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Remote Asthma Reviews in a Primary Care Setting

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Background to the project

Asthma affects over 5 million people in the United Kingdom (British Lung Foundation, BLF, 2021), with evidence suggesting that poor management is a contributing factor to a majority of asthma related morbidity (British Thoracic Society, BTS, 2019).

It is recommended that asthma reviews in Primary Care should be conducted at least annually, with personalised treatment tailored to the patient's needs (Royal College of Physicians, 2014) and take the opportunity to reinforce good inhaler technique and trigger avoidance (BTS, 2019). Historically, asthma reviews have been face-to-face appointments, however, following the impact of the global pandemic, SARS-Cov-2; it is common for such reviews to be missed potentially leaving patients at risk. This paper explores the use of remote consultations for asthma reviews, with focus on a protocol to support this type of review in a primary care setting, ensuring patient safety is paramount.

Key words: Asthma, Remote consultations, Video consultations, General Practice, Primary care, SARS-Cov-2.

Introduction

In March 2020, primary care found themselves transforming overnight to remote care to minimise the transmission of SAR-Cov-2, with no specific guidelines being in place at the time until the General Medical Council and the Royal College of Nursing (RCN, 2020) produced interim guidance during 2020. However, advice from BTS (2020) did not change regarding asthma management and that remote consultations should take place to ensure patient safety (Beany et al, 2020). For this to be affective, it had been recognised that a remote asthma protocol required being in place.

Context and aim

The aim was to implement an asthma protocol for remote reviews in general practice. The protocol was to ensure remote consultations were as effective as a face-to-face review, ensuring safety and a standardised approach. Early engagement of stakeholders had been important to support the change and quality improvement. The protocol was to be utilised alongside the already established asthma template on the surgery software and clearly documented whether a remote or face-to-face consultation has taken place.

To ensure patient safety, safety netting had been a high priority with a low threshold to offer a face-to-face appointment if any concerns regarding the asthma control and/or their inhaler technique.

Electronic resources, such as Asthma UK (2021), for inhaler technique videos provided to patients.

Methodology

To establish an effective change in practice, the PDSA model of change (NHS England & NHS Improvement, 2021) was used. The use of the cycle aided the improvement, ensuring safe care and a patient-centred approach with an aim to improve care and minimise any reluctance to change.

Internal and external factors which may affect the protocol were identified by using a SWOT analysis tool (figure 1) as any barriers may have slowed down or stopped the protocol from succeeding (De Silva, 2015).

Qualitative questionnaires were sent to clinical staff undertaking the remote reviews to gain an insight into the clinicians' personal views and experiences (Holloway & Galvin, 2017). The asthma register was audited against previous years comparing how many face-to-face reviews were undertaken compared to remotely completed reviews.

As the PDSA model is cyclical in nature, it allows for any adjustments and improvements after analysing any results and the cycle is then repeated. However, as this initiative was new in its development any requirements and adaptations are not visible yet.

Conclusion

The use of technology and remote consultations are becoming the norm, however patient safety is paramount. Ensuring patient safety and safety-netting advice is embedded in all practitioners day-to-day practice; ensuring patients are aware of any deterioration and symptoms not improving as they would expect and identifying when they need to seek further advice. This advice is however delivered differently for remote consultations and may be via a text message or an email with any differences in the patient not being seen directly in front of them.

Clinical protocols help to provide a quality and evidence-based service; however, additional considerations are required when performed remotely to ensure the safety of patients and the clinician. The remote consultations were well received by patients and clinicians. Preliminary results indicated an uptake in routine asthma reviews due to remote access for patients who ordinarily struggled to attend the clinic due to factors such as work commitments, childcare, being housebound and those who experience mental health issues such as anxiety, which may have been exacerbated by the pandemic (Khan, et al, 2020).

A repeat analysis using the PDSA cycle will take place to ensure continual improvement, with adaptations to include patient feedback questionnaires and audits to establish of how many patients received face-to-face consultations compared to remote for comparison to previous years.

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Strengths	Weaknesses
<ul style="list-style-type: none"> • Asthma register of patients • Recall system- text message, phone call or letter invite • Practice nurses with asthma training/experience • AccuRX technology • Proactive working environment • Effective leadership and management 	<ul style="list-style-type: none"> • High percentage of non- attendance for face-to-face reviews • Newly qualified staff • No standardised approach to remote asthma consultations
Opportunities	Threats
<ul style="list-style-type: none"> • Online training • Increase staff knowledge • New computer equipment with cameras • Extra funding • Increased staff numbers • Covid19 	<ul style="list-style-type: none"> • Covid19 • Staffing levels-sickness, isolating due to covid and/or household members • Staff Annual leave • Intermittent internet connection-externally and internally • Technological threats • Patients without smartphones • Staff resistance • Patient preference

Figure 1 - SWOT analysis (Stolovitch & Keeps, 2006)