

The building blocks of a good asthma review in adults



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

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

Key components of an asthma review

Assessing control to target care

National guidelines recommend the use of validated assessment tests such as the Asthma Control Test (ACT) and Asthma Control Questionnaire (ACQ).¹

The Royal College of Physicians '3 Questions'² can also be used, which is included in the Quality and Outcomes Framework (QOF) in England.³

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, 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?

✓ **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.⁴ Is there a record of any or all of the following in the notes?

- Recurrent episodes of symptoms ('attacks')
- 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.

✓ **Have you reviewed inhaler technique for currently prescribed inhaler types?**

Poor technique may be responsible for inadequate control. Observing technique is not enough, poor technique must be corrected.¹

✓ **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.¹

✓ **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.¹

✓ **Have you reviewed lifestyle and triggers including those associated with occupation (e.g. exposure to fumes, particles), 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?⁵**

✓ **Have you reviewed the 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 filling of repeat prescriptions (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 express the problem with SABA overreliance and to correct misinformation. For example, using SABA prior to exercise as routine practice, which is 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 and clear advice to support 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.





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

The asthma slide rule 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.

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.

Prioritise what to deal with first and arrange an urgent follow-up to cover the other urgent items as soon as realistically possible. Longer appointments would be ideal in these scenarios, or consider a telephone follow-up (except for inhaler technique coaching).

Also consider delegating some of the roles if time is stretched e.g. inhaler technique coaching carried out by a community pharmacist you know 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 orange box).

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.shorturl.at/hzAB3>

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>.

Telephone consultations

Telephone consultations may be useful in those patients who are reluctant to attend the practice or non-attenders and indeed are recommended in the current BTS/SIGN national guidance for some situations.¹

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

<https://www.pcrs-uk.org/resource/tobacco-dependency-pragmatic-guide>
Making every contact count <https://www.makingeverycontactcount.co.uk/>
Very Brief Advice 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. The healthcare professional must be appropriately trained themselves on the techniques and able to train users. Generic prescribing of inhalers 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.¹ 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

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

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3. British Medical Association and NHS England. 2019/20 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF): Guidance for GMS contract 2019/20 in England. April 2019. Available at: <https://www.england.nhs.uk/wp-content/uploads/2019/05/gms-contract-qof-guidance-april-2019.pdf>
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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; see <https://www.pcrs-uk.org/arc> for further information. The PCRS is grateful to AstraZeneca for supporting the ARC initiative in the UK through an educational grant and secondment of a programme manager. AstraZeneca played no part in the creation of the resource.

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