

Paediatric Asthma & Wheeze Guidelines for use at Wexham Park & Frimley Park Hospitals

Key Points

- Salbutamol weaning plans are no longer recommended. Salbutamol should be used as required and safe salbutamol discharge advice provided
- Peak flow measurements to be performed in all over 6 years of age
- Use of oral dexamethasone as a suitable alternative to oral prednisolone
- Ensure a thorough history is taken using the Epic Asthma/Wheeze Proforma for ages 5-16
- Ensure appropriate follow-up is arranged for all patients discharged home.

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Key words: Asthma, wheeze, paediatric, management, discharge

This is a controlled document. If you are using a printed copy, check it against the guidelines site to ensure you are using the latest edition.

Print copies must be destroyed after use.

Abbreviations

BTS/SIGN	British Thoracic Society/ Scottish Intercollegiate Guidelines Network
GINA	Global Strategy for Asthma Management and Prevention
VIW	Viral Induced Wheeze

Contents

Summary	2
Viral Induced Wheeze Age 1-5 years: Acute Management	3
Viral Induced Wheeze Age 1-5 years: Discharge Planning	4
Asthma/Wheeze Age 5-16 years: Acute Management	5
Asthma/Wheeze Age 5-16 years: Acute Management (continued)	6
Asthma/Wheeze Age 5-16 years: Discharge Planning	7
Acute Asthma/Wheeze Clerking Proforma	8
Appendix 1: Referral Pathways & Guidance	10
External Referral Guidance	11
Internal Referral Guidance	12
References	14
Full version control record	15

Summary

Acute management

- Treat according to severity of acute exacerbation
- Give oral steroids within 1 hour of presentation if applicable
- Record peak flow measurements in over 6 years of age
- Notify the Paediatric Respiratory Nurse Specialist for asthma admissions

Chronic Management

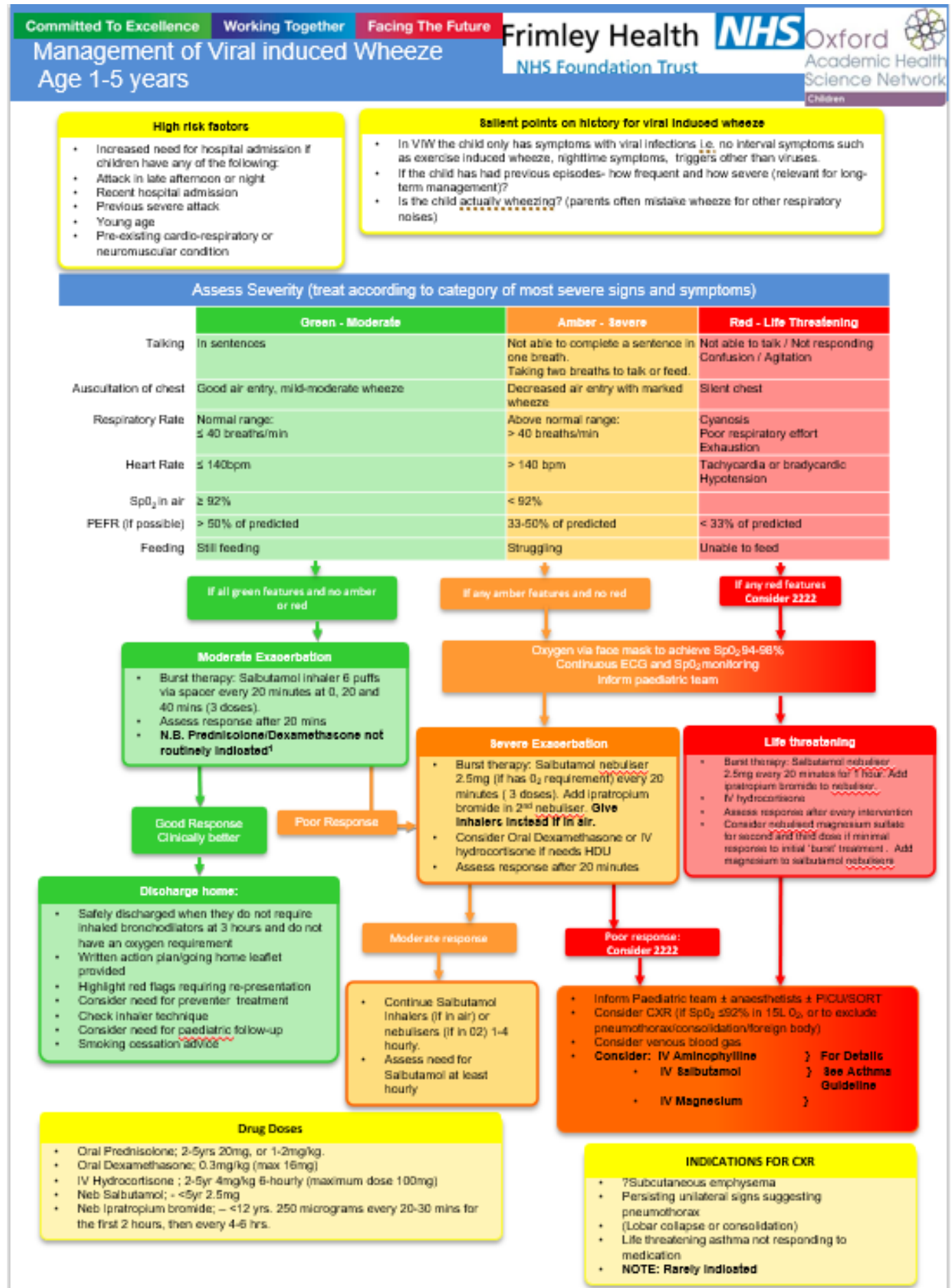
- Use appropriate medication dosage as per BTS/SIGN or NICE guidance
- Address adherence, inhaler technique and co-morbidities before stepping up treatment

Discharge planning

- Provide a written personalised care plan
- Check inhaler technique
- Record smoking status and offer smoking cessation support
- Request follow up to a paediatric asthma clinic within 4 weeks if admitted due to asthma & primary care follow up in 2 working days

The Paediatric Respiratory Nursing team operates Monday-Friday (exc. Bank holidays) and can be contacted via telephone (Wexham Park ext. 153129/153058, Frimley Park ext. 132595/133129) or by visiting the respiratory nursing office on Ward 24 and F1. Outside of these hours, please refer via Epic.

Viral Induced Wheeze Age 1-5 years: Acute Management



Viral Induced Wheeze Age 1-5 years: Discharge Planning

Discharge Planning

Timing of Discharge

- Children with acute wheeze can be safely discharged when they have been spaced to 3 -4 hourly bronchodilators and do not have an oxygen requirement.

Check Inhaler Technique

- All children admitted with acute wheeze should have an assessment of their inhaler technique during their admission.
- The assessment should be documented in the child's notes with the technique graded (e.g. good, moderate, poor).

Use and Care of Spacers

- The spacer should be compatible with the pMDI being used.
- A facemask should be used until the child is old enough to use the mouthpiece reliably (usually aged 4)
- The drug should be administered by repeated single puffs followed by 6 -10 tidal breaths
- Spacers should be cleaned monthly and replaced yearly
- They should be washed according to manufacturer's instructions

Long-term Management of Intermittent Pre-school Wheeze

- Children can generally be managed with intermittent bronchodilator therapy
- Consider a **trial** of inhaled corticosteroid treatment in children with frequent / severe episodic viral wheeze. This should be **reviewed and discontinued if no benefit in 4 -8 weeks**.
- Preschool children with multi-trigger wheeze and older children with asthma should be managed according to the BTS Step-wise Asthma pathway.

Written Wheeze Action Plan

- All children seen in hospital with acute wheeze should be given a written wheeze management plan. This should consist of:
 - Advice regarding salbutamol use after discharge
 - Red flags requiring re-presentation to hospital
 - Details of preventer medication if relevant



**Frimley Healthier
Together discharge
advice**

Follow up

- All children seen in hospital with acute wheeze should be advised to contact their GP if they have ongoing concerns regarding recurrent presentations
- Children with recurrent **admissions** to hospital should be followed up 1 -2 months after admission (See **Appendix 1 of Paediatric Asthma/Wheeze Guideline for referral guidance**)

Smoking Cessation Advice

In all children admitted with acute wheeze, a social history including history of smokers/vapers in the household should be taken.

Smoking cessation advice should be offered to families. Useful resources: <http://www.nhs.uk/smokefree> or local service.

References:

- Oral Prednisolone for preschool children with Acute Virus-induced Wheeze** Panickal et al; N Engl J Med 2009; 360:323-38
- Leukotriene receptor antagonists as maintenance and intermittent therapy for episodic viral wheeze in children** Boudier et al; Cochrane database Syst Rev, 2015 Oct 19

Authors:

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Reviewed and adapted 2023: Dr Kian Lee, Dr Peter G. S. & Nina Somerville, Frimley Health NHS Trust
Also based on guidelines written by:
Dr Craig McDonald, Bucks Healthcare NHS trust
Dr Andy Ives, Oxford University Hospitals NHS trust
As part of the Oxford Academic Health Science Network guideline group
Review Date August 2021

Asthma/Wheeze Age 5-16 years: Acute Management

Committed To Excellence

Working Together

Facing The Future

Frimley Health
NHS Foundation Trust

NHS

Oxford
Academic Health
Science Network
Children

Management of Acute Wheeze/Asthma Age 5-16 years

High risk factors

Lower threshold for hospital admission if children have any of the following

- Attack in late afternoon or night
- Recent hospital admission
- Previous severe attack
- Multiple courses of oral steroids
- Young age
- Pre-existing cardio-respiratory condition

Consider other diagnosis if any of the following are present:

- If <5yrs see alternative guideline on management of viral induced wheeze
- Fever or productive cough (pneumonia)
- Dysphagia (epiglottitis)
- Inspiratory stridor (croup)
- Breathlessness with light headedness and peripheral tingling (hyperventilation)
- Asymmetry on auscultation (pneumonia or foreign body)
- Excessive vomiting (GORD)

Assess Severity (treat according to category of most severe signs and symptoms)

	Green - Moderate	Amber - Severe	Red - Life Threatening
Talking	In sentences	Not able to complete a sentence in one breath. Taking two breaths to talk or feed.	Not able to talk / Not responding Confusion / Agitation
Auscultation of chest	Good air entry, mild-moderate wheeze	Decreased air entry with marked wheeze	Silent chest
Respiratory Rate	Normal range: ≤ 30 breaths/min	Above normal range: > 30 breaths/min (>5yr)	Cyanosis Poor respiratory effort Exhaustion
Heart Rate	≤ 125 bpm	> 125 bpm (>5 yrs)	Tachycardia or bradycardic Hypotension
SpO ₂ in air	≥ 92%	< 92%	<90%
PEFR (if possible)	> 50% of predicted	33-50% of predicted	< 33% of predicted

If all green features and no amber or red

Moderate Exacerbation

- Burst therapy: Salbutamol inhaler 10 puffs via spacer every 20 minutes (0, 20 and 40 mins) Consider oral dexamethasone 0.3mg/kg (max 16mg) single dose if diagnosis of asthma
- Assess response 20 mins after burst therapy

Good Response
Clinically better

Discharge home:

- Safe to discharge when they do not require inhaled bronchodilators at 3-4 hours (see page 3 for guidance) and peak flow >75% of best/predicted (6+ years)
- Written action plan & going home information
- Highlight red flags requiring re-presentation
- Consider need for preventer treatment if suspected asthma
- Check inhaler technique
- Advise to see GP within 48 hours or the next working day
- Request appointment within 4 weeks if admitted due to asthma (See Appendix 1 of Paediatric Asthma/Wheeze Guideline)
- Smoking cessation advice

Poor Response

If any amber features and no red

Oxygen via face mask to achieve SpO₂ 94-98%
Continuous ECG and SpO₂ monitoring

Severe Exacerbation

- Burst therapy: Salbutamol inhaler + spacer 10 puffs (if in air) or Salbutamol nebuliser 5mg (if 02 required) every 20 mins for 1 hour. Add ipratropium bromide to nebs if not responding.
- Oral dexamethasone 0.3mg/kg single dose. IF NOT ALREADY GIVEN.
- Assess response after 20 mins
- Consider nebulised magnesium sulfate for second and third dose if minimal response to initial 'burst' treatment. Add magnesium to salbutamol nebulisers

Improvement?

- Continue salbutamol inhalers (if in air) or nebulisers (if in 02) 1-4 hourly.
- Give second dose of dexamethasone after 24 hours if symptoms not resolved
- Titrate ipratropium bromide 4-6 hourly or discontinue
- Assess need for salbutamol at least hourly

Poor response:
Call 2222

- Inform senior Paediatrician ± anaesthetists ± PICU/SORT
- CXR (if SpO₂ ≤92% in 15L O₂, or to exclude pneumothorax/consolidation/foreign body)
- Consider venous blood gas
- Consider:
 - IV magnesium sulfate }
 - IV aminophylline } For Details
 - IV salbutamol } See next page

Life threatening

- Burst therapy: Salbutamol nebuliser 5mg every 20 minutes for 1 hour. Add ipratropium bromide to nebuliser.
- IV hydrocortisone
- Assess response after every intervention
- Consider nebulised magnesium sulfate for second and third dose if minimal response to initial 'burst' treatment. Add magnesium to salbutamol nebulisers

Drug Doses

- PO dexamethasone: 0.3mg/kg MAX 16mgs. Can repeat after 24 hours if symptoms persist. Alternative 3 days of oral prednisolone 1-2mg/kg OD, max 40mg
- IV hydrocortisone: >5yrs 4mg/kg 6hourly (maximum dose 100mg)
- Nebulised salbutamol: - >5yr 5mg
- Nebulised ipratropium bromide: - <12 yrs. 250 micrograms every 20-30 mins for the first 2 hours, then every 6hrs; >12yrs 500 micrograms every 6hrs
- Nebulised magnesium sulfate: 150mgs given with salbutamol burst therapy. Proceed to IV magnesium sulfate if nebulised is given

INDICATIONS FOR CXR

- ?Subcutaneous emphysema
- Persisting unilateral signs suggesting pneumothorax
- (Lobar collapse or consolidation)
- Life threatening asthma not responding to medication
- NOTE: Rarely indicated!

BTSGN Guideline for the management of Asthma. Revised publication 2019. <https://www.brit-thoracic.org.uk/qualityimprovement/guidelines/asthma/> pages 108-110

Asthma/Wheeze Age 5-16 years: Acute Management (continued)

Management of acute wheeze – Age 5-16 years

Management of Severe / Life Threatening Episodes

STEP 1

- 15L/min Oxygen via non-rebreather mask
- 3 × salbutamol nebulisers
- 3 × ipratropium nebulisers
- IV hydrocortisone
- (Consider magnesium sulfate nebulisers)

STEP 2

- Discuss with consultant paediatrician
- IV magnesium sulfate
- IV aminophylline bolus. Reassess after bolus.
- Followed by aminophylline infusion
- Salbutamol nebulisers (every 20 mins)
- Ipratropium nebulisers (every 6 hours)

STEP 3

- If no improvement with IV Aminophylline:
- IV Salbutamol bolus.
- Salbutamol nebulisers (every 20 mins)
- Ipratropium nebulisers (every 6 hours)

STEP 4

- If NO improvement following IV Magnesium Sulfate AND IV Aminophylline
- Discuss with SORT / anaesthetics
- IV Salbutamol bolus (if not already given)
- Followed by IV Salbutamol infusion

IMPENDING CARDIORESPIRATORY ARREST

- Worsening agitation/level of consciousness SaO₂
- < 90% in 15L oxygen via Non-rebreathe mask
- Poor respiratory effort
- High CO₂ + Acidaemia (pH < 7.2)
- Hypotension

INTUBATE & VENTILATE

Intubation & Ventilation

INTUBATION

- Often difficult to ventilate post intubation
- Risk of hypotension/cardiac arrest
- Senior anaesthetic assistance
- Rapid sequence induction
- 10-20 mL/kg fluid bolus pre induction
- Ketamine 1-2 mg/kg
- Suxamethonium 2 mg/kg or Rocuronium 1 mg/Kg
- Cuffed ETT
- Continue paralysis
- Consider disconnection and manual deflation if haemodynamic collapse

INITIAL VENTILATOR SETTINGS

- PCV - may need high PIP
- Rate 8-15/min
- Allow completion of expiration– watch
- ETCO₂ trace / ventilator flow loops
- (Age independent)
- Inspiratory time 0.8-1 sec
- PEEP 3-5 cmH₂O
- FiO₂ 1

Doses

DRUG DOSES

- **IV Magnesium Sulfate (with ECG monitoring)**
40 mg/kg (max dose = 2g). Give over at least 20 min. Dilute to 100mg/ml with 0.9% saline.
NB Can be given after nebulised MgSO₄
- **IV Aminophylline (with ECG monitoring)**
 - Bolus: 5mg/kg (max dose = 500mg). Give over at least 20 min. Dilute 1mg/ml with 0.9% saline.
 - Infusion: Dilute 1mg/ml with 0.9% saline
 - 1-12yrs - 1mg/kg/hr
 - >12yrs 500/700 micrograms/kg/hr
- **IV Salbutamol (with ECG monitoring)**
 - Bolus (>2 yrs 15 micrograms/kg). Inject over 5 mins
 - Infusion (0.52 micrograms/kg/min)
 - Dilute to 50 micrograms/ml with 5% Dextrose or 0.9% Saline.

SALBUTAMOL TOXICITY

- Tachycardia/tachyarrhythmia
- Hyperglycaemia
- Metabolic acidosis
- Elevated lactate
- Hypokalaemia

Asthma/Wheeze Age 5-16 years: Discharge Planning

Discharge Planning

Check Inhaler Technique

- All children admitted with acute wheeze should have an assessment of their inhaler technique and device checked during their admission.
- All pMDIs should be used with an age appropriate spacer

Use and Care of Spacers

- The spacer should be compatible with the pMDI being used.
- A facemask should be used until the child is old enough to use the mouthpiece reliably (usually by age 4-5).
- Spacers should be cleaned monthly and replaced yearly.
- They should be washed in detergent and dried in air.

Medication Review

- All children admitted with an acute asthma exacerbation should have a review of their current prophylaxis and be managed according to the BTS/SIGN guidance.
- Ensure adherence is checked with current preventer treatment before stepping up therapy

Timing of Discharge

- Children with acute wheeze can be safely discharged when they have been spaced to 3-4 hourly bronchodilators (BTS/SIGN 2019) and do not have an oxygen requirement.

Children that **can** be considered for discharge when stable 3 hours post SABA:

- Good response to initial SABA
- Peak flow over 75% of best/predicted
- Baseline treatment plan: BTS Low/NICE moderate ICS +/- Montelukast (i.e. BTS/SIGN Step 2).
- No previous HDU/ITU/Prolonged ward admissions.
- No more than 2 PAU/ED attendance in the last year
- No oral steroids in the last month.
- Good family support and understanding of ongoing management.

Any patient being considered for discharge less than 4 hours post SABA MUST be reviewed by a senior, experienced clinician (ST4 or above). Open Access to PAU for 48 hours.

Written Personalised Asthma Action Plan

- All children seen in hospital with acute wheeze should be given a written asthma management plan (e.g. Asthma & Lung UK) This should consist of:
 - When to take reliever medication and red flags for medical review
 - Details of preventer including brand name, dose, colour and times when to take.
 - Other regular medications and when to take them.
 - Any documented allergies or triggers.



**FRIMLEY HEALTHIER TOGETHER
DISCHARGE ADVICE for safe salbutamol
use after discharge**

Followup

- All children admitted to hospital due to asthma should be advised to see their GP within **48 hours of discharge or the next working day**
 - Children with **admissions** to hospital should be followed up by a paediatrician or specialist nurse within 4 weeks of admission (see referral guidance)
 - Consider referral to a paediatric asthma service for investigations of other comorbidities and review of lung function, symptoms and medications.
 - Consider referral to a respiratory paediatrician if
 - Life threatening features on initial presentation
 - Recurrent exacerbations despite:
 - Unstable BTS Step 3 or Step 4 in over 5's (800mcg inhaled corticosteroids PLUS LABA +/- LTRA)
- (See Appendix 1 of Paediatric Asthma/Wheeze Guideline for referral guidance)**

Smoking Cessation Advice

In all children admitted with acute wheeze/asthma, a social history including history of smokers/vapers/e-cigarettes in the household should be taken, including the young person if over the age of 11. Smoking cessation advice should be offered to families - <http://www.nhs.uk/smokefree> or local stop smoking services.

Flu Vaccination

In winter months all children with asthma should be vaccinated with the influenza vaccine

Original Authors: Dr Charlotte Rampton, Dr Anna Bates, Dr Craig McDonald – Bucks Healthcare NHS trust
Local amendments by Dr Emma Fitzsimons, Emma Bushell, Dr Kian Lee, Dr Parthick Aldridge (2020) Frimley Health NHS trust. Dr Kian Lee, Dr Peter Sebire & Nina Somerville (2023) Frimley Health NHS trust.
References:

British guideline on the management of asthma. BTS/SIGN, May 2008; revised October 2014; revised September 2016 Revised July 2019

1. Management of acute wheeze in secondary care; 2-16 years. August 2012. Children and Young People Urgent Care Board

2. Magnesium trial in Children (MAGNETIC): a randomised placebo controlled trial and economic evaluation of nebulised magnesium sulphate in acute severe asthma in children Powell, C et al, <https://ncbi.nlm.nih.gov/pubmed>, cited July 2019.

Acute Asthma/Wheeze Clerking Proforma

The clerking proforma on Epic should be completed for those presenting with acute asthma or wheeze over 5 years of age to obtain a focused clinical history, identify any potential children/young people with undiagnosed asthma and to help improve our care quality standards outlined by the National bundle of care for children and young people with asthma.

Sample proforma:

Asthma/Wheeze [5-16 years] Clerking Proforma

Please use blue hyperlinks to update the relevant section within Epic and then refresh your note.

Please update problem list as able. Note: birth history comments will not refresh currently.

	Time of arrival: @ADMITDTTM@ Referred from: *** Mode of arrival: {arrival:60075}
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Presenting complaint(s)

@PRPROBN@

Active problems currently documented on Epic

@PROBL@

Previous admissions in the past 12 months, including historical HDU/PICU

Interval symptoms (i.e symptoms with exercise, nocturnal symptoms or triggers other than viruses)

Triggers of asthma/wheeze symptoms

URTI : {Yes/ No:28063::"No"}

Smoking: {Yes/ No:28063::"No"}

Fumes : {Yes/ No:28063::"No"}

Pets: {Yes/ No:28063::"No"}

Exercise: {Yes/ No:28063::"No"}

Allergies (food/pollen): {Yes/ No:28063::"No"}

Dust: {Yes/ No:28063::"No"}

Cold air: {Yes/ No:28063::"No"}

Hot air / Humidity : {Yes/ No:28063::"No"}

Emotions : {Yes/ No:28063::"No"}

Damp : {Yes/ No:28063::"No"}

Mould: {Yes/ No:28063::"No"}

Pollution: {Yes/ No:28063::"No"}

Other: {Yes/ No:28063::"No"}

[Family and Social History](#) and Tobacco smoke exposure

@FAMHX@

Close family Atopic Hx : {Yes/ No:28063::"No"}

@EDSOCH@

Safeguarding or psychological issues : {Yes/ No:28063::"No"}

@TOBHX@

Status for patient (over age 11) smoke/vape {Yes/ No:28063::"No"}

Parents smoke/vape : {Yes/ No:28063::"No"}

Smoking cessation offered: {Yes/ No:28063::"No"}

If yes, who by:

Salbutamol given prior to arrival? {Yes/ No:28063::"No"}

If yes, time given:

Any other medications given today? {Yes/ No:28063::"No"}

If yes, drug and time given:

Peak flow: predicted ***

Peak flow: best ***

Peak flow: on presentation ***

**If peak flow <50% of predicted or best, escalate to Registrar. Please complete height for patient*

Medical & Surgical History

@PMH@

@PSH@

Pregnancy / Birth History

@GAB@

Birthweight: @BIRTHWEIGHT@

Drug History

@PTAMEDICATION@

Allergies

@ALLERGY@

Immunisations

{Immunization status:11719}

Growth / Development

{DEVELOPMENTAL ISSUES:33880}

Growth Parameters

@LASTHT1@

@LASTWT1@

Observations since admission

@VITALSM@

Examination

@EXAM@

Impression / Differential diagnosis

1. **Initial impression:** {Asthma episode severity:26763}

2. ***

Plan

1. **ASSESS RESPONSE TO TREATMENT:** record respiration rate, peak flow rate, heart rate and oxygen saturations every 1 hour

2. ***

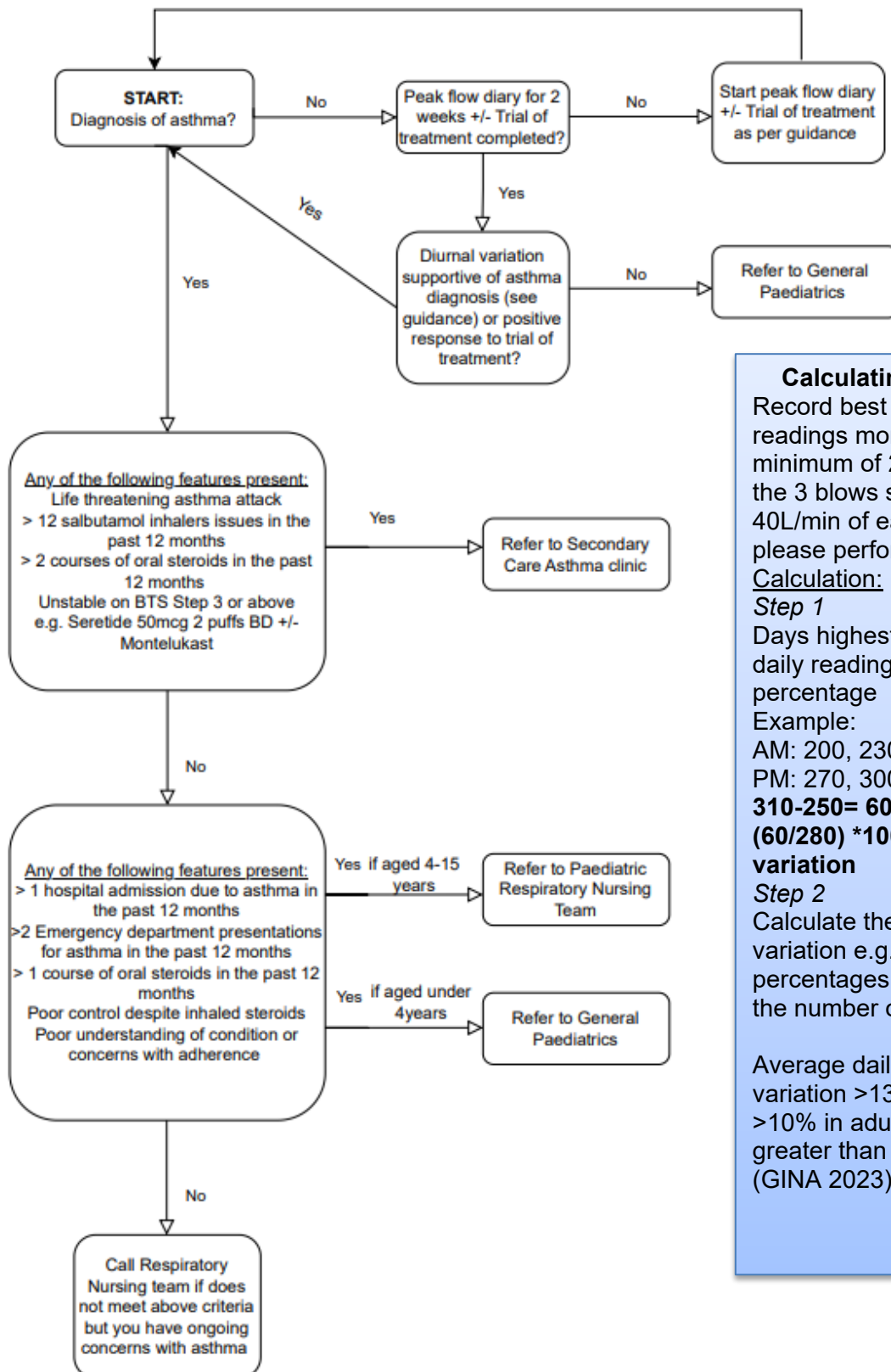
Appendix 1: Referral Pathways & Guidance

Think asthma:

Wheeze/cough/shortness of breath/chest tightness
History of personal atopy (food allergy, eczema, allergic rhinitis) or close family history of atopy
Interval symptoms (not associated with illness alone)

Secondary Care Asthma Clinic	General Paediatrics	Paediatric Respiratory Nurses
Dr Lee & Dr Sebire - Life threatening episode requiring IV treatment +/- PICU/HDU 2 or more episodes in 12 months requiring oral steroids - Unstable on BTS Step 3 (Low Dose/ NICE moderate dose or above)	- Diagnosis queries/Uncertainty with diagnosis - Children under 4 without life threatening episodes	<u>Nurse led clinic (no named consultant):</u> Any child aged 4 -15 years who are either diagnosed or have a suspected diagnosis of asthma (i.e.. Personal atopy, immediate family history of atopy, interval symptoms) who present with any of the following: > x1 hospital admission for wheeze within the last 12 months > x2 emergency attendances for wheeze within the last 12 months > x1 courses of oral steroids within the last 12 months - Uncontrolled asthma, despite inhaled corticosteroids - Poor understanding of their symptoms/medications, poor adherence, or poor inhaler technique - Maximum BTS Step 3 (BTS Low dose ICS + LABA, +/- LTRA) <u>Consultant Support:</u> Any child aged up to 15 years. A single session for patient education and inhaler technique/personalised asthma action plans or additional testing. Follow up to be with the named Consultant or discharged to primary care/GP

External Referral Guidance



Calculating diurnal variation

Record best of 3 peak flow readings morning and evening for a minimum of 2 weeks. Please note, the 3 blows should be within 40L/min of each other, if not then please perform further blows.

Calculation:

Step 1

Days highest-Days lowest/ Mean of daily readings x 100= daily percentage

Example:

AM: 200, 230, **250**

PM: 270, 300, **310**

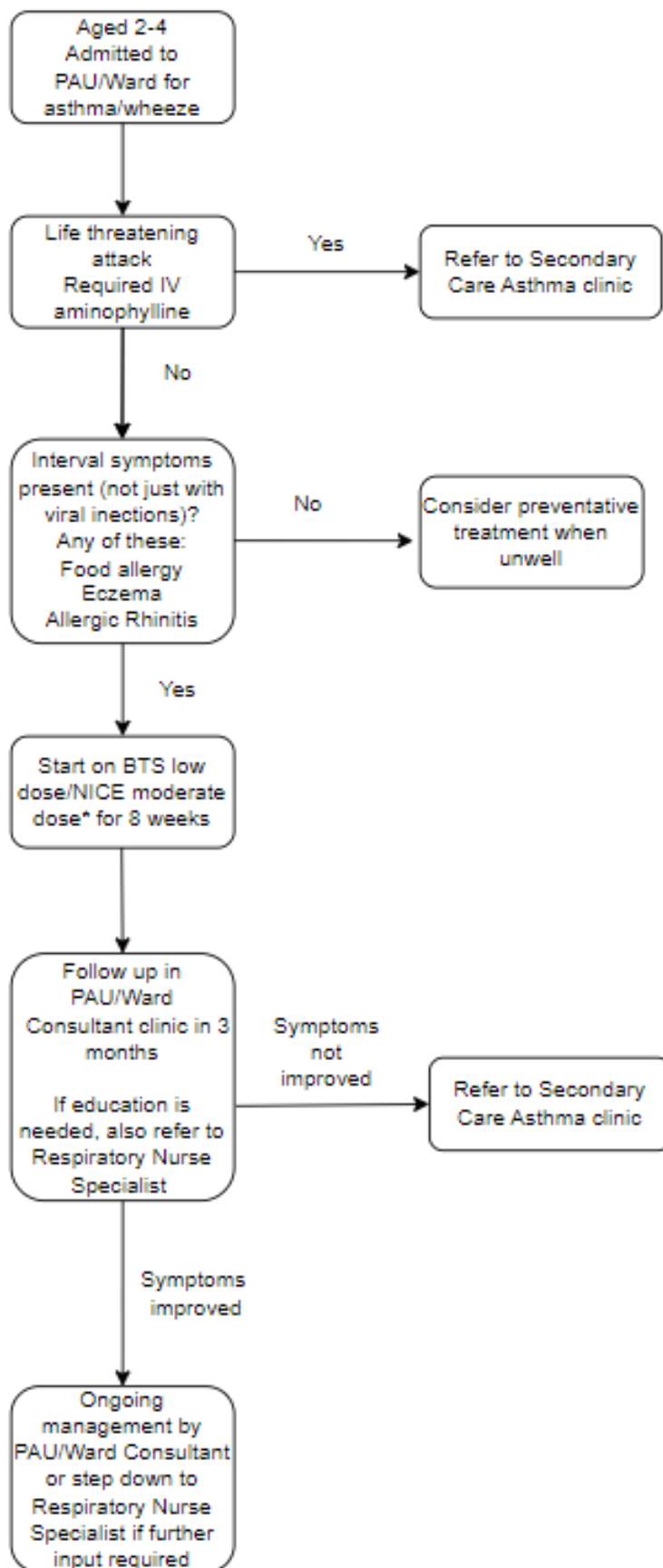
310-250= 60. (310+250)/2= 280

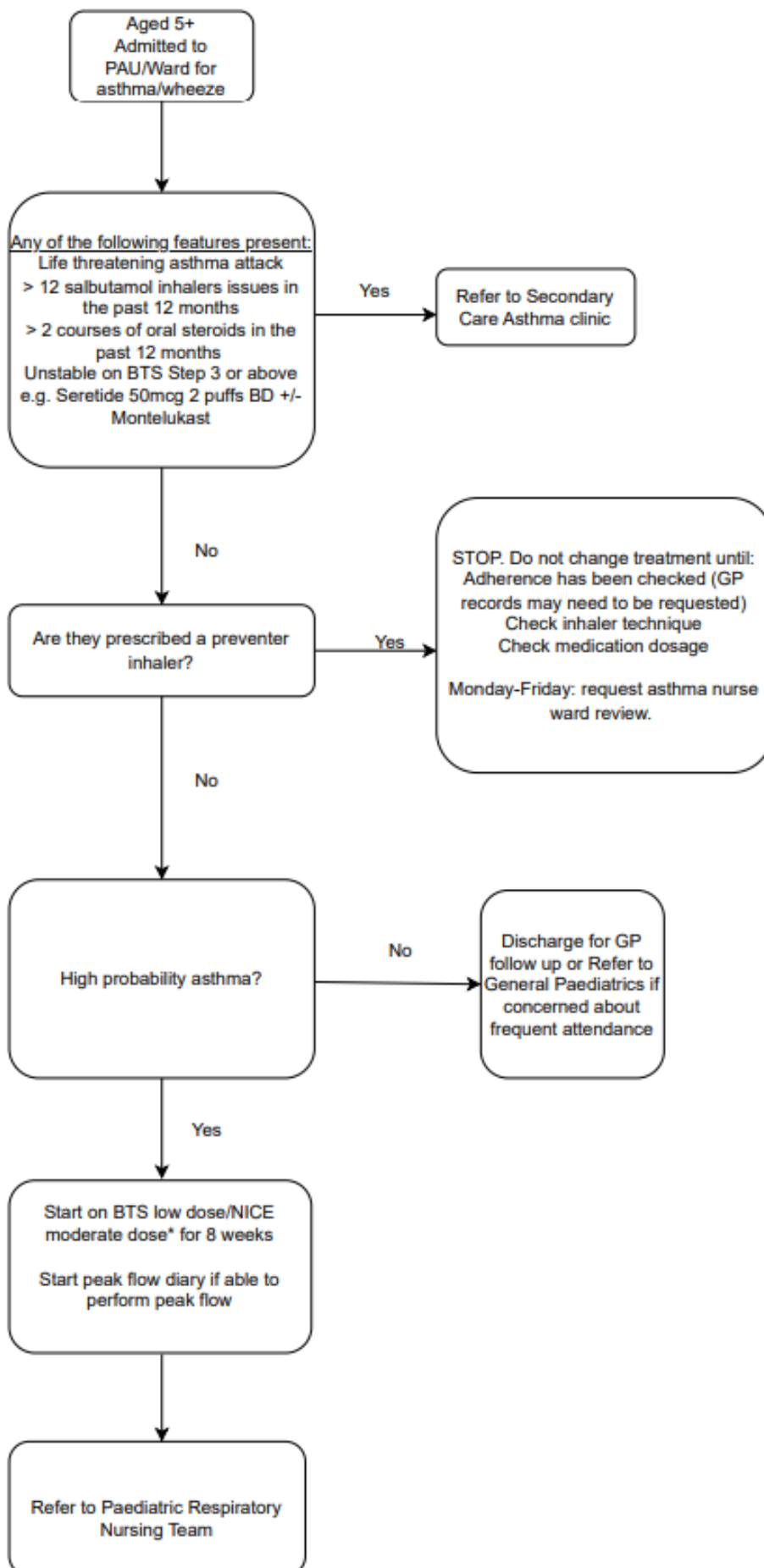
(60/280) *100= 21.4% diurnal variation

Step 2

Calculate the average daily diurnal variation e.g., add all the daily percentages together and divide by the number of days.

Average daily diurnal peak flow variation >13% in children and >10% in adults is considered greater than in healthy people (GINA 2023)

Internal Referral Guidance



References

1. *Oral Prednisolone for preschool children with Acute Virus-induced Wheeze*. Panickar J et al; N Engl J Med 2009; 360:329-338
2. *Leukotriene receptor antagonists as maintenance and intermittent therapy for episodic viral wheeze in children*. Brodlie M et al; Cochrane database Syst Rev, 2015 Oct 19
3. BTS/ SIGN [Guidelines on Management of Asthma](#) (July 2019)
4. Powell C, Kolamunnage-Dona R, Lowe J, Boland A, Petrou S, Doull I, et al. Magnesium sulphate in acute severe asthma in children (MAGNETIC): a randomised, placebo-controlled trial. Lancet 2013;1(4):301-8.
5. Jiske Steensma, Chris Bird. Is oral dexamethasone as good as oral prednisolone for childhood wheeze requiring steroids? Archives of Disease in Childhood Jul 2018, 103 (7) 707-708; DOI: 10.1136/archdischild-2018-315254
6. NICE. NG80 [Asthma: diagnosis, monitoring and chronic asthma management](#). (Dec 2017)
7. Global Initiative for Asthma. [Global Strategy for Asthma Management and Prevention](#). 2023

Full version control record

Version:	3.1
Guidelines Lead(s):	Dr Kian Lee (Paediatric Consultant) Dr Peter Sebire (Paediatric Consultant) Nina Somerville (Lead Paediatric Respiratory Nurse Specialist)
Contributor(s):	
Lead Director / Chief of Service:	Dr Rekha Sanghavi
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Pharmaceutical dosing advice and formulary compliance checked by:	Chido Mukoko, Lead Pharmacist for Women & Children (FPH), 8 July 2024
Key words:	Asthma, wheeze, paediatric, management, discharge

This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	Nov 2019	Dr Kian Lee	Draft	
2.0	Jan 2020	Dr Kian Lee	Final	Approved at Audit & Guidelines Meeting November 2019
2.1	Oct 2023	Dr Kian Lee, Dr Peter Sebire, Nina Somerville	Draft	Scheduled review
3.0	Oct 2023	Dr Kian Lee, Dr Peter Sebire, Nina Somerville	Final	Approved at Paediatric Clinical Governance Meeting October 2023
3.1	July 2024	Dr K Lee, Dr P Sebire, N Somerville, C Mukoko	Interim	Correction to Salbutamol dosage for 1-5 yo patients.

Related Documents

Document Type	Document Name
Guideline	Acute management of viral induced wheeze ages 1-5 Frimley Health NHS Foundation Trust & Oxford Academic Health Science Network

	Local amendments: Dr Fitzsimons (2020), Dr Kian Lee, Dr Peter Sebire & Nina Somerville (2023) Based on guidelines by: Dr McDonald (Bucks Healthcare NHS Trust) Dr Ives (Oxford University Hospitals NHS Trust)
Guideline	Management of acute wheeze/asthma age 5-16 Frimley Health NHS Foundation Trust & Oxford Academic Health Science Network Local amendments: Dr Emma Fitzsimons, Emma Bushell, Dr Kian Lee, Dr Patrick Aldridge (2020). Dr Kian Lee, Dr Peter Sebire & Nina Somerville (2023) Original authors: Dr Charlotte Rampton, Dr Anna Bates, Dr Craig McDonald
Guidance	National bundle of care for children and young people with asthma. NHS England (2022)