impact

Lung Health
Asthma Guided Consultation

Exacerbation Report

Consultation Completed: 1st March 2019

Mr Hooper is a 69 year old man who has had asthma since childhood and has been taking treatment equivalent to **Step 4** of the BTS / SIGN Asthma Guidelines. This is his **1st** entry to the Lung Health software.

Exacerbation Review

During the patient's Initial Assessment, symptoms indicating a possible exacerbation were observed and an Exacerbation Review was undertaken during the consultation. The patient reported that:

- Chest symptoms are significantly worse than usual
- They are waking up at night or waking more than usual due to their asthma
- Symptoms are interfering with their usual day-to-day activities
- They are using their reliever inhaler more than usual

Symptom Severity

- Home peak flows were not recorded.
- The patient recorded a PEF of 85, which is 17% of predicted.
- The patient was able to speak in complete sentences, which is **normal**.
- The patient's respiratory rate was 45 breaths per minute, which is **abnormal**.
- The patient's heart rate was 85 beats per minute, which is **normal**.
- Arterial Oxygen Saturation was not recorded today and this was presumed to be because the test was not available.

Summary

This is a significant exacerbation that has responded to high dose bronchodilators.

The RCP score for last week is **3/3** and the patient has required extra bronchodilation **4** times per day.

A written management plan has been supplied and it has been confirmed that the patient understands it and has been advised on how to monitor changes in the next few weeks. A PEF Meter has been issued to the patient.

The following prescribing actions were made:

- New drug for asthma: oral steroids

An earlier planned review should be made for 1 month

Other Checks and Advice

Inhaler technique with current medication has been checked and was initially found to be **inadequate** for current devices. **No solutions were chosen.**

The technique is now considered **satisfactory.**

Clinical Examination

The patient underwent a clinical examination today and the following abnormal findings were noted:

- Patient is using accessory muscles for breathing
- Patient is centrally cyanosed
- Respiratory rate of 45 (breaths per minute) is raised, and this took the patient into an exacerbation assessment
- Patient's percussion was dull (*left side*)
- Patient's breath sounds were abnormal:
    - An inspiratory wheeze was observed, which indicates a possibility of inspiratory stridor, and a chest x-ray has been requested (details below)
    - Crackles were observed (*chest*)

Other comments were noted:

sounds rough

Referrals, Tests and Labs

Tests

The following tests were requested in the package and should be arranged:

- **Chest X-ray** *()*

Labs

They reported coloured sputum and a **Sputum Sample** has been sent (*sent)*

QOF Codes Reported

		5-Byte v2	CTV3	Value
Asthma Register				
Reversibility	Peak flow rate before bronchodilation	339A	XaEHe	85
RCP 3	Asthma disturbing sleep	663N	663N.	
Questions	Asthma daytime symptoms	663q	XaIIZ	

	Asthma restricts exercise	663e	663e.
Smoking	Current smoker	137R	137R.

Thank you for agreeing that your data may be used anonymously for the purposes of evaluating the asthma service and for research.

Review ID:119

Nurse Summary

Nurse Name:	Nurse Signature:	Date:

GP Recommendations and Requests

I authorise the NSHI Nurse Advisor to implement the above medicinal/non-medicinal intervention(s) in line with the Practice Treatment Protocol on the practice computer system		
GP Name:	GP Signature:	Date:
Review appointment required? Yes/No	If Yes, give date:	

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