Checklist for healthcare professionals conducting asthma reviews

Task	Notes	Points to consider
Goal setting	Discuss with patient what they want to be able to achieve which they currently cannot due to their asthma	• E.g. Patient fears and health beliefs. Conflicting goals. • Language, is an interpreter/advocate needed?
Patient concordance and exacerbation assessment		
Reliever inhaler: If the patient has been issued more than 6 inhalers in the past 12 months, they are at a higher risk of an asthma exacerbation	Although there should not be any restriction on patient ordering reliever inhalers – if usage exceeds 1 inhaler every 3 months on a regular basis, then asthma therapy needs to be reviewed. Consider reliever supply for work/school here. If patient on Repeat Dispensing for asthma inhalers: • Ensure that there is a process in place for the community pharmacist to be able to inform the practice if patient is ordering their reliever inhaler every month…OR • Ensure salbutamol inhaler is not prescribed via the repeat dispensing route.	With respect to symptoms, controlled asthma = no symptoms. It is, however recognised that occasional symptoms may occur <u>twice or less per week</u>. A patient with controlled asthma may require a <u>maximum of 4 puffs</u> of salbutamol a week. A salbutamol inhaler usually contains <u>200 metered dose actuations (puffs).</u> In a patient with controlled asthma, one salbutamol inhaler therefore should be sufficient for **<u>50 weeks!!!!</u>**
Preventer inhaler: If the patient has been issued fewer than 9 preventer inhalers in the past 12 months their treatment requires optimising.	• The use of regular (every day) low dose inhaled corticosteroids is better than irregular use of high dose corticosteroids. • Please have a look at the NICE Clinical guideline on Medicines Adherence: http://guidance.nice.org.uk/CG76	• Does the patient actually require the dose of inhaled corticosteroid they are on currently? • Are they using their maintenance inhalers? • Are they using their maintenance inhalers effectively? • Does their treatment require stepping up or down? • 'Denial' – how do they feel about treatment when well? • Symptoms of adrenal suppression are very non-specific. • Inhaled fluticasone 1mg (500mcg BD) = oral prednisolone 7.5mg – 9.1mg od
Asthma attacks, requiring rescue treatment or hospitalisations in the past year	• Check medication issue history on how many times oral steroids have been issued in the previous 12 months. • Check system for history of emergency treatment/admissions for asthma	• Is the patient concordant with inhaled treatment?
Asthma Control Test ™		
Check patient's completed questionnaire and Asthma Control Test ™ (ACT). (If not completed prior to appointment then complete with them). <u>http://www.asthma.org.uk/Sites/healthcare-professionals/pages/asthma-control-test</u>	Reception staff may ask whether questionnaire completed – if not then ask patient to complete whilst waiting.	If the ACT score is below 20, this means that the patient's asthma is not controlled: • Are they using their maintenance inhalers? • Are they using their maintenance inhalers effectively? • Does their treatment require stepping up? If the ACT score is 20 – 24: • How can the patient's therapy be optimised? If ACT score is 25: • Does the patient's treatment require stepping down? • Symptoms of adrenal suppression are very non-specific. • Inhaled fluticasone 1mg (500mcg BD) = oral prednisolone 7.5mg – 9.1mg od

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<table>
<tr><th>Task</th><th colspan="2">Notes</th><th>Points to consider</th></tr>
<tr><td colspan="4">Peak flow</td></tr>
<tr><td>Check peak flow
(in context of asthma overall,
• Remember if unstable will vary and a good value may give false security.
• COPD and restriction may influence best –consider spirometry if in doubt)</td><td colspan="2"><table><tr><th>Observed result Peak flow (L/Min)</th><th>Interpretation</th></tr><tr><td>>75% - 100%*</td><td>Good control</td></tr><tr><td>>50% - <75%*</td><td>Asthma is getting worse</td></tr><tr><td>>33% - <50%*</td><td>Severe symptoms - Asthma attack</td></tr><tr><td>Less than 33%*</td><td>Asthma emergency</td></tr><tr><td colspan="2">* of annual best or expected peak flow</td></tr></table></td><td>• Are they using their maintenance inhalers?
• Are they using their maintenance inhalers effectively?
• Does their treatment require stepping up?
• Does their treatment require stepping down?
• Consider step up/down on/off LABAS/combination inhalers – asthma varies over time.</td></tr>
<tr><td colspan="4">Inhaler technique review</td></tr>
<tr><td>Observe patients inhaler technique using patient's salbutamol inhaler – if not available consider using placebo</td><td colspan="2" rowspan="3">Please see Inhaler technique assessment checklists for more details on particular inhalers.</td><td rowspan="3">• Is the patient on more than 1 type of inhaler e.g. a pMDI and an Accuhaler? – If so, then consider switching to the one type of device that patient uses most effectively.
• What inhaled steroid dose is the patient on? – consider reviewing dose. (see overleaf for steroid dose conversion table)
• Would a combination 'preventer' be appropriate for the patient?
• If patient is on a combination inhaler, make sure LABA and steroid dose is optimised to ensure patient adherence. E.g. if patient is on a Seretide Evohaler '125' 2 puffs twice daily, the equivalent dry powder inhaler and dose is Seretide '250' Accuhaler – 1 dose inhaled twice daily – easier</td></tr>
<tr><td>Discuss patients' inhaler technique. (good, poor, patients concerns)</td></tr>
<tr><td>Reinforce/teach correct technique.</td></tr>
<tr><td colspan="4">Medicines optimisation, Asthma action plan, follow-up</td></tr>
<tr><td>Asthma Medicines Optimisation.</td><td colspan="2">Consider referring to community pharmacist for:
• A 'New Medicines Service' if new inhaler initiated.
• A Medicines Use Review to reiterate inhaler technique and importance of 'preventer' use.</td><td>• As the HCP – do you feel that the patient need changes made to their asthma management plan?
• Can you make these changes?
• Need for GP / prescribing clinician to change medication and GP follow up?</td></tr>
<tr><td>Construct an Asthma Action Plan with patient using EMIS or Asthma UK template and provide other sources of information/reference e.g.
http://www.asthma.org.uk/sites/healthcare-professionals
(Asthma UK)
http://www.pcrs-uk.org/asthma-resources
(Primary Care Respiratory Society)</td><td colspan="2">Everyone with asthma should have a written action plan with the following details:
○ triggers
○ current treatment
○ how to prevent relapse
○ when and how to seek help in an emergency
• Advise patient to carry Asthma Action Plan with them at all times
• Advise patient to bring actual inhalers, devices and other medication and Action Plan whenever medication is to be reviewed.</td><td>• Does the patient know the importance of a preventer inhaler?
• Does the patient use preventer inhalers effectively?
• Is there someone in the patient's family/carers/companions who helps them with their asthma whom you need to include in constructing a plan?</td></tr>
<tr><td>Book follow up appointment with patient</td><td colspan="3">Review in 4 – 6 weeks -This could simply be a telephone consultation going through the Asthma Control Test and seeing the patient if need be.</td></tr>
<tr><td colspan="4">This review should take you 35 – 45minutes to conduct</td></tr>
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