Steroid Tablets

When my asthma gets very bad I might need to have steroid tablets called "prednisolone".

My usual dose would be ..... mgs

taken once a day for ..... days.

Asthma check-ups

It's really important that I get regular check-ups of my asthma, and I need to see my asthma nurse at least every 6 months

Spacers

Spacers make it much easier to use a puffer inhaler. They are the best way of getting the medicine down into my lungs. So if I have one I will always use it, especially when I have a really bad asthma attack and need lots of my blue inhaler.

This Asthma Plan was filled out by

..... (name)

..... (signature)

..... (title/post)

..... (date)

Where can I find out more about asthma?

My doctor or asthma nurse are the best people to give advice on looking after my asthma. But there are lots of websites that give asthma information, and two good ones are:

- www.asthma.org.uk
- www.nhs.uk, and then I type in the word "asthma" into the search box at the top right of the page

For more help and support I can also phone the Asthma UK Advice-line on 0800 121 6244

Useful Contact Numbers

Shropdoc

Tel. 0844 06 88 88

Princess Royal Hospital

1. The Children's Assessment Unit
   Tel. 01952 565918

2. The Children's Respiratory Nurse Specialists
   Tel. 01952 565931 or
   01952 565932 or
   01952 641222 ext. 4003

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This is .....'s Asthma Plan

NHS
The Shrewsbury and Telford Hospital
NHS Trust

When my asthma is good

My Blue Reliever Inhaler

The medicine is called .....

I take 1 to 2 puffs when I wheeze or cough, or if my chest feels tight and it's hard to breathe.

It starts to work in minutes and wears off fully in about 3-4 hours.

My best peak flow is ..... litres/min

My Preventer Inhaler

The medicine is .....(name)

.....(strength)

Its colour is .....

Every morning I take ..... Puffs

and in the evening ..... Puffs

Other preventer medicines I take are

.....	.....	.....
.....	.....	.....
(name)	(dose)	(times a day)

I take all these treatments every day, even when I am really well, to keep me well

Question: Does running, playing or doing PE always make you wheezy?

Action: Then try taking 1 or 2 puffs of blue inhaler before exercise

When my asthma gets worse

I will know that my asthma is getting worse if any of the following are happening

- I have a cough, or a wheeze and it's getting harder to breathe. Sometimes it might feel that my chest is tight or hurts
- I am waking up at night because of my asthma,
- I am taking 2 puffs of my blue inhaler and it wears off after 2 or 3 hours
- My Peak Flow, is less than.....litres/min

When this happens

I increase my Blue Inhaler and take 3 to 4 puffs every 4 hours

This helps, but I don't get better in about 24 hours

then I should be seen by my doctor or nurse that day

But if 4 puffs doesn't help at all, or doesn't last 3 to 4 hours

→ Treat as an Asthma Attack

Question: Do you need to take your blue inhaler every day?

Action: This means your asthma is not well controlled & you need to talk to your doctor or asthma nurse soon

When I have an asthma attack

I may be having an asthma attack if any of the following are happening

- 4 puffs of my Blue Inhaler is not helping at all
- I can't walk or talk easily
- I am breathing hard and fast
- I am coughing or wheezing a lot
- My peak flow is less than .....litres/min

When this happens

→ I should take 2 puffs of my Blue Inhaler every 2 minutes, up to 10 puffs, until I feel better

I feel better

But I don't want this to happen again,

- I need to keep taking 3 to 4 puffs every 4 hours
- I need to see my doctor or asthma nurse today

I don't feel better & have had 10 puffs

→ I need to call **999** or see a doctor straight away

If the ambulance takes longer than 15 minutes to arrive, and it's still very hard to breathe, I'll take 10 more puffs every 15 to 30 minutes until help arrives

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Asthma Discharge Checklist

Patient Details (Affix sticker)

1. Diagnosis of Asthma → Assess probability

HIGH	✓	INTERMEDIATE	✓	LOW	✓
Recurrent episodes of wheeze, cough, tight chest & breathlessness that vary over time		Some but not all of the "High Probability" features		Symptoms from birth	
				Excessive vomiting	
Identifiable trigger factors such as URTIs, exertion, pollen, dust & smoke exposure				Wet cough (recurrent or persistent)	
				No wheeze heard during exacerbations	
Personal and/or family history of atopy, particularly eczema, rhinitis & hay fever				Focal chest signs, clubbing, poor growth	
				No clear response to bronchodilator	
Wheeze heard by health professional				**Low Probability Group** **ED attenders:** D/W On-call Paediatrics **CAU or Ward attenders:** D/W Consultant General Paediatrician	
Responds to bronchodilator					
No symptoms or signs to suggest other diagnosis					

2. Bronchodilator Response → Salbutamol Response Form (PTO or use stickers on ward/CAU)

Good response		Partial response		No response	

3. Prophylaxis → Increase or start?

		✓
1.	**Already prescribed prophylaxis but not using it or not using regularly** — **ACTION: reinforce need for prophylaxis**	
2.	**Using prophylaxis but incorrect inhaler technique** — **ACTION: give training and provide PIL on inhaler usage**	
3.	**Prophylaxis needs escalation (good adherence & technique)** — **ACTION: follow BTS Asthma Step-by-step guidance**	
4.	**Not on prophylaxis but required** — **ACTION: see guidance overleaf**	
5.	**Not on prophylaxis and not required** — **ACTION: see guidance overleaf**	

SAFETY BREAK → Is the child fit for discharge? See Acute Asthma Guideline

4. Medication on discharge

	✓
Provide a written "Asthma Management Plan" for all attenders	

Medications	Dose	Frequency

5. Discharge → When stable & on 3-4 hourly bronchodilator record the following:

		✓
Asthma Management Plan completed, given & explained		
Asthma information leaflets given & explained		
Inhaler technique demonstrated, checked and appropriate PIL given		
Trigger factors identified and discussed (e.g. pets, pollens, house dust mite)		
Parental smoking discussed / smoking cessation discussed if appropriate		
Early asthma review	**ACTION: For <u>every</u> case advise parents request GP review within 48 hours of discharge**	
Medium to Long-term Follow-up (select appropriate options - see guidance overleaf)	1. Primary care follow-up only — **ACTION: File this form in notes**	
	2. Respiratory Nurse — **ACTION: Send carbon copy to the Paediatric Respiratory Nurses**	
	3. Consultant General Paediatrician — **ACTION: Referral letter required**	
	4. Consultant Respiratory Paediatrician — **ACTION: Referral letter *required***	

Completed by	**Name**	**Registration no.**
	Signature	**Date**

lgd

SECTION 2: Salbutamol Response

Pre-salbutamol	
Time	(HH:MM)
HR	/ min
RR	/ min
SpO_2	%
O_2	
Talking / feeding	Normal / Reduced / Can't
Wheezing	None / Mild / Mod / Severe
Recession	None / Mild / Mod / Severe

→

Post-salbutamol	
Time	(HH:MM)
HR	/ min
RR	/ min
SpO_2	%
O_2	
Talking / feeding	Normal / Reduced / Can't
Wheezing	None / Mild / Mod / Severe
Recession	None / Mild / Mod / Severe

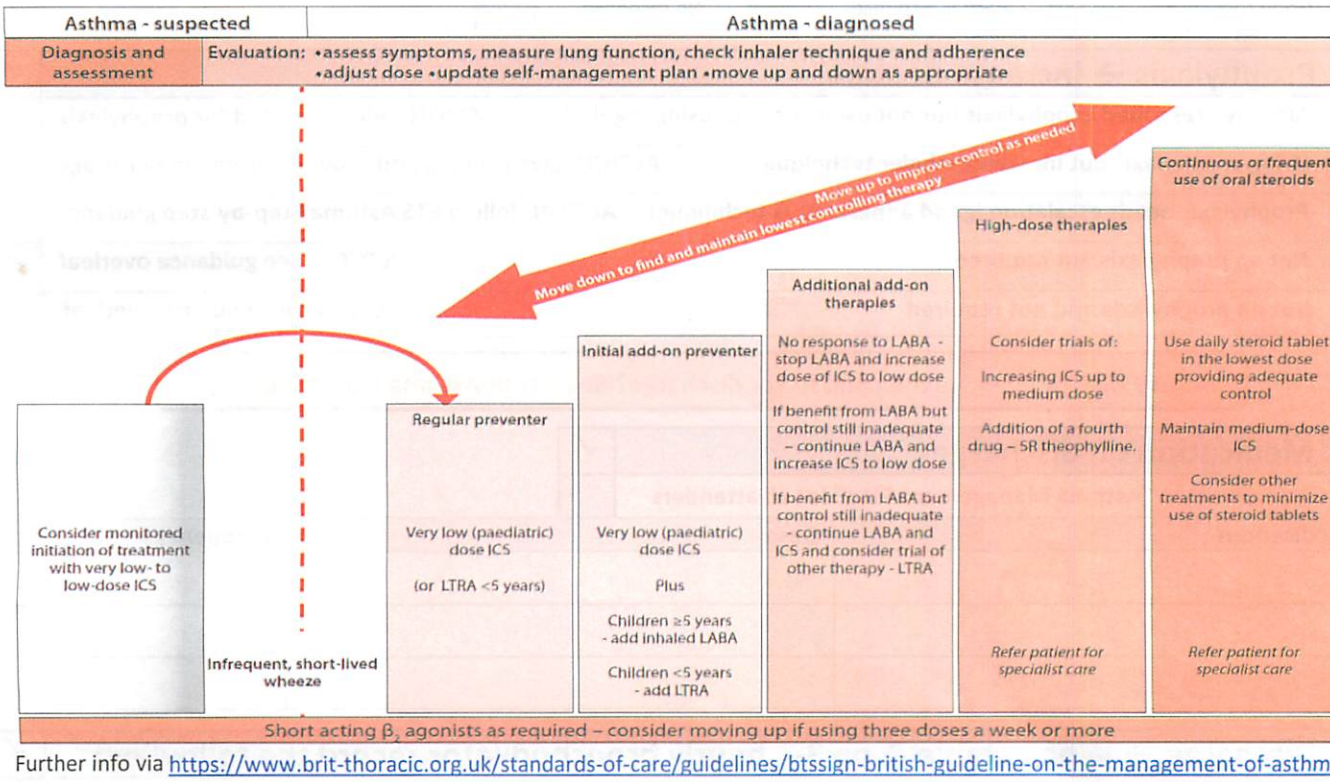
→

Response	✓
↓	
Good	
or	
Partial	
or	
None	

SECTION 3: When to consider prophylaxis for asthma

Prophylaxis for asthma should be considered for the following:

- Salbutamol is required regularly between URTIs i.e. more than once or twice a week
- Asthma symptoms three times a week or more
- Night-time symptoms once a week or more
- Acute asthma results in a hospital admission



Further info via https://www.brit-thoracic.org.uk/standards-of-care/guidelines/btssign-british-guideline-on-the-management-of-asthma/

SECTION 5: When to refer to the Paediatric Respiratory Nurse or Consultant

Children's Respiratory Nurse Referral Criteria

Children's Ward, CAU & ED Attenders	Outpatients
Any attendance for asthma having received prednisolone via GP or A&E within past 12 months	Clinician concern that Primary Care asthma education and support is sub-optimal
Re-attendance within 12 months for acute asthma	
Life-threatening asthma	
Admission or poor control* despite prior treatment with ≥ 200 micrograms inhaled Beclometasone or Budesonide (or 100 micrograms of Fluticasone) and another add-on/preventer medication	
Treatment adherence concerns	
Poor inhaler technique requiring more support despite Primary Care input	

Respiratory Consultant Paediatrician Referral Criteria

Children's Ward, CAU & ED Attenders	Outpatients
Asthma exacerbation admissions with associated or prior anaphylaxis	Asthma requiring prophylaxis in a child with prior episode of anaphylaxis
Life-threatening asthma – refer on same/next working day	
Admission or poor control* despite prior treatment with ≥ 400 micrograms inhaled Beclometasone or Budesonide (or 200 micrograms of Fluticasone) and another add-on/preventer medication	
Diagnostic doubt	

For further information refer to Intranet Guideline "When to refer asthma to Respiratory Nurse or Paediatrician