You Have 10 Minutes for an Asthma Review
Your Time Starts NOW

Introduction

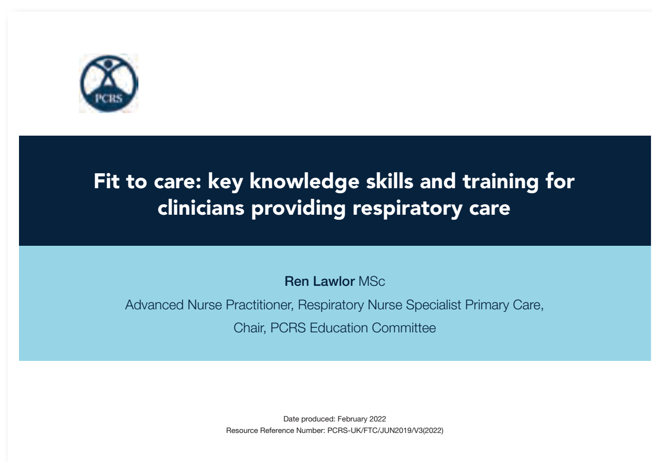
In an ideal world, asthma review appointments will be between 20 to 30 minutes in duration. But we are not living in an ideal world. Staff shortages due to ill health, burnout, and workforce issues are compounding an already pressured system, and in many practices, the maths doesn't stack up; there are simply not enough hours in the year to see everybody in the recommended time.

If practices are struggling to recruit staff to do the reviews, the time allocation for asthma reviews may be reduced to 10 minutes. Whatever the situation in your practice, there are some key steps you can take to ensure that if you do only have 10 minutes to see your patient with asthma, whether at an annual review, for a new diagnosis, a flare-up, or for a post-attack review, the basics are covered.

Getting Asthma Review Ready

In order to ensure you maximise your time during an asthma review, preparation beforehand is essential and will ultimately save you time in the long run.

WHO is 'Fit to Care'? Asthma Reviews are carried out by those trained to do so. The PCRS Fit to Care document sets out the skills, knowledge, and training required for healthcare professionals at standard, advanced, and expert levels, irrespective of profession.



PCRS

Fit to care: key knowledge skills and training for clinicians providing respiratory care

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WHERE and **WHEN** are you going to be seeing the patient?

Practice and Practitioner

Regardless of whether or not you are going to be seeing the patient face-to-face, speaking on the telephone, or via video consultation, some things need to be in place to support success.

- **Administration Team**: Review the invite process; who needs prioritising?
- **Equipment**: Make sure you have everything you need at your workstation:
  - **Placebo** devices
  - **Internet** access to show/send inhaler technique videos if no placebos.

- **Guidelines**: Local guidelines are to hand.
- 3D **Airways models** or a **diagram** of the airways - scan the QR code to view IPCRG How we Breathe Video - https://www.youtube.com/watch?v=zrA3f5LzFeY

- **Personal Asthma Action Plans (PAAP)** either paper or digital (Asthma and Lung UK provide lots of information on asthma action plans - scan the QR code to view A+LUK page https://www.asthmaandlung.org.uk/research-health-professionals/health-professionals)

Patient

- **PAAP**: Patient has a copy of their PAAP or a new one with them.
- **Asthma Control Test (ACT)**: Ideally filled out before their appointment - scan the QR code to view Asthma Control Test - https://www.asthmacontroltest.com/en-gb/welcome/)

- **Inhalers**: The patient has their inhalers with them.

Your Time Starts NOW

WHY am I seeing this patient and do they know WHY they are taking inhalers?

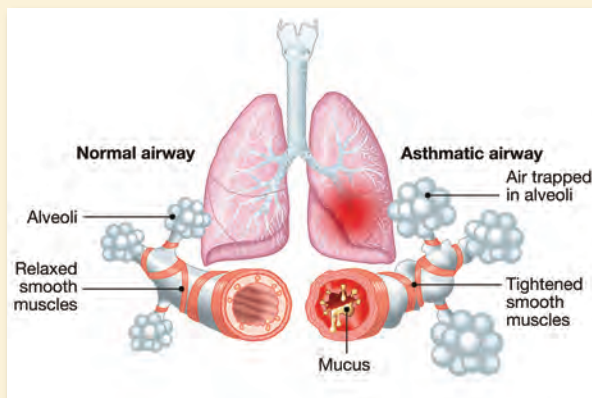
Is there evidence of **objective variability** at the time of their **diagnosis**?

This should be obvious and easy to find, but very often it isn't. If there is any doubt, this is not something that can be tackled in a 10-minute review appointment. This will require a separate appointment with a clinician confident in diagnosing asthma. This is NOT a wasted appointment but is vital to ensuring the patient gets the correct diagnosis. If you are that confident clinician, it may be worth abandoning the review at this point and focusing on unpicking the asthma diagnosis here and now.

WHY am I taking these inhalers?

Below is a script that can be adapted and will hopefully support your patient to understand what is going on in their airways if they need a refresher or are unsure.

As you can see, this is a model of a wide-open airway, and air can flow easily through it. The surrounding muscles are nice and relaxed. You can see from this model that there is a lot of inflammation on the inside of the airway and how narrow the opening has become. If left untreated, over time, the inflammation gets worse, and you can see from this model that there is now also mucus plugging up the airway. When the airways are narrow like this, it can be difficult to breathe, and you may cough or wheeze.



This is why you need a preventer inhaler. An inhaler that you take regularly every day; they work slowly over time, are long-lasting, and reduce inflammation while opening up the airways.

In this model, we can see the muscle bands are tightening around the airways. Your rescue inhaler, which tends to be blue, relaxes these muscles on the outside of the airways. It is a quick rescue that makes you feel better, but the relief is temporary and only lasts a few hours. The muscles are relaxed by the rescue inhaler, BUT it ONLY works on these muscles and does nothing for the inflammation on the inside.'

WHAT does supported self-management look like to the patient?

Start with an overview of the PAAP and ensure they understand every point, pausing for feedback or questions.

1 Every day asthma care:

My asthma is being managed well:

- With this daily routine I should expect/aim to have no symptoms.
- If I have not had any symptoms or needed my reliever inhaler for at least 12 weeks, I can ask my GP or asthma nurse to review my medicines in case they can reduce the dose.
- My personal best peak flow is:

My daily asthma routine:

My preventer inhaler (insert name/colour):

....

I need to take my preventer inhaler every day even when I feel well.

I take .... puff(s) in the morning

and .... puff(s) at night.

My reliever inhaler (insert name/colour):

....

I take my reliever inhaler only if I need to

I take .... puff(s) of my reliever inhaler if any of these things happen:

- I'm wheezing
- My chest feels tight
- I'm finding it hard to breathe
- I'm coughing

Other medicines and devices (e.g spacer, peak flow meter) I use for my asthma every day:

2 When I feel worse:

My asthma is getting worse if I'm experiencing any of these:

- My symptoms are coming back (wheeze, tightness in my chest, feeling breathless, cough).
- I am waking up at night.
- My symptoms are interfering with my usual day-to-day activities (eg at work, exercising).
- I am using my reliever inhaler three times a week or more.
- My peak flow drops to below: ....

URGENT! If you need your reliever inhaler more than every four hours, you need to take emergency action now. See section 3.

What I can do to get on top of my asthma now:

If I haven't been using my preventer inhaler, I'll start using it regularly again or if I have been using it:

- Increase my preventer inhaler dose to .... puffs .... times a day until my symptoms have gone and my peak flow is back to my personal best.
- Take my reliever inhaler as needed (up to .... puffs every four hours).
- Carry my reliever inhaler with me when I'm out.

URGENT! See a doctor or nurse within 24 hours if you get worse at any time or you haven't improved after seven days.

Other advice from my GP about what to do if my asthma is worse (eg MART or rescue steroid tablets):

3 In an asthma attack:

I'm having an asthma attack if I'm experiencing any of these:

- My reliever inhaler is not helping or I need it more than every four hours.
- I find it difficult to walk or talk.
- I find it difficult to breathe.
- I'm wheezing a lot, or I have a very tight chest, or I'm coughing a lot.
- My peak flow is below: ....

What to do in an asthma attack

1. Sit up straight - try to keep calm.
2. Take one puff of your reliever inhaler (usually blue) every 30-60 seconds up to 10 puffs.
3. If you feel worse at any point OR you don't feel better after 10 puffs **call 999 for an ambulance**.
4. If the ambulance has not arrived after 10 minutes and your symptoms are not improving, repeat step 2.
5. If your symptoms are no better after repeating step 2, and the ambulance has still not arrived, **contact 999 again immediately**.

Important: this asthma attack advice does not apply to you if you use a MART inhaler.

After an asthma attack

- If you dealt with your asthma attack at home, see your GP today.
- If you were treated in hospital, see your GP within 48 hours of being discharged.
- Finish any medicines they prescribe you, even if you start to feel better.
- If you don't improve after treatment, see your GP urgently.

What to do in an asthma attack if I'm on MART:

Green Zone:

This is the zone of good asthma control. Get to 'Know Your Normal' so you can start to recognise when your asthma is getting worse.
If your asthma is well controlled by taking your preventer inhaler regularly, you shouldn't have to use your blue inhaler.

Amber Zone:

WHAT might cause worsening symptoms?

WHAT are the triggers and how can you avoid them?

WHAT support are you getting to stop smoking and are they interested in help?

WHAT has been happening over the last 12 months? Have they been in hospital or been given a course of prednisolone?

How about you start to think that your blue rescue inhaler is like the blue light on an ambulance? A warning sign. i.e., if you are using your blue inhaler more than twice a week, you are more likely to end up needing an ambulance because your asthma is not well controlled and inflammation is building up. Equally, remember that it is important to always carry it around with you everywhere, as it will help you in an emergency while you wait to see your GP or for an ambulance to arrive.

If you are getting symptoms and having to use your rescue inhaler more than when you are in the Green Zone, THIS is when you need to speak to your GP or nurse, who can then establish whether or not you need prednisolone to prevent an asthma attack or hospital admission.

Red Zone:

In an emergency, when you are struggling to breathe, to talk, or your rescue inhaler is not working, you can use your inhaler up to 10 puffs every 30 seconds.

Talk them through the images of what to do in an emergency.

HOW **does my patient take their inhalers and HOW do I know if they are taking them regularly?**

At this point go back to the **Green zone** of the PAAP.

- **Inhalers**: What have they got with them and is there device consistency?
- **Adherence**: Discuss the prescription history and what 'ideal adherence' is.
- **Technique**: Check their inhaler technique. If not available, ask them to suck in 'Quick and Deeply'. If they can do this, they are suitable for a Dry Powder Inhaler (DPI), which is a lower-carbon option, and you may want to consider a swap if they have poor control and/or technique. Rather than criticising a poor technique, consider the following:

'That technique was not right for that device, BUT it was the perfect technique for a different device that you may be better suited to. Would you be interested in trying something different?'

Now demonstrate the inhaler technique either yourself or by showing a video. This is especially important if you are swapping to a different device.

Send the patient a link if they have internet access to a video – [scan the QR code to view the inhaler technique videos] see https://www.asthmaandlung.org.uk/living-with/inhaler-videos.

Your Time is UP

10 minutes may feel like a ridiculously short amount of time, and some of you reading this may be horrified that this is even being suggested. Unfortunately, though, this is the reality many of us are living with in general practice. We don't always have the luxury of time, and it is key that we maximise our time with our asthma patients and ensure the absolute key basics are covered and understood.

Patients should leave knowing:

- **WHY** they are taking their inhalers
- **HOW** to take them and
- **WHAT** to do if they have worsening asthma symptoms or an asthma attack.

Living with asthma is rarely a smooth journey. I believe, though, that it can and should be a lot smoother for our patients. It is our duty of care to ensure it is as smooth a journey as possible, starting them out on the right foot as they walk out of our door after diagnosis and down the right path going forward. We must minimise the speed bumps and the potholes, steer them away from the cliff edge, keep them on the right path, and guide or carry them when they need us most. We must support patients to accept their asthma, ensuring that they are not burdened by it, and spend our precious time at an asthma review wisely.

SIGNPOSTING TO VIDEOS AND INFORMATION YOU CAN SHARE WITH YOUR PATIENTS:-

https://www.nhs.uk/conditions/asthma/ - Includes a helpful video on how asthma affects the lungs

Asthma Action Plans for your patients -
https://www.asthmaandlung.org.uk/conditions/asthma/your-asthma-action-plan

Asthma and Lung UK Inhaler technique videos
https://www.asthmaandlung.org.uk/living-with/inhaler-videos

How **NOT** to do an asthma review – *a patient's experience of their asthma review*

For the last couple of years my annual asthma review has arrived in the form of a text message with a link to a webform to fill in – fine for those of us with the technology to do so. The text message states that the nurses will "only contact you if they need to arrange a further review over the phone or in person".

The online form asks a series of questions about the past four weeks, followed by a similar themed series of questions about the past twelve months. If the answers do not suit your required state, you can select the "other" option; however, you are limited to only 500 characters of written description, which is not ideal when trying to explain how you have been feeling or what it is that you require.

Towards the end, it does ask if you have an asthma action plan; however, it is simply a "yes" or "no" question, with no option to share any information on when you last had one, if you want one, or what you might find useful by having one.

Given that I have had serious life and health changes over the past two years with a new, non-respiratory-related serious chronic illness being diagnosed, I am surprised that I have not been called in to review my health and asthma situation and have a new asthma action plan created with me.

Filling out this asthma review form has not given me any confidence. I know that there is no longer an asthma nurse at my surgery and could only wish for an asthma review with the care, attention, and passion shown by the wonderful respiratory specialists at PCRS.

PCRS would like to thank AJ for sharing his experience.