Respiratory Health Implementation Group Child Health

South Wales Paediatric Respiratory Network

September 21st 2018
1-5pm
Venue: PoW MPEC Lecture room A

Meeting Minutes

Present

Julian Forton
Lena Thia
Rachel Evans
Huma Mazhar
Kate Creese
Vishwa Narayan
Saurabh Patwardhan
Nakul Gupta
Lynfa Day
Janet James
Laura Hayter
Bhavee Patel
Kate Morgan
Ross Burrows

Apologies

Jeff Morgan
Martin Edwards
Dan Rigler
Zoe Roberts

1. Review Minutes from last meeting

Membership and clinical leads corrected
No other comments

2. October 2018 Audit – database presentation, plans and timeline
   Julian Forton

JF presented plans for the South Wales Asthma Audit for October 2018. The database was reviewed and modified with additional questions added thought to be important and worth asking.
The following was agreed

Bullet points

1) JF to modify database and send out regional databases to all clinical leads in time for the start of the audit on 1st October 2018

2) A paper proforma of the database input form will be circulated (JF) so that data can be collected by the discharging doctor, and entered into the data base at a later date
3) All clinical leads to identify computer where the access database works and can be accessed by designated staff who will input data.
4) Clinical leads to communicate with local staff about the audit i.e. other consultants and ward staff, and identify a lead responsible for data input (themselves, junior doctor, asthma nurse….)
5) Databases will be sent to JF at end of the month (Monday 29th October). An XL spreadsheet of the data will be returned to each clinical lead so that they can review their own data. All data will also be analysed centrally, and presented at next SWPRN meeting.

3. Workstream Group 1: South Wales Asthma Action Care Plan

Jyotsna Vaswani (RGwH) Lynfa Day (RGH) Dan Rigler (Morriston) Laura Hayter (POW) Claire Briggs (UHW)

Workstream output was noted

Content of asthma action plan was discussed using the existing plan that is currently used by Glangwili, Withybush, Prince Charles, UHW and possibly Bridgend, as a template

Bullet points:

Additional elements to include

- Triggers
- What to do with exercise
- A statement on steroid responsiveness
- Contacts
- Some discussion was had with regard to number of puffs to admimister and when. Consensus was reached with
  1) 6-10 puffs in the event of mild new symptoms
  2) 10 puffs 4 hourly requires assessment with GP appointment that day
  3) Up to 10 puffs 4 hourly as a threshold up to which salbutamol can be safely administered on discharge was agreed
  4) 2 puffs is what you take before exercise

- JF will modify, circulate and now take forward for presentation with RHIG on Thursday 27/10/2018

3. Workstream Group 2 : South Wales Inpatient care pathway

Jyotsna Vaswani (RGwH) Rachel Evans (Morriston) Humphrey Okuonghae (PCH) Sue Lewis (UHW) Martin Edwards (UHW in absentium) Saurabh Patwardan (Carmarthen in absentium) Bhavee Patel (Morriston)

Workstream output was noted

Content of acute asthma care pathway was discussed using

1) Existing template
2) Gwent inpatient pathway
3) Morriston inpatient pathway

- Concerns regarding the length of the impatient proforma were highlighted

- The value of numerous directed questions was discussed – certainly of value for audit and may need to be modified to include the NAPAC specific questions when NAPC audit commences next year
- It was decided to concentrate on a single A4 flowchart of care for acute asthma and allow hospitals to generate their own paperwork for hospital pathway.
- Discussions highlighted the following agreed principles:

1) The flowchart should be one page
2) The evidence for magnesium nebulisers was questioned - there is inadequate evidence to include routinely in acute care – few centres are using it outside Wales. Magnesium nebulisers were removed from acute therapy but left as an option.
3) The importance of early steroid administration needs to be emphasized – if given as liquid at the time of the first nebuliser (observed by the doctor when administered by nurse) it is unlikely to be vomited.
4) Dexamethasone was discussed –there is little evidence for this in hospital – studies show increase reattendance. It may be the future but is not the present if we go by national recommendations and evidence base. If introduced, it will need a wide educational program so that its management is made clear to the wider community (GPs) – not included in the proforma at this stage.
5) As a new innovation, a 4 hour assessment should be highlighted where a proactive decision is made or at least considered, to escalate those children still on one hourly nebulisers to IV therapy. This is to prevent 12 hours of hourly nebs overnight
6) There needs to be made clear, a distinction between IV bolus therapy and IVI – particularly for salbutamol where there exists a bolus treatment and an IVI – these are separate treatments - salbutamol does not need a loading dose. Conversely, Aminmohylline needs a loading dose followed by IVI and there is no such thing as an aminophylline bolus treatment. This anecdotally appears to be poorly understood in the wider consultant body, with the term salbutamol loading dose being confused with salbutamol bolus. This is poorly stated in the current algorithm that was produced a few years ago.
7) A discussion was had about introducing IV salbutamol as an initial IV bolus treatment (with an option for IV magnesium at this stage as well). This can then be followed by escalation after reassessment to IVI
8) The choice of IVI order was discussed. It was accepted that both were of equal value.
   The advantages of aminophylline
   - children will have already received much salbutamol and be saturated with beta agonist – so give something else
   - Giving aminophyyline after IV salbutamol bolus and before IVI salbutamol naturally makes a distinction between these 2 salbutamol treatments and avoids the confusion that exists
   - Salbutamol produced acidosis

   The advantage of salbutamol
   - The risk of toxicity in those on oral theophylines if in error the loading dose is not omitted.

9) The advantages of compromise so that we “Do the right thing first” were accepted by all present and there was a willingness to compromise for this outcome. The advantages of standardising care will be to reduce human error, deliver consistent approach for junior learning - this is a system change over and above each individual institution and requires give and take. A consensus was drawn that aminophylline should be first line IVI after IV salbutamol +/- IV magnesium boluses.

Representatives from all institutions were present and are asked to establish consensus within their institutions.

Bullet points:

- JF will generate an acute care pathway and circulate. This hopefully allows for variation between institutions on the subject of which IV boluses to give and which IVI to give, untl consensus is established. This will be taken forward for presentation to RHIG on Thursday 27/10/2018