

## **BTS Clinical Statement on Occupational Asthma**

### **Appendix 5: Audit: Audit tool for primary care**

The following audit criteria have been developed by the Clinical Statement Group, for use in a primary care, but may also be used in a non-specialist secondary care setting. The possibility of OA should be considered in all individuals of working age with new symptoms suggestive of asthma, reappearance of childhood asthma, deteriorating asthma control, or unexplained airway obstruction. The following should be documented in the healthcare records:

- what sort of work they do;
- if employed, whether symptoms are better on days away from work (e.g., rest days or holidays);
- for patients with either high risk jobs, or symptoms that improve away from work, what actions have been taken to ensure early referral for specialist assessment.

### **Audit tool for occupational asthma specialist services**

Previous OA audit criteria were developed and published for the original Standard of Care in 2008<sup>1</sup> and, based on user feedback, adapted for the 2012 update<sup>2</sup>. A survey of UK specialist centres, carried out in 2018, found consensus agreement that it was important to have nationally agreed audit criteria to assess the quality of care received by patients with OA. Specialists were given the opportunity to agree or disagree with the existing audit criteria (published in 2012), and to suggest improvements. The following audit tool has been produced based on the existing audit criteria, and the results of the survey recommendations.

All patients with suspected OA should, as a minimum, have the following clearly documented in their health records.

By first visit:

- a full list of relevant occupations held, their durations, and likely exposures;
- whether their current job is likely to involve exposure to a known asthmagen;
- presence or absence of asthma prior to entering their current job (or trade);
- presence or absence of work-related respiratory symptoms;
- presence or absence of work-related eye or nasal symptoms;
- duration and latency of any work-related symptoms reported;
- whether their workplace has occupational health provision;
- whether they are under OA health surveillance;
- whether they are aware of other affected workers in the same workplace;
- FEV<sub>1</sub>, FVC, and the degree of airflow limitation, compared to predicted values.

By second visit:

- if performed, the results of serial PEF measurements for at least 3 continuous weeks including rest days, with at least 4 good quality readings per day, analysed to assess work relatedness;
- if performed, the results of other respiratory function tests (e.g. bronchodilator reversibility, FeNO, non-specific bronchial responsiveness);
- if performed, the results of appropriate specific IgE or skin prick tests.

Once a diagnosis of OA has been made:

- letter to patient confirming the diagnosis and (where appropriate) advice regarding likely health outcomes of continued exposure;
- compensation advice (IIDB and civil action) where appropriate to the case.

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### References:

1. Fishwick D, Barber CM, Bradshaw LM, Harris-Roberts J, Francis M, Naylor S, Ayres J, Burge PS, Corne JM, Cullinan P, Frank TL, Hendrick D, Hoyle J, Jaakkola M, Newman-Taylor A, Nicholson P, Niven R, Pickering A, Rawbone R, Stenton C, Warburton CJ, Curran AD; British Thoracic Society Standards of Care Subcommittee Guidelines on Occupational Asthma. Standards of care for occupational asthma. Thorax. 2008 Mar;63(3):240-50
2. Fishwick D, Barber CM, Bradshaw LM, Ayres JG, Barraclough R, Burge S, Corne JM, Cullinan P, Frank TL, Hendrick D, Hoyle J, Curran AD, Niven R, Pickering T, Reid P, Robertson A, Stenton C, Warburton CJ, Nicholson PJ. Standards of care for occupational asthma: an update. Thorax. 2012 Mar;67(3):278-80