Acute Asthma / Wheeze Pathway (not for Bronchiolitis)

Clinical Assessment / Management Tool for Children & Young People Older than 1 year old with Acute Wheeze



Management – Primary Care and Community Setting

Patient	ASSESSMENT	Low Risk MILD - GREEN	Intermediate Risk MODERATE - AMBER	High Risk SEVERE - RED	IMMEDIATELY LIFE- THREATENING - PURPLE	Normal Values
>1 yr with wheeze presents: *avoid oral steroids in episodic wheezers (wheezers only with colds). Oral steroids play a role in treating acute exacerbations in multiple trigger wheezers (asthma, eczema, allergies) Consider other diagnoses: • Cough without a wheeze	Behaviour	Alert; No increased work of breathing	Alert; Some increased work of breathing	May be agitated; Unable to talk freely or feed	Can only speak in single words; Confusion or drowsy; Coma	Respiratory Rate at rest [b/min] 1-2yrs 25-35
	O2 Sat in air	≥ 95%; Pink	≥ 92%; Pink	< 92%; Pale	< 92%; Cyanosis; Grey	>2-5 yrs 25-30
	Heart Rate	Normal	Normal	Under 5yr >140/min Over 5 yr >125/min	Under 5yr >140/min Over 5 yr >125/min Maybe bradycardic	>5-12 yrs 20-25 >12 yrs 15-20 Heart Rate [bpm]
	Respiratory	Normal Respiratory rate Normal Respiratory effort	Under 5 yr <40 breaths/min Over 5 yr <30 breaths/min Mild Respiratory distress: mild	Under 5 yr >40 breaths/min Over 5 yr >30 breaths/min Moderate Respiratory distress:	Severe Respiratory distress Poor respiratory effort: Silent chest Marked use of accessory muscles	1-2yrs 100-150 >2-5 yrs 95-140 >5-12 yrs 80-125 >12 yrs 60-100
	Peak Flow ^o (only for children > 6yrs with established technique)	PEFR >75% I/min best/predicted	recession and some accessory muscle use PEFR 50-75% I/min best/predicted	moderate recession & clear accessory muscle use PEFR <50% I/min best/predicted	and recession PEFR <33% I/min best/predicted or too breathless to do PEFR	Ref: Advanced Paediatric Life Support 5th Edition. Life Advance Support group edited by Martin Samuels; Susan Wieteska Wiley Blackwell/2011 BMJ Books
foreign bodycroup		GREEN ACTION	AMBER ACTION	URGENT ACTION		TION IF LIFE REATENING
bronchiolitis Pronulting Pronultin Pronultin Pronultin Pronultin		Salbutamol 2-5 'puffs' via inhaler & spacer (check inhaler technique) - use higher dose if Tx started by parent as per asthma action plan. Advise – Person prescribing ensure it is given properly • Continue Salbutamol 4 hourly as per instructions on safety netting	 Salbutamol (check inhaler technique) x 10 'puffs' via inhaler and spacer Reassess after 20 – 30 minutes Oral Prednisolone within 1 hour for 3 days if known asthmatic <2 years - avoid steroids if episodic wheeze. 10mg/day if multiple trigger wheezer.* 2-5 years 20 mg/day 	 Refer immediately to emergency care by 999 Alert Paediatrician Oxygen to maintain O₂ Sat > 94%, using paediatric nasal cannula if available Salbutamol 100 mcg x 10 'puffs' via inhaler & spacer OR Salbutamol 2.5 – 5 mg Nebulised Repeat every 20 minutes whilst awaiting transfer If not responding add Ipratropium 20mcg/dose - 8 puffs or 250 micrograms/dose nebulised mixed with the 		nebuliser whilst arranging hospital admission - 999
Action: May 2016 • Rev Action: May 2016 • Rev Action		 document. Provide: Appropriate and clear guidance should be given to the patient/carer in the form of an <u>Acute exacerbation</u> of <u>Asthma/Wheeze</u> safety netting sheet. If exacerbation of asthma, ensure 	Ver 5 years 30-40 mg/day YES IMPROVEMENT? Lower threshold for referral to hospital if concerns about social circumstances/ability to cope at	 salbutamol. Oral Prednisolone start immediately: 2-5 years 20 mg/day Over 5 years 30-40 mg/day Paramedics to give nebulised Salbutamol, driven by O₂, according to protocol Stabilise child for transfer and stay with child whilst waiting Send relevant documentation 		
1. <u>Asthma</u> / <u>wheeze</u> inhaler technique 2. Written <u>Asthma/M</u>	<u>heeze</u> action plan P / Practice Nurse –	 they have a <u>personal asthma plan</u>. Confirm they are comfortable with the decisions / advice given and then think "<u>Safeguarding</u>" before sending home. Consider referral to <u>acute paediatric</u> community nursing team if available 	 home or if previous severe/life threatening asthma attack Follow Amber Action if: Relief not lasting 4 hours Symptoms worsen or treatment is becoming less effective 	NO		Emergency Paediatric Unit

This document was arrived at after careful consideration of the evidence available including but not exclusively NICE, SIGN, EBM data and NHS evidence, as applicable. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient in consultation with the patient and / or carer.



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Glossary of Terms			
ABC	Airways, Breathing, Circulation		
APLS	Advanced Paediatric Life Support		
AVPU	Alert Voice Pain Unresponsive		
B/P	Blood Pressure		
CPD	Continuous Professional Development		
CRT	Capillary Refill Time		
ED	Hospital Emergency Department		
GCS	Glasgow Coma Scale		
HR	Heart Rate		
ΜΟΙ	Mechanism of Injury		
PEWS	Paediatric Early Warning Score		
RR	Respiratory Rate		
WBC	White Blood Cell Count		

