

How good are health professionals in determining the level of asthma symptom control? A study to compare symptom assessments by doctors and nurses with patient health status and satisfaction

D Bellamy, S Warlow, G Bellamy, J Pillinger, G Smith, L Clayton, P Thomas

James Fisher Medical Centre, Bournemouth, Dorset

Introduction

There is, at present, no consensus as to the most appropriate questions to ask patients about asthma symptom control. The symptom score validated by Jones¹ is quick and simple, but gives little insight into the way asthma affects health status. In this study, we have attempted to assess the efficacy of a similar symptom-based score.²

Method

One hundred and eighty-two patients were asked to independently complete a validated 20-question health status form, with an added overall appraisal of their impression of asthma control, before seeing a doctor or nurse.

Results

There was a steady rise in total health status scores with increasing asthma severity/BTS step. A comparison was made between the health professional-evaluated symptom score and the health status score. Agreement between the two sets of scores was disappointing with a correlation coefficient of 0.35 (95% CI 0.22–0.47). There was no significant difference between nurse and GP appraisals. ■

Source of funding: Merck, Sharpe and Dohme

References

1. Jones KP, Bain DJG, Middleton M, *et al.* Correlates of asthma morbidity in primary care. *BMJ* 1992;304:361–4
2. Grant P, Neville E, Lord K, *et al.* Development and validation of a questionnaire for the assessment of quality of life in asthma patients. *J Applied Therapeutics* 1996;1:121–36

The impact of respiratory symptoms on primary care workload and prescribing costs in children

JA Cropper, TL Frank, PI Frank, SA Kay, M James¹, P Hannaford²

Wythenshawe Hospital, Manchester; ¹Centre for Health Planning and Management, Keele University, Staffordshire, ²RCGP Centre for Primary Care Research and Epidemiology, University of Aberdeen

Introduction

This study considers the impact of respiratory illness upon healthcare utilisation to provide a framework for predicting demand. The primary care element of the results from a comprehensive set of data is presented here.

Methods

A stratified random sample of 713 children was selected from 2659 respondents to a postal questionnaire survey carried out in two general practice populations in 1993. Children were stratified into four main groups according to the number of positive responses to five key questions. The selection groups were used as an indicator of likelihood of asthma

diagnosis. A search was made of these children's practice records, covering a two-year period which included surgery consultations, home visits (both by doctors and nurses) and prescribed medications.

Results

There was a significant association between the number of positive responses and the main outcome measures (number and cost of prescriptions, number of consultations and home visits). Thus, total annual costs increased from a mean of £10.47 for children with no positive outcomes to £48.08 for those with four or more ($p < 0.001$). Total surgery consultations increased from a mean of 2.45 (no positive responses) to 4.55 (four or more positive responses) per year ($p < 0.001$).

Conclusions

As likelihood of asthma diagnosis increased in this population, more demand was made upon primary care resources for treatment for respiratory illness. The implications of these findings are discussed in terms of predicting demand for asthma care in general practice. ■

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Why don't patients attend the asthma clinic?

K Gruffydd-Jones, I Nicholson, L Best, E Connell
Box Surgery, Box, Wiltshire

Introduction and aims

Structured nurse-run asthma care has been shown to improve patient morbidity. However, many patients do not attend the clinic for such care. The primary aim of this study was to find out why patients do not attend our practice asthma clinic. A secondary aim was to look at the morbidity characteristics of these patients.

Method

Non-attenders were identified from the practice asthma register and a telephone questionnaire was carried out by the practice nurses with these non-attenders (or with the parents of children aged 5–16).

Results

Of 568 asthmatic patients over the age of five years (practice list = 6300), 357 were non-attenders. Of these, 215 (63%) perceived that they no longer had asthma/their asthma was not serious enough to warrant a routine check-up and 106 (30%) saw their own GP instead. Logistic reasons for non-attendance, such as timing of appointments or difficulty with transport, accounted for less than 7% of patients. The major subgroup of patients with a low perception of their asthma severity had significantly less symptomatology, nighttime waking and oral steroid usage than the group as a whole. However, the group of non-attenders who saw their own GP exhibited significantly higher morbidity for the same parameters.

Conclusions

In our asthma-interested practice, there is a high number of asthma clinic non-attenders. The main

reasons for non-attendance are low perception of asthma severity and visits to their own GP instead. The latter group appeared to exhibit a relatively high level of asthma morbidity. Given the proven worth of structured asthma care, practices need to identify such patients and channel them into their structured asthma care system. ■

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Is it possible to write a research protocol in 10 hours?

A Sheikh, ML Levy¹

Department of General Practice, Imperial College School of Medicine, London; ¹The Kenton Bridge Medical Centre, Harrow

Aims

To produce three asthma-related protocols within 10 hours while simultaneously enhancing the research protocol writing skills of participants.

Background

The research capacity within primary care could be improved through the identification of novel strategies. The General Practitioners In Asthma Group (GPIAG), which has an interest in improving patient care and research into respiratory medicine, held a research protocol workshop in London in December 1998.

Methods

All 34 participants were allocated to one of three groups led by a team of experienced researchers. The groups selected one of two possible questions determined through a pre-workshop consultative process between members of the GPIAG. They were then required to devise a complete research protocol during the workshop.

Outcomes

Participants completed an anonymous semistructured questionnaire immediately before and after the workshop, documenting their research protocol writing skills (six-point Likert scale). Paired responses were compared using the Wilcoxon test.

Results

Each group successfully completed a draft research protocol, and a study group from within each was identified to complete the protocol and bid for monies to fund the projects. Thirty participants (88%) completed both the pre- and post-workshop questionnaires. Participants believed there were improvements in their ability to: formulate an answerable research question ($p < 0.01$); choose an appropriate methodology to answer the question ($p < 0.01$); choose appropriate outcome measures ($p = 0.03$); choose appropriate statistical methods ($p = 0.01$); devise a research timeline ($p < 0.01$); and overall ability to write a research protocol ($p < 0.01$).

Conclusions

It is possible to write a research protocol within 10 hours while simultaneously increasing the research

writing skills of participants. ■

Source of funding: Astra Pharmaceuticals (accommodation and venue)

Emergency prehospital care in London: How well does the ambulance service treat acute asthma patients?

H Snooks, C Hartley-Sharpe, H Booth, M Rudolf
Clinical Audit Research Unit, London Ambulance Service, London

Introduction

Little is known of the quality of care given to acute asthma patients by emergency ambulance crews, although prehospital administration of nebulised salbutamol has become commonplace.

Rationale for study

This asthma audit was carried out to measure accuracy of diagnosis, adherence to treatment protocol and benefit to patients. A multidisciplinary advisory group was set up, including representatives from an ambulance service, accident and emergency (A&E) department, primary care and a patient group.

Methods

A retrospective audit included patients who had had a discharge diagnosis of asthma or had been administered salbutamol by London Ambulance Service crews in the catchment areas of four London hospitals between January and March 1995. A&E and prehospital documentation was collected for each case; data were analysed using SPSS. Qualitative interviews were also carried out with patients.

Results

A literature review highlighted discrepancies between national guidelines and local treatment protocols. Of 189 patients diagnosed with asthma in A&E, 100 (58%) were administered salbutamol by the attending ambulance crew; of the others, 36 fell outside treatment protocols and 16 were not recognised as suffering from asthma. Only 15 patients administered salbutamol by the crew were diagnosed with complaints other than asthma. Drug administration protocols were followed in 97% of cases. Observations documented 46% PEF, 52% RR, and 72% PR. Due to missing readings, changes in patient condition were difficult to assess; however, the mean change in PEF between initial readings and A&E was +39.61/min. Patients interviewed were full of praise for their ambulance crews.

Conclusions

Quality of care was good with protocol adherence and high patient satisfaction. However, lack of observations and narrow protocols restricted treatment. Patient report forms, treatment protocols and training programmes have been revised as a result of this audit and a reaudit is now underway to measure their effects on patient care. ■