Involving the patient in their care

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National Heart and Lung Institute Division,
Deputy Director of Education,
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Senior Vice Dean ICNMS
The perception
The reality
The reality
Patient Centred Care: My definition

Care with which you would be equally satisfied if the patient was your mother, partner or yourself.
Patient Centred Care: My definition

Care with which you would be equally satisfied if the patient was your mother, partner or yourself.

Putting the service back into medicine?
Why should we bother about patient centred care?

Because:

- If we don’t, we will be wrong footed by public opinion and as a profession we should lead and not be dragged
- It is professionally satisfying
Patient Centred Care: What are the drivers?
Absolutely To Avoid!!"

Jan 23, 2008
Very small room (impossible to stay for 2 people!) Dirty. The bathroom has never been cleaned in 5 days. The only window of the room was locked and although we asked for the key to open it several times we did not get it.

Fantastic View of London Bridge!

I stayed here for 1 night on the 30th May 08, the hotel was in a fantastic location on the Thames, upon opening my curtains in the morning i was greeted with a fantastic view of the London Bridge. The breakfast was very nice and all the staff were very helpful, we had an executive room, which was very modern...
Avoid these doctors
Read about and rate your doctor in Canada, UK, and Australia. Free!
RateMDs.com
Give your Doctor a Checkup!

What can I do here?

- Browse Doctors (by region)
- Doctor Search (by name)

Using the above links, you can also add doctors and rate them. And it's all FREE!

Total Ratings: 535,378

Total Doctors: 143,869

Ratings Added Yesterday: 576

RateMDs.com allows patients to rate and read about their doctors and dentists.

This is a fairly new website, so please help others by adding your doctors and rating them!

We average over 600 new ratings per DAY, so please keep checking back.
What patients say about this GP practice.

I am able to get through to the practice by telephone
Rarely

I am able to get an appointment when I want one
Never

I am treated with dignity and respect
Always

Anonymous last visited this GP practice in July 2010.

What I like
one of the worse surgeries i have come across in my life appointments not given before 48 hours and doctors are always asking patients to go to out of hours doctor or a/e casualty in case no appointments.

What I don't like
doctors never prescribe medicine and they say the reason the government have asked them to cut 25 percent on medication/expenses.recently i took my daughter for high tempreature /cogh they ask me to give lemon & honey.
So are our services fit for purpose?
So are our services fit for purpose?

• How are we doing at present and how do we measure it?
• Is communication optimal? Are some missing out?
• Are the logistics of our services as good as they could be?
• What will help us go forwards?
So are our services fit for purpose?

• How are we doing at present and how do we measure it?
• Is communication optimal? Are some missing out?
• Are the logistics of our services as good as they could be?
• What will help us go forwards?
IS THE NHS BECOMING MORE PATIENT-CENTRED?

Trends from the national surveys of NHS patients in England 2002-07

NICK RICHARDS, ANGELA COULTER
SEPTEMBER 2007
Picker Institute Patient Surveys: 2002-7 - Patients having complete confidence and trust in their health professionals

Figure 3: Proportion of patients who had complete confidence and trust in the healthcare professionals treating them (2004-6)

- General practitioners: 76%
- Other primary care staff: 81%
- Hospital doctors: 80%
- Hospital nurses: 75%
- Psychiatrists: 59%
- Community psychiatric nurses: 73%
Picker Institute Patient Surveys: 2002-7 – GP gave clear comprehensible answers and explanations

Figure 7: GP gave clear comprehensible answers and explanations

<table>
<thead>
<tr>
<th>Year</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
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<tbody>
<tr>
<td>Score</td>
<td>75%</td>
<td>76%</td>
<td>76%</td>
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</tbody>
</table>
Information given to patients about *side effects*

Figure 13: Amount of information given to primary care patients on medication side-effects

- 58% given enough information
- 41% not given enough information or would have liked more
Information given to patients about **side effects**

Only 37% of hospital patients being given new medications felt that they had been given complete information about side effects.

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**Figure 13: Amount of information given to primary care patients on medication side-effects**

- 58% given enough information
- 41% not given enough information or would have liked more

---

Picker Institute Patient Surveys: 2002-7
We would like to hear any comments or suggestions of how we can improve your attendance at our outpatient clinic today.

COMMENTS/SUGGESTIONS

It would be nice if the receptionist doesn't shout out your details when you check in i.e. Dr's name, your address, data protection and all that.

Thank You
We would like to hear any comments or suggestions of how we can improve your attendance at our outpatient clinic today.

COMMENTS/SUGGESTIONS

Health care excellent
but Passenger Lift Service poor.
We would like to hear any comments or suggestions of how we can improve your attendance at our outpatient clinic today.

COMMENTS/SUGGESTIONS

Better than W. Middle
But the Cashier needs to be more human.

Thank You
We would like to hear any comments or suggestions of how we can improve your attendance at our outpatient clinic today.

COMMENTS/SUGGESTIONS

The nurses need to show an empathetic attitude.
A simple "Hello and how are you" would do nicely.
At the end of the day they are meant to be humane.

Patient for Out Patient Clinic

Thank You

08/09/05.
We would like to hear any comments or suggestions of how we can improve your attendance at our outpatient clinic today.

COMMENTS/SUGGESTIONS

Our attendance was perfect, yours was awful.
My APPT was at 3:45 pm it is now 4:40 pm.
Not one of your staff has the courtesy to inform anyone of
the waiting area that you are all running late.
The receptionist feels it is all acceptable & normal to be kept
waiting hours, then why bother making an APPT. It’s below standard
and it is not acceptable.

Thank You
ORIGINAL ARTICLE

Understanding reasons for asthma outpatient (non-)attendance and exploring the role of telephone and e-consulting in facilitating access to care: exploratory qualitative study

J D van Baar, H Joosten, J Car, G K Freeman, M R Partridge, C van Weel, A Sheikh

Objective: To understand factors influencing patients' decisions to attend for outpatient follow up consultations for asthma and to explore patients' attitudes to telephone and email consultations in facilitating access to asthma care.

Design: Exploratory qualitative study using in depth interviews.

Setting: Hospital outpatient clinic in West London.

Participants: Nineteen patients, with moderate to severe asthma (12 "attenders" and 7 "non-attenders").

Results: Patients' main reasons for attending were the wish to improve control over asthma symptoms and a concern not to jeopardise the valued relationship with their doctor. Memory lapses; poor health; and disillusionment with the structure of outpatient care were important factors implicated in non-attendance. The patients were generally sceptical about the suggestion that greater opportunity for telephone consulting might improve access to care. They expressed concerns about the difficulties in effectively communicating through non-face to face media and were worried that clinicians would not be in a position to perform an adequate physical examination over the telephone. Email and text messaging were viewed as potentially useful for sending appointment reminders and sharing clinical information but were not considered to be acceptable alternatives to the face to face clinic encounter.

Conclusions: Memory lapses, impaired mobility due to poor health, and disillusionment with outpatient clinic organisation resulting in long waiting times and discontinuity of care are factors that deter patients from attending for hospital asthma assessments. The idea of telephone review assessments was viewed with scepticism by most study subjects. Particular attention should be given to explaining to patients the benefits of telephone consultations, and to seeking their views as to whether they would like to try them out before replacing face to face consultations with them. Email and text messaging may have a role in issuing reminders about imminent appointments.

Asthma affects over five million people in the UK. Regular review coupled with self-management is a corner of quality care and has, when coupled with self-management plans, been shown to be effective in reducing asthma morbidity. UK data, however, reveal that over one third of asthma patients do not attend their hospital outpatient appointments, with comparable non-attendance rates in other specialties. Despite such high rates and the associated costs to the National Health Service (current estimates are £400 million/year), we know surprisingly little about why patients do not attend for scheduled outpatient follow up visits. There is a need to progress beyond simply blaming those who do not attend to think creatively about how access to care can be improved.

The experiences of primary care can offer some useful insights. Here the situation is even worse with up to two thirds of patients with asthma not attending for their annual assessment, perhaps because patients believe that their asthma is so mild that the relative inconvenience of attending outweighs the possible advantages of an asthma review. Building on this understanding, it has been possible to achieve significant reductions in non-attendance rates—without compromising quality of care—by offering convenient telephone based asthma reviews, as shown in a recent primary care trial. Whether such an option would be acceptable to patients seen in a hospital setting, whose asthma is potentially more severe, is unclear. The question is highly topical with current policy initiatives aiming to improve attendance primarily by increasing patients' choice of hospital and booked appointments.

We sought to explore patients' reasons for attendance and non-attendance for asthma review appointments to determine the main factors that influenced their decision making. In view of a possible broader role for information technology innovations in facilitating care, we also investigated patients' views on the role of telephone and email consulting in facilitating asthma outpatient care.

METHODS

Patients

The study sample comprised 50 patients with moderate to severe asthma (British Thoracic Society asthma guideline step 3 or 4) from the outpatient asthma clinic of a West London teaching hospital. They had either attended all follow up appointments in the previous 6 months ("attenders") or had missed one or two follow up consultations during this period ("non-attenders"). In the 6 months preceding the study the non-attendance rate for asthma outpatients in the clinic was 26%.

Through purposive sampling we aimed to recruit participants with a range of age, sex, and ethnic backgrounds. We stipulated that included patients must have had at least two
Understanding reasons for asthma outpatient (non-)attendence and exploring the role of telephone and e-consulting in facilitating access to care: exploratory qualitative study

J D van Baar, H Joosten, J Car, G K Freeman, M R Partridge, C van Weel, A Sheikh

Objectives: To understand factors influencing patients’ decisions to attend for outpatient follow up consultations for asthma and to explore patients’ attitudes to telephone and email consultations. We also looked at how often patients were able to attend outpatient appointments and what factors affected attendance.

Design: Qualitative study using participant observation and in-depth interviews.

Setting: Hospital outpatient clinic in West London.

Participants: Nineteen patients with moderate to severe asthma (12 “attenders” and 7 “non-attenders”).

Results: Patients’ main reasons for non-attendance were the wish to improve control over asthma symptoms and a concern not to jeopardise their valued relationship with their doctor. Memory lapses, poor health, and disillusionment with the structure of outpatient care were important factors implicated in non-attendance. The patients were generally sceptical about the suggestion that greater opportunity for telephone and e-consulting might improve access to care. They expressed concerns about the difficulties in effectively communicating through non-face to face media and were worried that decisions would not be in a position to perform an adequate physical examination over the telephone. Email and text messaging were viewed as potentially useful for sending appointment reminders and sharing clinical information but were not considered to be acceptable alternatives to the face to face clinic encounter.

Conclusions: Memory lapses, impaired mobility due to poor health, and frustration with outpatient clinic organisation resulting in long waiting times and discontinuity of care are factors that deter patients from attending for hospital asthma assessments. The idea of telephone review assessments was viewed with scepticism by most study subjects. Particular attention should be given to explaining to patients the benefits of telephone consultations, and replacing face to face consultant reminders about imminent appointments.

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METHODS

Patients

The study sample comprised 50 patients with moderate to severe asthma (British Thoracic Society asthma guideline step ≥3) from the outpatient asthma clinic of a West London teaching hospital. They had either attended all follow up appointments in the previous 6 months (“attenders”) or had missed one or two follow up consultations during this period (“non-attenders”). In the 6 months preceding the study the non-attendance rate for asthma outpatients in the clinic was 26%.

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1) Forgot
2) Didn’t see the same doctor each time
1) Forgot

2) Didn’t see the same doctor each time

3) Kept waiting last time
Compliance related to time waiting to see the doctor

- Waited < 30 minutes: Compliance = 67%
- Waited 31 - 59 minutes: Compliance = 48%
- Waited an hour or more: Compliance = 31%

*Geersten et al, J Chron Dis 1973 26: 689-698*
So are our services fit for purpose?

• How are we doing at present and how do we measure it?
• Is communication optimal? Are some missing out?
• Are the logistics of our services as good as they could be?
• What will help us go forwards?
The consultation
The consultation

250 million consultations take place between patients and GPs in the UK every year
The consultation

6000 consultations per year?
The consultation

4 consultations per year
The consultation

4 consultations per year

Less if male; more if elderly
How often does the average person go to an Emergency Department or call a 999 Ambulance?
The average person goes here only once every 7 years
The average person calls one of these every 16 years
So what is commonplace to us is strange, unreal and uncommon for our patients
Hearing the patients views

Most patients are interrupted by the doctor within 18 seconds of their opening statement.

(Beckman HB and Frankel RM Ann Intern Med 1984)
How long would patients talk for if not interrupted?

- The average spontaneous talking time was 92 seconds
- 78% of patients had finished within 2 minutes

(Langewitz W et al BMJ 2002;325: 682)
Compliance and Doctor-Patient Communication

Communication Score: 23+/−5 (Range 6-30)  27+/−3 (p>0.001)

Adherence

<70%  >70%

(Am J Respir Crit Care Med 1998;157:1810-17)
But one group may be being particularly overlooked
15% of our patients may be unable to use simple written health information
Can all patients read?

- 127 patients with RA attending a UK Hospital clinic… 15% were functionally illiterate. (Gordon M.-M et al Rheumatology 2002;41:750-754)

- Using the REALM Questionnaire (Rapid estimation of adult literacy in medicine) 15% of patients with COPD were shown not to be able to use the written word. (Taylor J, Dawson S, Sridhar M, Partridge M. Functional illiteracy amongst those with chronic obstructive pulmonary disease (COPD). Eur Respir J 2005;26:57s)

- 483 people with asthma attending a US hospital… 13% read at below 3rd Grade (Williams MV et al Chest 1998 114;1008-15)
Literacy and Health

- People with limited literacy skills:
  - Report poorer overall health
  - Are less likely to make use of screening
  - Present in later stages of disease
  - Are more likely to be hospitalized
  - Have poorer understanding of treatment
  - Have lower adherence to medical regimens

Shame and health literacy

- 202 African Americans underwent the TOFHLA
- 42.6% significantly impaired literacy (More likely to be elderly males with minimal high school education)
- 40% of those reported shame
- 67.2% had never told their spouses
- 53.4% had never told their children
- 19% had never told anyone

Parikh NS et al Pat Educ Counsel 1996;27:33-39
How do we detect a problem?
Can doctors guess who has impaired literacy?

• 140 patients seeing 18 resident physicians
• S-TOFHLA measured in all
• 24% had limited literacy
• Doctors identified only half of those

Rogers ES et al Cancer Control 2006 ;13:225-9
A picture is worth a thousand words

Confucius
A picture is worth a thousand words

Confucius
A picture is worth a thousand words

Confucius
A picture is worth a thousand words

Confucius
<table>
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<th>Names of Pills</th>
<th>What It’s For</th>
<th>Morning/Breakfast</th>
<th>Afternoon/Lunch</th>
<th>Evening/Dinner</th>
<th>Night/Bedtime</th>
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Was Confucius right?

Antibiotic use in a female low literacy population

Text only: Text plus pictogram

Comprehension 70% 95% (p<0.01)

Compliance 72% 90% (p<0.01)

Dowse and Ehlers Pat Ed Counsel 2005
So are our services fit for purpose?

• How are we doing at present and how do we measure it?
• Is communication optimal? Are some missing out?
• Are the logistics of our services as good as they could be?
• What will help us go forwards?
For the non emergency situation

- Are Clinics optimally timed?
- Do we underuse the telephone for follow up?
Are Clinics held at convenient times?

- 300 sequential attendees at Cardio-respiratory clinics
- 165 patients (62.5%) wanted out of hours clinic or a clinic on a Saturday or Sunday.
- (38.8%) saying that this was specifically because they were working

Feeney C, Roberts NJ Partridge MR. BMC Health Services Research. 2005, 5.47
One third of patients attending a busy respiratory clinic were suitable to have their next consultation by telephone rather than face to face

Roberts NJ and Partridge MR Resp Med 2007
So are our services fit for purpose?

- How are we doing at present and how do we measure it?
- Is communication optimal? Are some missing out?
- Are the logistics of our services as good as they could be?
- **What will help us go forwards?**
PREPARING FOR YOUR OUTPATIENT APPOINTMENT

Information for patients
This consultation is for your benefit and it is often helpful to think in advance how you wish to use the time with the doctor to your best advantage.

Before your appointment, you may find it helpful to consider the following:

1. **Your symptoms**
   It is often helpful to think about the major things that are concerning you and to make a list of them to discuss with the doctor:

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

2. **Past illnesses and operations**
   The Doctor is likely to want to know whether you have been ill in the past. You might wish to make a note of any illnesses or operations before you come for your appointment.

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

3. **Your medicines**
   The Doctor will need to know which medicines you are currently taking. It would be helpful if you brought either a repeat prescription form or the medicine packets to your appointment so that the Doctor can check the medicines you are using.

4. **Your questions or concerns**
   For example, you may wish to ask the doctor:
   - What treatments are available for my condition?
   - What are the risks and benefits of the various treatments?
   - How long will the treatment last?
   - Is there anything I can do to help myself?
   - What should I do if my condition doesn’t improve or gets worse?
   - Is there a local support group or national association for my condition?
Use of leaflets to empower patients in primary care  
(Little P et al BMJ 2004)

- 635 consecutive patients aged 16-80 attending 5 UK General practices
- Randomised to receive a general leaflet, a leaflet about depression, neither or both
- General leaflet asked them to list issues they want to raise and stressing that doctor wanted them to raise any concerns or problems
- Evaluation by pre and post consultation questionnaires and MISS
Use of leaflets to empower patients in primary care (Little P et al BMJ 2004)

- Only significant difference was the effect of leaflet on patient satisfaction, and this was greatest the shorter the consultation; for consultations lasting 5, 8 & 10 minutes satisfaction increased by 14%, 10% and 7% respectively.
Computers on Wheels (COWS) and Electronic Medical records are coming

And Computerised Decision Support Systems may free up time and software may facilitate the giving of personalised advice to patients
CHARING CROSS HOSPITAL PICTORIAL ASTHMA ACTION PLAN

Imperial College
London

Software by School of Informatics, University of Manchester

Is the patient an adult, aged over 18? Does the patient wish to receive advice as to how to alter treatment themself?

Asthma Action Plan copyright Imperial College, 2006
Software copyright University of Manchester, 2006
Photographs of inhaler devices reproduced with the kind permission of the Chief Editor of MIMS
Version 1.7.0, October 2006

No (Exit)    Yes (Proceed)
Inhalers

Inhaled Corticosteroids
- Beclomethasone (pMDI)
- Beclomethasone (QVAR - pMDI)
- Beclomethasone (QVAR - autohaler)
- Beclomethasone (QVAR - EASI-BREATHE)
- Budesonide (pMDI)
- Budesonide (turbohaler)
- Ciclesonide (pMDI)
- Fluticasone (pMDI)
- Fluticasone (Accuhaler)
- Mometasone (twisthaler)

Combination (ICS + LABA)
- Seretide (pMDI)
- Seretide (Accuhaler)
- Symbicort (Turbohaler)

Spacer Used?
- Yes

Dose
- 50 micrograms
- 100 micrograms
- 200 micrograms
- 250 micrograms

Warning!
Remember these plans are for use in adults only

Number of Puffs: 0
Times Per Day: 0

Picture of Selection

Preventive Inhaler
Additional Inhaler
Tablets Used
Reliever Inhaler

Continue
**Tablets**

- **Montelukast**
  - 10 mg at bedtime

- **Uniphyllin**
  - 200 micrograms
  - 400 micrograms

- **Prednisolone**

  *Total dose in milligrams taken in one day*

  Prednisolone is usually best taken in one daily dose in the morning. Very occasionally, patients will be maintained on an alternate day dosing regimen.
Best Peak Flow Reading in the Last Year

You may change the value by changing the text in the text box, using the up and down buttons or by moving the slider on the picture of the peak flow meter.

300

Continue
If you are feeling well and your peak flow reading is above 250 you should take:

- **Above 250**

  - 2 puffs of your Beclomethasone inhaler twice per day
  - 2 doses of your Salmeterol inhaler twice per day

- **As Required Therapy**

  - Take your blue, reliever inhaler (Salbutamol) for unexpected coughing, wheezing or breathlessness

[Continue to Zone2]
If you are woken at night by coughing, chest tightness or breathlessness or you need your blue reliever inhaler often or your peak flow reading has fallen to between 210 and 250, you should increase your routine therapy to:

- 4 puffs of your Beclomethasone inhaler 4 times a day
- Change Dose
- Change to Twice a day
- 2 doses of your Salmeterol inhaler twice per day

When you feel better and your peak flow has returned to above 250 and remained there for at least 48 hours you can return to your normal maintenance therapy.

The aim is to increase the dosage of inhaled steroid two, three or fourfold according to the starting dose toward a maximum of 2000 micrograms of Beclomethasone equivalent per day. When asthma is unstable a four times daily dose regimen is preferable but if doubts about the patient’s ability to take medicines four times a day the the same dosage should be taken and split twice daily.
If you are woken at night by coughing, chest tightness or breathlessness or you need your blue reliever inhaler often or your peak flow reading has fallen to between 210 and 250, you should increase your routine therapy to:

8 puffs of your Beclomethasone inhaler twice a day

Change Dose

Change to 4 a day

2 doses of your Salmeterol inhaler twice per day

When you feel better and your peak flow has returned to above 250 and remained there for at least 48 hours you can return to your normal maintenance therapy.

The aim is to increase the dosage of inhaled steroid two, three or fourfold according to the starting dose toward a maximum of 2000 micrograms of Beclomethasone equivalent per day. When asthma is unstable a four times daily dose regimen is preferable but if doubts about the patient's ability to take medicines four times a day the same dosage is given twice daily.
If you are becoming increasingly breathless and having to use your blue reliever inhaler every 4 to 6 hours or more often or your peak flow is between 150 and 210, you should take:

4 puffs of your Beclomethasone inhaler 4 times a day

2 doses of your Salmeterol inhaler twice per day

Between 150 and 210

6 Prednisolone tablets (5mg strength) immediately and every morning until your symptoms are better and your peak flow is above 250 for two days, then take 3 tablets every morning for the same number of days that it took you to get better and then stop the tablets. Let your doctor or nurse know within 24 to 36 hours that you have started such a course of tablets.

Continue to Zone 4
It is a medical emergency if your symptoms continue to get worse and your peak flow readings have fallen below 150. The action to take is:

Get help immediately by telephoning your doctor or calling for an ambulance by dialling 999 or 911. You should take 8 Prednisolone (steroid) tablets immediately (5 mg strength).

Under these circumstances it’s fine to use you reliever inhaler every 5 to 10 minutes until you receive medical assistance.
The Asthma Action Plan may be printed in any or all of the forms identified below. To preview the plan on the screen before printing, select Preview.

<table>
<thead>
<tr>
<th>Symbols Only</th>
<th>Preview</th>
<th>Print</th>
</tr>
</thead>
<tbody>
<tr>
<td>A plan with symbols and very minimal text</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Text Only</th>
<th>Preview</th>
<th>Print</th>
</tr>
</thead>
<tbody>
<tr>
<td>A plan written entirely in text</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symbols and Text</th>
<th>Preview</th>
<th>Print</th>
</tr>
</thead>
<tbody>
<tr>
<td>A plan with symbols and text</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- □ Black and White Printer
- ✔ Show Labels

Check box for black and white printer, uncheck for colour printer.
Inhaler labels are always printed for a black and white printer.
Inhaler labels are not displayed by default for colour printers.

A text copy of the plan is now available in the clipboard and can be pasted into another application.
CHARING CROSS HOSPITAL PICTORIAL ASTHMA ACTION PLAN
John Smith

Zone 1
Above 440
As Required

Zone 2
Between 360 and 440

Zone 3
Between 280 and 360

Zone 4
Below 280

If you are feeling well and your peak flow reading is above 440 you should take:
1 dose of your Symbicort inhaler twice per day
1 micrograms of Montelukast tablets once per day
Take your blue reliever inhaler (Salbutamol) for unexpected coughing, wheezing or breathlessness

If you are woken at night by coughing, chest tightness or breathlessness or you need your blue reliever inhaler often or your peak flow reading has fallen to between 360 and 440, you should increase your routine therapy to:
2 doses of your Symbicort inhaler 4 times per day
When you feel better and your peak flow has returned to above 440 and remained there for at least 48 hours you can return to your normal maintenance therapy

If you are becoming increasingly breathless and having to use your blue reliever inhaler every 4 to 6 hours or more often or your peak flow is between 280 and 360, you should take:
6 Prednisolone tablets (5mg strength) immediately and every morning until your symptoms are better and your peak flow is above 440 for two days, then take 3 tablets every morning for the same number of days that it took you to get better and then stop the tablets. Let your doctor or nurse know within 24 to 36 hours that you have started such a course of tablets. Also take 2 doses of your Symbicort inhaler 4 times per day

It is a medical emergency if your symptoms continue to get worse and your peak flow readings have fallen below 260
Get help immediately by telephoning your doctor or calling for an ambulance by dialling 999 or 911.
You should take 8 Prednisolone (steroid) tablets immediately (5mg strength)
Under these circumstances it's fine to use your reliever inhaler every 5 to 10 minutes until you receive medical assistance
The Drug-Induced Lung Diseases

Pascal Foucher, Philippe Camus, and the GEPPi

Department of Pulmonary Diseases and Intensive Care Unit, University Hospital, Dijon - FRANCE

This is the place to get up-to-date information about drug-induced lung diseases over the Net.

You may access the data either by drug names (generic name, alphabetical order), or by clinical or radiological patterns of involvement.

You should read this first.
Patterns of Involvement of the Respiratory System

I. Interstitial lung disease
II. Pulmonary edema
III. Pulmonary hemorrhage
IV. Airways disease
V. Pleural changes
VI. Vascular changes
VII. Mediastinal changes
/VIII. Major airways involvement
IX. Muscle and nerves
X. Constitutional/systemic symptoms
XI. Variegated effects

You may want to get the complete list of clinical and radiological patterns here.
Drugs that may injure the Respiratory System

All the drugs known to be able to damage the respiratory system are listed below by alphabetical order (generic names). (Complete list here)

Or search here:

(generic name, therapeutic class)

Approximated search

Miscellaneous data

Last update: 2005-09-10
Drugs that may injure the Respiratory System

Cabergoline *
Calcium salts **
Camptothecin *
Captopril ****
Carbamazepine ***
Carbimazole *
Carmustine (BCNU) ***
Carvedilol **
Cefotiam *
Celecoxib *
Celiprolol *
Cephalexin *
Cephalosporins *
Chlorambucil **
Patterns:  
V (a): Pleural effusion  
V (c): Pleural/pericardial thickening or effusion


Conclusion:

• Times are changing
• Medical care is often excellent, but
• The niceties of service are in danger of being overlooked
• If customer service is important in the Gas Industry or in restaurants isn’t it even more important for those who are frightened or poorly?
• Standing back and looking at the patient journey through our departments can be illuminating (and depressing!)
Thank you

http://www1.imperial.ac.uk/medicine/people/m.partridge/