asthma

Named healthcare professionals with appropriate qualifications
Ongoing training and educational support.

Primary care asthma Review

Offer at least annual review to all those on the asthma register

Time taken: approximately 20 minutes

Conducted by healthcare professional with appropriate education

Aim: To identify if asthma is CONTROLLED or UNCONTROLLED and take action

Prioritise those at greatest risk of attack

- Identification via computer searches and reviews of medical records at least annually.
- Placement on an 'At risk' register for Asthma
- System devised to 'flag up' risk and prioritise attendance

Prioritisation of care

- Proactive recruitment to attend for asthma assessment
- Telephoning persistent 'DNA' (Did Not Attend)
- Priority / same-day appointments for those with deteriorating symptoms who are 'At Risk'
- Consider telephone assessments
- Liaison with community pharmacists, schools, school nurses & community colleagues e.g. community nurses

Clinical audit and evaluation

SIGN Definition of Factors Contributing to 'AT RISK'

- Previous near-fatal asthma
- Previous admission for asthma in the past year (including Accident & Emergency)
- Requiring three or more classes of medication
- Heavy use of short-acting B2 agonist
- 'Brittle asthma'

*How to identify of those at greatest risk- computer searches

- Previous near-fatal asthma
- Hospital attendance with asthma attack in past 2 months (Including Accident and Emergency attendances)
- Presentation with asthma attack in primary care in past 2 months
- Two or more courses of oral steroids and/or antibiotics in past 6 months
- Heavy use of short-acting B2 agonist (> 3 canisters in 6 months)
- DNA asthma clinic or excepted from QOF
- Repeated days of school with asthma
- 'Brittle asthma'