

# PAEDIATRIC ASTHMA MEDICINES USE REVIEW SERVICE AUDIT

Pharmacy Name:

Pharmacy Code:

Patient	PMR No.	DOB	Age	Date of Review	Review 1 or 2?	Last review with GP/Nurse		Patient RCP Score	Use of Reliever (Blue) Inhaler in last month			Compliance Issue (complete any that apply)			Patient Concordant?		Intervention (complete all that apply)			
						<12 months	>12 months		Average number of puffs / day	More, Less or Same as usual	Highest use / day within last month	Belief	Device	Medicine	Yes	No	Patient Education	Carer Education	Device training	HCP Referral
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See instructions overleaf

**Notes:**

1. To complete box either insert figure or simply tick the box
2. Date of review and is this the initial review (1) or follow-up (2)

**3. Compliance issue:**

**Belief:** Is the patient non-compliant due to their beliefs/mis-beliefs about their treatment?

Patients may make a risk/benefit analysis in which beliefs about the need to take their medicines are balanced against the potential/perceived benefits/adverse effects

**Formulation:** Does the patient have difficulty with practical issues about the medicine - difficulty in swallowing, taste etc

**Side effects:** Dry throat, headache etc

4. **Concordance:** Does the patient understand their condition and treatment and are they in agreement with the diagnosis and treatment regime.

**5. Pharmacist Intervention:**

**Patient/carer Education:** Providing information or education to the patient/carer on the appropriate use of the medicines

**Device Training:** Inhaler technique check and issues addressed

**Referral:** Patient referral for action by another healthcare professional - GP, asthma nurse