**ASSESS SEVERITY AND START BRONCHODILATOR**

- **Mild/Moderate**
  - Can walk and speak whole sentences in one breath
  - Give 4–12 puffs salbutamol (100 microg per actuation) via pMDI plus spacer

- **Severe**
  - Any of: unable to speak in sentences, visibly breathless, increased work of breathing, oxygen saturation 90–94%
  - Salbutamol 12 puffs (100 microg per actuation) via pMDI plus spacer
  - Ipratropium 8 puffs (21 microg/actuation) via pMDI plus spacer
  - OR
  - Use intermittent nebulisation if patient cannot breathe through spacer. Give 5 mg nebulised salbutamol. Add 500 microg ipratropium to nebulised solution.
  - Drive nebuliser with air unless oxygen needed
  - Start oxygen
  - Titrate to target oxygen saturation 93–95%

- **Life-threatening**
  - Any of: drowsy, collapsed, exhausted, cyanotic, poor respiratory effort, oxygen saturation less than 90%
  - Salbutamol 2.5 mg nebulises in continuous nebulisation. Ipratropium 500 microg added to nebulised solution.
  - Start oxygen
  - Titrate to target oxygen saturation of 93–95%

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**REASSESS RESPONSE TO TREATMENT (1 HOUR AFTER STARTING BRONCHODILATOR)**

- **Dyspnoea resolved**
  - Observe for more than 1 hour after dyspnoea resolves
  - POST-ACTUE CARE
    - Ensure person (or carer) is able to monitor and manage asthma at home
    - Provide oral prednisolone for 5–10 days
    - Ensure person has regular inhaled corticosteroid
    - Check and coach in correct inhaler technique
    - Provide spacer if needed
    - Provide interim asthma action plan
    - Advise/arrange follow-up review

- **Symptoms and signs unresolved**
  - Any of: any persisting dyspnoea, inability to lie flat without dyspnoea, FEV1 <60% predicted,
  - Arrang hospital admission
  - Continue bronchodilator and add-on treatment

- **Persisting severe or life-threatening acute asthma**
  - Transfer to higher-level care
  - OR
  - Discuss transfer or retrieval with senior medical staff