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 treatment/maintenance therapy as well as any relevant notes on technique and any 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 Thoracic Society’s Guidelines recommend the use of validated standard assessment tests like the Royal College of Physicians Three Questions. 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 (RCPCQ’s)

<table>
<thead>
<tr>
<th>Score</th>
<th>In the last month</th>
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<tbody>
<tr>
<td>1</td>
<td>Have you had difficulty sleeping because of asthma symptoms (including cough)?</td>
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<td>2</td>
<td>Have you had usual asthma symptoms during the day (cough, wheeze, chest tightness or breathlessness)?</td>
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<td>3</td>
<td>Has your asthma interfered with your usual activities e.g. (housework, college, work)?</td>
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MRC Dyspnoea Score

<table>
<thead>
<tr>
<th>Grade</th>
<th>Read Code</th>
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<tbody>
<tr>
<td>1</td>
<td>#173H</td>
</tr>
<tr>
<td>2</td>
<td>#173F</td>
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<tr>
<td>3</td>
<td>#173J</td>
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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

Not troubled by breathlessness except on strenuous exercise
Short of breath when hurrying or walking at a slight incline
Wells slower than contemporaries on level ground because of breathlessness
Has to stop for breath when walking at a normal pace
Stops for breath after walking 100m or after a few minutes on level ground

Other indicators of severity and control
Lung function does not correlate well with dyspnoea, functional role or quality of life and therefore should not be used to inform the impact of the disease. 3 Serial FEV1 readings will, however, detect patients with rapidly progressive disease or airflow limitation. Specialist referral is required if you suspect dyspnoea at clinical review and should be undertaken by a professionally appropriate trained to do so. 4

Other indicators of control included patient reported outcome measures e.g. COPD Readiness Tool (http://www.copd.org) and the clinical record will note the frequency of exacerbations requiring unscheduled visits and/or antibiotics/laced courses.

Further assessment in more severe disease
Polymedication is associated with more patients of eligible for SOTP are identified and referred for assessment. The Read code for oxygen saturation is P25.60

Recall study New index
Severe breathlessness may make it difficult and severe COPD is associated with a cachexia in some people, low BMI is associated with a poor prognosis. 5 Patients with a BMI<20 may need to be referred for specific dietary advice.

Observing 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 (card sent how they are coping and what support services/ advice they require which may be available.

Management
How has dyspnoea been confirmed by lung function test information with GBR and guidelines on COPD
Be aware treatment is fine with evidence-based local and national guidelines for recommendations, stepping up treatment as needed
Be aware you supporting self-management and care with www.asthma.org.uk? Have you discussed and agreed treatment plan together and given the patient the chance to ask about treatments? 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 support is essential for supported self-management of long term conditions. How can you help the COPD management plans meet the patient’s needs?

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 may be part of essential treatment and progression reviewed regularly.

Only 5% of smokers who want to quit smoking actually access a stop smoking support service each year, yet we know that support increases the likelihood of quitting.

It has a key role of primary care to “Make Every Contact Count” (MECC), through clinicians offering advice (PCTB), the practice displaying posters and videos information, and well-trained reception staff facilitating access to opportunities for supportive engagement.

References
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The building blocks of a good Asthma or COPD review in adults

Open and pull out