THE BUILDING BLOCKS OF A GOOD ASTHMA OR COPD REVIEW IN ADULTS

Assess

Assess control, severity and risk of exacerbations using validated 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)
- 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

The British Asthma Guideline recommends the use of standard validated assessment tests like the Royal College of Physicians Three Questions.[1] The aim of treatment should be for no nocturnal waking or activity limitation and minimal symptoms More than two episodes of symptoms is an indicator of sub-optimal control.

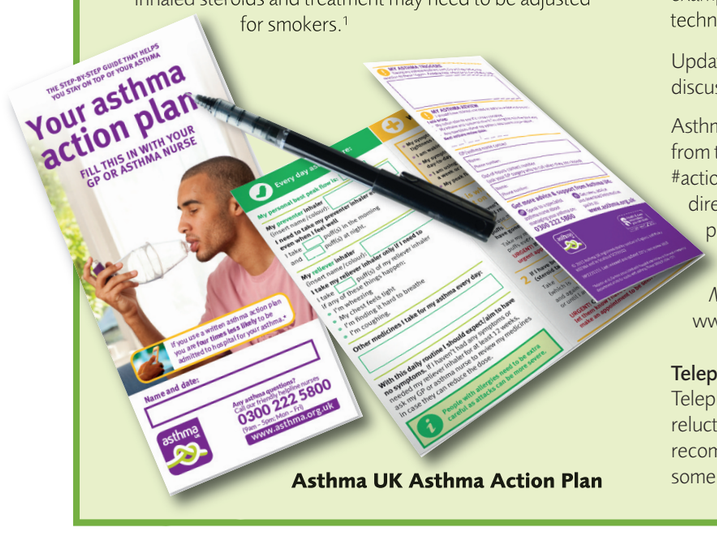
The Royal College of Physicians three questions (RCP3Qs)[2]

Score	In the last month	Read Code
1	Have you had difficulty sleeping because of asthma symptoms (including cough)?	#663P
2	Have you had usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?	#663q
3	Has your asthma interfered with your usual activities (e.g. housework, college, work)?	#663N

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 person's best peak flow when fit and well.

Management

- ☐ 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]



Asthma UK Asthma Action Plan

- ☐ 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?
- ☐ 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? 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). How can you support patient to improve care? For example, watch inhaler technique video together and reassess technique (see links in orange box below).

Update asthma action plan taking into account what you have discussed and agreed together.

Asthma UK provides an action plan you can download direct from the internet at www.asthma.org.uk/advice/resources/ #action-plans. Action plans are also available to download direct through EMIS WEB, see www.asthma.org.uk/ professionals/emis-action-plans/

Patients may wish to download the document *Make the most of your asthma review* available at: www.asthma.org.uk/advice/resources/#adults

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]

KEY COMPONENTS OF A COPD REVIEW

Assessment of severity

The use of validated breathlessness questionnaires together with lung function recordings and patient reported outcome measures will provide a good picture of the severity of disease.

MRC Dyspnoea Score[3]

Grade	Read Code	Ask the patient to read the five statements below and (or read out and explain to the patient and ask them to) indicate which the following applies to them
1	#173H	Not troubled by breathlessness except on strenuous exercise
2	#173I	Short of breath when hurrying or walking up a slight hill
3	#173J	Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace
4	#173K	Stops for breath after walking 100m or after a few minutes on level ground
5	#173L	Too breathless to leave the house, or breathless when dressing or undressing

Other indicators of severity and control

Lung function does not correlate well with dyspnoea, functional status or quality of life and may therefore under- or over-estimate the impact of the disease.[4] Serial FEV_1 readings will, however, detect patients with rapidly progressing disease who may need specialist referral. If you are undertaking spirometry at clinical review, it must be undertaken by a professional appropriately trained to do so.[5,6]

Other indicators of control included patient reported outcome measures e.g. COPD Assessment Test (http://www.catestonline.org) and the clinical record will indicate the frequency of exacerbations requiring unscheduled visits and/or antibiotics/steroid courses.

Further assessment in more severe disease

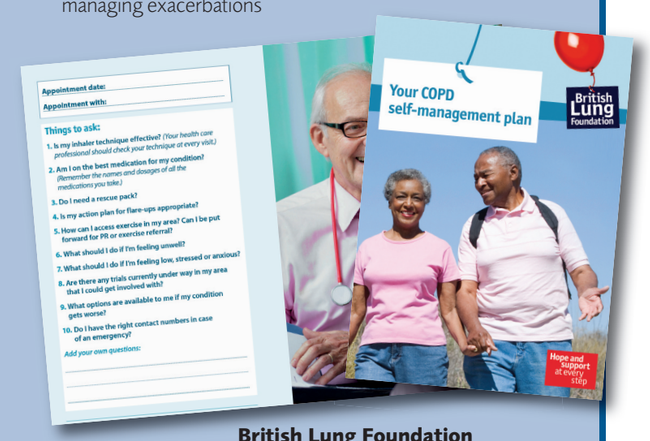
Pulse oximetry should be available to ensure patients eligible for LTOT are identified and referred for assessment. The Read code for oxygen saturation is #8A44.

Record Body Mass Index: Severe breathlessness may make eating difficult, and severe COPD is associated with cachexia in some people. Low BMI is associated with a poor prognosis.[7] Patients with a BMI <20 may need to be referred for specialist dietary advice.

Detecting depression and social impact of disease: Depression and anxiety are relatively common in patients with COPD particularly with those who have more severe disease as symptoms affect activities of daily living. Discuss with the patient (and carer) how they are coping and what support services/ advice they require which may be available

Management

- ☐ Has diagnosis been confirmed by lung function test performed by a qualified person?[6]
- ☐ Review treatment in line with evidence-based local and national recommendations stepping up treatment as required
- ☐ Are you supporting self-management and self-care with patient – have you discussed and agreed options together and given the patient the chance to ask about treatment? This is an opportunity to engage fully with the patient and discuss what is important to them in the management of their condition. A good rapport is essential for supported self-management of long term conditions. How can you tailor the COPD management plan to meet the patient's needs? What realistic goals are you going to agree, for example reduce/ stop smoking, attend pulmonary rehabilitation class? Have you provided, discussed and agreed a written action plan, including rescue medication and is the patient confident to know when and how to use any rescue medication? The British Lung Foundation provides a range of self-management tools to support self-management including a plan for managing exacerbations



British Lung Foundation Self-Management Tool

- ☐ Have you provided smoking cessation advice where appropriate?
- ☐ Have you discussed the importance of keeping active and offered the opportunity to attend pulmonary rehabilitation if appropriate? Pulmonary rehabilitation relieves dyspnoea, improves emotional function and enhances patient sense of self-control over their condition.[8] Exercise should be encouraged in all patients and those with MRC >3 should be referred for pulmonary rehabilitation[5]
- ☐ Have you reviewed drug treatment and inhaler technique? Poor inhaler technique renders inhaled treatment ineffective[5]
- ☐ Have you assessed and reviewed the patient for other co-morbidities (e.g. heart failure, diabetes, osteoporosis), which may be contributing to symptoms, and offered preventative medication such as flu and pneumococcal vaccination
- ☐ Discuss the BLF COPD Patient Passport and offer the patient the chance to complete the Passport for themselves and discuss with you http://passport.blf.org.uk/

Tobacco Dependency and Smoking Cessation Support

Smoking increases use of healthcare services and reduces the effectiveness of inhaled medicines in asthma and COPD. 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.

It is a key role of primary care to "Make Every Contact Count" (MECC), through clinicians offering 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 http://www.makingeverycontactcount.co.uk/index.html
Very Brief Advice - http://www.nice.org.uk/Guidance/PH1
Smoking cessation training - http://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. 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/
Greater Manchester Inhaler Technique Improvement Project http://wessexahsn.org.uk/videos/show?tag=Inhaler%20Technique

References

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2. Pearson MG, Bucknall CE, editors. Measuring clinical outcomes in asthma: a patient-focused approach. London. Royal College of Physicians; 1999.
3. Fletcher CM, Elmes PC, Fairbairn MB, *et al*. The significance of respiratory symptoms and the diagnosis of chronic bronchitis in a working population. *Br Med J* 1959;**2**:257-266.
4. Bestall JC, Paul EA, Garrod RA *et al*. Usefulness of the MRC dyspnoea scale as a measure of disability in patients with COPD. *Thorax* 1999;**54**:581-6
5. National Institute for Health and Clinical Excellence, National Clinical Guideline for the management of COPD in adults in primary care secondary care. Updated 2010. *Thorax* 2004; **59**(Suppl 1): S1-232 Available at www.NICE.org.uk
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7. Levy M, Quanjer PH, Booker R *et al*. Diagnostic Spirometry in Primary Care: Proposed standards for general practice compliant with American Thoracic Society and European Respiratory Society recommendations. *Prim Care Respir J* 2009; **18**: 130–147 doi:10.4104/pcrj.2009.00054 http://www.nature.com/articles/pcrj200954
8. Lacasse Y, Goldstein R, Lasserson TJ, Martin S. Pulmonary rehabilitation for COPD. *Cochrane Database of Systematic Reviews* 2006, Issue 4 Article number CD003793

Further Useful Information

- PCRS-UK Quick Guide to the Diagnosis and Management of Asthma https://www.pcrs-uk.org/resource/Guidelines-and-guidance/AQG
- PCRS-UK Quick Guide to the Diagnosis and Management of COPD https://www.pcrs-uk.org/resource/Guidelines-and-guidance/QGCOPD
- PCRS-UK Table of Inhaled Drugs https://www.pcrs-uk.org/resource/Guidelines-and-guidance/table-inhaled-drugs
- Pinnock H, Fletcher M, Holmes S, Keeley D, Leyshon J, Price D, Russell R, Versnel J, Wagstaff B. Setting the standard for routine asthma consultations: a discussion of the aims, process and outcomes of reviewing people with asthma in primary care. *Prim Care Respir J* 2010; **19**: 75-83

Acronyms

- COPD – Chronic Obstructive Pulmonary Disease
- GP – General Practitioners
- FEV1 – Forced expiratory volume in 1 second
- ICS – Inhaled corticosteroid
- LABA – Long-acting beta-agonist
- LTOT – Long term oxygen therapy
- MART - Maintenance and reliever therapy
- OOH – Out of hours
- PR - Pulmonary rehabilitation
- SABA - short-acting beta-agonists

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