

# Good building blocks of an asthma review

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### Assess

Assess control, severity and risk of exacerbations using a validated or endorsed tool

### Review

Review diagnosis and management including the following:

- Confirmation that the diagnosis is correct
- Clinical examination/history
- Check inhaler technique
- Managing tobacco addiction
- Drug therapy
- Compliance/adherence
- Lifestyle and social issues
- Co-morbidities
- Identify and mitigate triggers where possible

### Collaborate

Work with the patient to develop, maintain and review a self-management/action plan specific to the patient's needs to encompass:

- Information on regular treatment/maintenance therapy as well as any relevant notes on technique and any repeat prescription advice
- What to do if symptoms become worse
- What to do in an emergency/defining an emergency (including information on rescue pack if appropriate) who to contact, when and how
- Information on staying well/avoiding triggers
- Other advice and information on who to contact with questions

### Telephone and Video Consultations

In the wake of the COVID-19 pandemic many asthma reviews will be being carried out remotely by either telephone or video. Many patients and staff have found this not only acceptable and safe, but in many cases a preferable method. PCRS has a video discussing some top tips for virtual respiratory reviews – <https://bit.ly/2YwM74D>. It is important to remember that not everything can be dealt with remotely and if needs be patients should be seen face to face.

## KEY COMPONENTS OF AN ASTHMA REVIEW

### Assessing control to target care

National guidelines and the Quality and Outcomes Framework (QoF) recommend the use of validated assessment tests such as the Asthma Control Test (ACT) and Asthma Control Questionnaire (ACQ).<sup>1</sup> The Royal College of Physicians '3 Questions'<sup>2</sup> can also be used.<sup>3</sup>

Asthma control is measured by the frequency of symptoms and blue reliever inhaler use. The aim of treatment should be for no nocturnal waking or activity limitation, minimal symptoms, no side-effects and minimal blue reliever inhaler use. More than two episodes of symptoms in the past month and more than three blue reliever inhaler doses in the past week are indicators of sub-optimal control.

Review the prescribing record of relief medication and oral steroid courses and note any unscheduled visits to GP, OOH or hospital for treatment of respiratory conditions that may indicate poor control. Ask the patient about the use of SABA (or additional doses of ICS/LABA if being used as part of 'Maintenance and Reliever Therapy'). Review peak flow measurements (if available) and record the patient's best peak flow when fit and well.

It is good practice to record in the patient's notes what the

ICS/LABA ratio is. If it's less than four ICS or ICS/LABA and six or more SABA in a year, then an urgent follow-up is required to monitor management and symptoms, and to see if medicine behaviour change constitutes a safer direction.

### Reviewing diagnosis and management

#### ✓ Have you checked the patient's asthma diagnosis is correct?

Check the patient's notes to see if there is evidence of objective tests demonstrating variability in airflow obstruction:

- Peak Flow diary demonstrating >20% variability would be considered abnormal
- Spirometry trace, with reversibility, demonstrating an increase of FEV1 of 200mls and 12% or greater than 400mls

If there is uncertainty, do you have access to a FeNO machine in order to demonstrate eosinophilic inflammation which may provide support for an asthma diagnosis? During the COVID-19 pandemic period spirometry has been put on hold and in many areas remains so. If there is diagnostic uncertainty, PCRS has produced a guide to support diagnostic work-up during COVID-19 - <https://bit.ly/3HcyljC>

## ✓ Have you checked the patient's medical history?

If a patient has all of the following typical clinical features, they are considered to have a high probability of asthma.<sup>4</sup> Is there a record of any or all of the following in the notes?

- Recurrent episodes of symptoms
- Wheeze confirmed by a healthcare professional
- A personal or family history of atopy
- A past record of variable airflow obstruction (see above)
- No features to suggest an alternative diagnosis

## ✓ Have you checked the patient's understanding of the pathophysiology of asthma and which inhaler does what with regards to bronchoconstriction and inflammation?

Draw a picture of the airways or use an airways model to demonstrate this. You can order airway models from neelam.zafar@Cipla.com. Use terminology such as, "asthma is like eczema on the inside, and the steroid reduces the inflammation in your airways, just like when you rub steroid cream onto eczema". Talk to the patient about where their blue reliever inhaler acts i.e. on the muscles surrounding the airway but does nothing to treat the inflammation. If you have access to a FeNO device a raised result will further demonstrate the presence of inflammation.

## ✓ Have you reviewed inhaler technique or currently prescribed inhaler types?

Poor technique may be responsible for inadequate control. Observing technique is not enough, poor technique must be corrected and appropriate coaching delivered. It is also important to ensure that there is consistency in the types of devices selected (avoiding mixing different devices such as pMDIs and DPIs).<sup>1</sup>

## ✓ Have you discussed and reviewed adherence to therapy?

Poor adherence to treatment may explain failure to control symptoms. Ensuring the patient understands how reliever and preventer treatment works and listening and responding to patients concerns and goals may improve adherence to treatment.<sup>1</sup>

## ✓ Have you reviewed smoking status and offered smoking cessation advice where appropriate to do so or referred to smoking cessation services?

Smoking reduces the effect of inhaled steroids and treatment may need to be adjusted for smokers.<sup>1</sup> It is also important to assess if children with asthma are subjected to passive smoking and appropriate advice and support delivered to parents and carers.

## ✓ Have you reviewed lifestyle and triggers including those associated with occupation (e.g. exposure to fumes, particles), and household (e.g. pets, dust)?

These should be reviewed and recorded, and goals set on minimising/ managing exposure.

## ✓ Have you reviewed the patient for other concomitant conditions such as rhinitis and treated rhinitis accordingly?

## ✓ Have you reviewed treatment in line with evidence-based local and national recommendations, stepping up and stepping down treatment as required?<sup>5</sup>

## ✓ Have you reviewed the personalised asthma action plan?

This is an opportunity to engage with the patient and discuss what is important to them in the management of their condition, and for education into what asthma is and how medication works. A good rapport is essential for supported self-management of long-term conditions.

## ✓ How can you tailor the asthma action plan to meet the patient's needs, and what realistic goals are you going to agree?

For example, reduce/stop smoking, lose weight, increase exercise, reduce unnecessary repeat prescriptions requests (e.g. unrequired SABA).

Finding that a patient may be over-reliant on their SABA should prompt you to work with them to achieve good asthma control. This is an opportunity to highlight the issues associated with SABA over-reliance and ensure patients are provided with support and help to identify a treatment and management course of action which is acceptable to the patient and their lifestyle and which provides appropriate treatment options that reduce the need for such over-reliance on SABA.

It is important to ensure that patients are kept apprised of the latest information on asthma management. For example, using SABA prior to exercise as routine practice, which may be based on old advice. Exercise related symptoms are in fact an indicator of poorly controlled asthma; or using SABA to 'open the airways' prior to using ICS.

It is also an opportunity to highlight the rebound effects of daily SABA use, such as building a tolerance to it. It's important to close this conversation with positive, supportive and clear advice to help your patient to live with well-controlled asthma. For example, a SABA canister should last a patient six months, indicating that no more than two doses a week are required, and that living without symptoms is an indicator of good asthma control. The healthcare professional should work with the patient in a collaborative, patient-centred approach to achieve good asthma control through appropriate drug and non-drug treatment.

The collage includes a 'Every day asthma care' form with sections for 'My asthma is being managed well', 'My daily asthma routine', and 'When I feel worse'. It also features a 'Your asthma action plan' card with a photo of a man using an inhaler, contact information for asthma.org.uk, and the text 'Fill this in with your GP or nurse'.



Utilising Asthma Right Care (ARC) resources will aid the SABA over-reliance conversation.

### The asthma slide rule

(<https://www.pcrs-uk.org/asthma-right-care>) is a tool that visualises the health risks associated with SABA overreliance using a red, amber and green scale to demonstrate what good asthma control looks like in terms of puffs.

A new series of **illustrations on asthma diagnosis and management** are available to use to support patient and healthcare professional training and coaching. These are available from the PCRS website – see XXXXXXXX

The Question and Challenge Cards pose questions and provide metaphors that aim to challenge both patient and clinician understanding and behaviours around what good asthma control looks like, with the aim of shifting behaviours towards regular anti-inflammatory treatment.

All ARC resources are freely available from: <https://www.pcrs-uk.org/asthma-right-care>.

### TOP TIP

If you have 20 minutes with a patient, don't try to cover everything and rush the session.

For example, if you're trying to cover inhaler technique, co-create an asthma plan, listen to the patient's ideas, concerns and expectations, and address SABA over-reliance – it won't be possible to cover all of these.

Working with the patient, prioritise what to deal with first and arrange a follow-up to cover the other items as soon as realistically possible. Longer appointments would be ideal in these scenarios.

Also consider delegating some of the roles if time is stretched e.g. inhaler technique coaching carried out by a community pharmacist or a colleague in your practice who is trained up to run this service.

### ✓ How can you support your patient to improve their care?

For example, watch an inhaler technique video together and reassess technique (see links in the box below).

Update the patient's asthma action plan taking into account what you have discussed and agreed together. Asthma UK provides an action plan, available at: <https://www.asthma.org.uk/advice/manage-your-asthma/action-plan/>. Action plans are also available to download direct through EMIS WEB, see <https://www.asthma.org.uk/for-professionals/professionals/emis-action-plans/> for guidance. Patients may wish to download Asthma UK's booklet 'Make the most of your asthma review' available at: <https://www.asthma.org.uk/5070072f/globalassets/health-advice/resources/adults/your-asthma-review-booklet.pdf>.

## Tobacco Dependency and Smoking Cessation Support

Smoking increases use of healthcare services and reduces the effectiveness of inhaled medicines in asthma. Intensive and evidence-based stop smoking support should be part of essential treatment and progress reviewed regularly.

Only 5% of smokers who want to quit smoking actually access a stop smoking service each year, yet we know that support increases the likelihood of quitting. Become a quit catalyst with support from the PCRS, available at: <https://www.pcrs-uk.org/resource/become-quit-catalyst>.

It is a key role of primary care to "Make Every Contact Count" (MECC), through clinicians offering very brief advice (VBA), the practice displaying posters and videos in reception, and well-trained reception staff facilitating access to opportunities for supportive engagement.

### Further information

Making every contact count <https://www.makingeverycontactcount.co.uk/>

Very Brief Advice [https://elearning.ncsct.co.uk/vba-stage\\_1](https://elearning.ncsct.co.uk/vba-stage_1)

Smoking cessation training <https://www.ncsct.co.uk/>

## INHALER TECHNIQUE

Patients should be taught how to use their inhaler when they are first prescribed inhaled medication and their technique should be reviewed at subsequent consultations with coaching to improve technique if necessary. The healthcare professional must be appropriately trained themselves on the techniques and able to train users. Generic prescribing of inhalers, or mixing inhaler device types should be avoided as this might lead to people with asthma being given an unfamiliar inhaler device which they are not able to use properly.<sup>1</sup> Placebo inhalers can be useful to demonstrate correct technique and it may be helpful to support education with training videos.



Asthma UK inhaler training videos and information at <https://www.asthma.org.uk/advice/inhalers-medicines-treatments/using-inhalers/>  
 Right Breathe [www.rightbreathe.com](http://www.rightbreathe.com)  
 PCRS Video on inhaler technique <https://vimeo.com/462186592/f7275a2613>

### Further Useful Information

- PCRS Asthma Guidelines in Practice <https://www.pcrs-uk.org/resource/asthma-guidelines-practice>
- Asthma Right Care <https://www.pcrs-uk.org/arc>
- PCRS Consensus guide for the use of FeNO testing to support asthma diagnosis <https://www.pcrs-uk.org/resource/feno-testing-asthma-diagnosis>
- Primary Care Respiratory Academy Asthma Videos, Podcasts and CPD modules <https://respiratoryacademy.co.uk/clinical/resources/>
- Poorly controlled and severe asthma: triggers for referral for adult or paediatric specialist care – a PCRS pragmatic guide <https://www.pcrs-uk.org/resource/triggers-referral-poorly-controlled-and-severe-asthma>
- PCRS – Inhaler devices - <https://www.pcrs-uk.org/resource/inhaler-devices>

### Acronyms

- GP – General Practitioner
- FEV1 – Forced expiratory volume in 1 second
- ICS – Inhaled corticosteroid
- LABA – Long-acting beta-agonist
- MART – Maintenance and reliever therapy
- OOH – Out of hours
- SABA – short-acting beta-agonist

### References

1. Scottish Intercollegiate Guidelines Network and British Thoracic Society. British guideline on the management of asthma: A national clinical guideline. July 2019. Available at: <https://www.brit-thoracic.org.uk/quality-improvement/guidelines/asthma/>
2. Pearson M G, Bucknall C E, editors. Measuring clinical outcomes in asthma: a patient-focused approach. London. Royal College of Physicians; 1999
3. British Medical Association and NHS England. 2020/21 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2020/2021 in England. April 2020. Available at: <https://www.england.nhs.uk/wp-content/uploads/2020/09/C0713-202021-General-Medical-Services-GMS-contract-Quality-and-Outcomes-Framework-QOF-Guidance.pdf>
4. Primary Care Respiratory Society. Asthma Guidelines in Practice – A PCRS-UK Consensus. Available at: <https://www.pcrs-uk.org/resource/asthma-guidelines-practice>
5. Global Initiative for Asthma. Asthma management and prevention for adults and children older than 5 years: A pocket guide for health professionals. 2021. Available at: <https://ginasthma.org/wp-content/uploads/2021/05/GINA-Pocket-Guide-2021-V2-WMS.pdf>

**NOTICE** This article has been created as a summary of a range of material from PCRS tools and encompasses the basics of a good respiratory review. It is not a tick box template – all consultations with patients should be approached holistically and tailored specifically to the patient's needs, requirements and other co-morbidities and situations.



This resource has been produced as part of the PCRS Asthma Right Care (ARC) initiative, which is part of a wider global social movement initiated by the IPCRG.