

# What Three Things?

Our new series to support delegation



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The Fit to Care document was initially developed to guide and support clinicians working with patients with respiratory disease. Since its first publication, primary care has seen huge changes in the dynamics of the workforce providing this care. The document now applies equally to doctors, nurses, pharmacists, physiotherapists, paramedics and other allied healthcare professionals involved in the care of people with respiratory conditions. This variation in disciplines aligns with national programmes aimed at improving patient care such as Getting it Right First Time – GIRFT (NHS England & NHS Improvement) and the Primary Care Improvement Portfolio (Health Improvement Scotland). These programmes work on the principle that a patient should expect to receive equitable, timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care. The programmes also advocate the sharing of responsibility within practice teams and the wider primary care system, and promoting effective multi-disciplinary working.

As this diversity of healthcare professionals continues to grow within primary care, it is essential that those who have responsibility for the delegation and supervision of clinical interactions between members of staff and patients, not only have sufficient knowledge and expertise to do so safely, but are also willing to provide education, updates, and support to ensure accurate approaches to safe practice. The skills of supervision are often easier for clinicians in your own professional speciality but with many other disciplines working in primary care good supervision requires an understanding of the training and skills of other professional groups as well as understanding the experience that each individual brings. It is easy, but dangerous, to assume that clinicians have all been trained in and think in similar ways.

To help with this responsibility Primary Care Respiratory Update will be providing you with regular suggestions of how you can help your colleagues. This regular piece will consider three things that you can incorporate into clinical supervision, whole team meetings or protected learning times.

## This issue's What Three Things: Asthma Control and Allergy

### 1. Monitoring asthma reviews –

#### What about the nose?

Co-morbid allergic and non-allergic rhinitis affect over 80% of people with asthma. People with asthma with severe rhinitis symptoms are four times more likely to have poorly controlled asthma than those without.<sup>1</sup> Patients with nasal symptoms are often chronic mouth breathers meaning particles bypass nasal filtration and go straight to the lungs. Adults with concomitant allergic rhinitis and

asthma had more annual visits to their general practitioner and increased risk of being hospitalised compared to adults with asthma alone.<sup>2</sup> Patients with asthma and allergic rhinitis also receive 50% more prescription for asthma-related medications annually than those with asthma only.<sup>3</sup>

This research demonstrates how important and effective having a discussion with patients around allergy and rhinitis can be. The potential risks of not exploring these

symptoms and treating them, is an increased reliance on reliever inhalers and/or an overall increase in inhaled corticosteroid potency to gain symptomatic control. Advising clinicians to open discussions with patients about nasal symptoms can avoid over treatment of inhalers and improve quality of life particularly in hay fever season.

See pages 6-17 for more information on Asthma and Allergy.

## 2. Hay fever and asthma

Hay fever affects between 10-15% of children and approx. 26% of adults although recent data suggests this could be as high as 49%. The length, duration, and intensity of the pollinating season varies from year to year, which can complicate identification of the responsible allergen. Trees generally pollinate in the spring, grasses pollinate at the end of spring and beginning of summer and weeds may pollinate from early spring to late autumn. This means that although most people consider hay fever to be a 'spring' condition it can actually impact all year round. The 2016 revision of the Allergic Rhinitis and its Impact on Asthma (ARIA) international guideline<sup>4</sup> notes that asthma is found in 15–38% of people with allergic rhinitis.

Although antihistamine treatment is a first line consideration for this population there are other approaches that patients can take to avoid/reduce the impact:

- Wear a mask, wraparound sunglasses and or a hat with a peak or large brim to keep pollen allergens out of the eyes and face.
- On high pollen days, shower, wash hair and change clothes when you arrive home.
- Keep windows closed. This is most important in the early mornings, when pollen is being released, and in the evening when the air cools.
- Avoid mowing lawns or raking leaves.
- Avoid drying clothes/linen outside when pollen counts are high.
- Wipe pets down with damp cloth to remove pollens.

For more information on managing hay fever see pages 6-10.

## 3. Asthma and Inhaler Technique – Potential implications of sub optimal technique

Inhaler errors are common with between 52% and 87% depending on the device in use. Ensuring that all clinicians are prepared to provide guidance and direction on inhaler use and nasal spray use can help to reduce:

- Poor symptom control
- Increase in side effects
- Increased dose
- Escalation of treatment
- Increased hospital admission
- Increased costs

93% of HCPs make at least one error throughout the seven steps of correct actuation of a pMDI so teaching and updating members of staff about the correct techniques can be beneficial for patients during reviews. Reference to online resources such as RightBreathe (<https://www.rightbreathe.com/>) and the UK Inhaler Group (<https://www.ukinhalergroup.co.uk/>) can help with training.



### References

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2. Corren J, Manning BE, Thompson SF, Hennessy S, Strom BL. Rhinitis therapy and the prevention of hospital care for asthma: a case-control study. *J Allergy Clin Immunol.* 2004 Mar;113(3):415-9. doi: 10.1016/j.jaci.2003.11.034. PMID: 15007339.
3. Halpern MT, Schmier JK, Richner R, Guo C, Toggias A. Allergic rhinitis: a potential cause of increased asthma medication use, costs, and morbidity. *J Asthma.* 2004 Feb;41(1):117-26. doi: 10.1081/jas-120026069. PMID: 15046386.
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