Setting Up a Nurse-run Asthma Clinic

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Many GPs believe the recent health reforms place too much emphasis on 'preventive' measures where they are not really warranted. However, few would deny the real value of enhanced preventive care for asthma sufferers, or the importance of the practice nurse role therein. Here, a former GP trainee gives his views on the advantages and problems of running a practice asthma clinic.

As a trainee in a 10-doctor urban practice, I noticed the erratic nature of consultation for asthma: the fact that patients would attend for episodes with no clear programme of prevention in between and the fact that they seemed to be satisfied with suboptimal health. The health centre already had an excellent treatment room setup and miniclinics for hypertension and diabetes already existed, using the model of screening and shared care between the nurse and individual GPs, but not so for asthma.

Yet asthma is an illness which lends itself to prevention rather than treatment. I believed that patients could do a lot to help themselves if they understood their condition, and knew that there was a possibility of undiagnosed mild asthma in the practice population. I therefore decided to set up an asthma clinic within the practice.

Improvement in inhaler care is one of the major advantages of the asthma clinic.

Background

While conventional medical textbooks are not very helpful, other sources of valuable information on management of asthma in general practice are available.[1–3] Attending several meetings of the local branch of the Asthma Society gave me an insight into what patients felt about their treatment.

The final stage was to look at how other people ran asthma services. With our enthusiastic practice nurse, I visited Ian Gregg's asthma clinic in Aldermoor Health Centre, Southampton (a doctor-run clinic) and also the Bridge House Medical Centre in Stratford-upon-Avon run by Greta Barnes — the original model for nurse-run asthma clinics.

We decided on a nurse-run clinic, largely because this was how previous clinics in the practice were set up. A number of GPs with different ideas about management would not have lent itself to a single policy, as had been found when setting up the hypertension and diabetic clinics. Instead, the asthma clinic would be a resource available to the GPs in the practice. Besides, it was felt that patients should be able to refer themselves for educational and screening purposes, and that a nurse-run clinic would be more conducive to this.

Setting up the clinic

The first stage was to present specific written proposals to the practice, for discussion at a practice meeting. The proposals were threefold:

- to set up the clinic for the reasons outlined above
- to use the clinic to put asthmatics on the age–sex register
- to hold a clinical meeting to review current treatment of asthma and the functioning of the clinic once it had been up and running for three months.

The practice having endorsed the plan, the asthma clinic was duly set up. Bridge House Medical Centre kindly gave us permission to use their

A wide range of patient information leaflets is available.

history cards which we purchased with funds from a drug company. Peak flow meters were bought with the aid of a grant from *Punch* magazine, and some purchased for sale directly to patients. The practice agreed to fund the nurse's time and drug companies provided demonstration equipment freely.

The clinic was to open for one afternoon a week using a spare consulting room; the first visit would take 20 min and subsequent visits 10 min. The clinic was initially run by myself with the practice nurse observing, but gradually she took over the running of the clinic while I observed.

There were two principal methods of referral to the clinic. First, doctors could refer patients either for a full 'work-up' or for education on, for example, how to use inhalation devices, or for some form of assessment such as peak flow monitoring. Second, patients could refer themselves for an assessment: both known asthmatics and those who suspected they might have asthma. However, people with acute attacks were not seen in the clinic but had to see their GP in the usual way.

The form of the clinic was based on the history card from Bridge House Medical Centre.[4] This asked about current symptoms, asthmatic history, provoking factors, height, weight, smoking habits and educational level, and included a measurement of BP and peak flow reading. The patient's educational level was assessed and gaps in their knowledge were filled in. They were also given a copy of a booklet produced by one of the drug companies and a full assessment. Where appropriate, patients would be asked to record their peak flow and symptoms twice a day on a special chart, usually for two to four weeks. They would then be followed up or referred to their GP as appropriate.

Subsequent modifications

Shortly after the clinic began it became clear that one of its main functions had become the recognition of suboptimally treated mild/chronic asthma, and the clinic doctor was able to prescribe inhaled steroids or sodium cromoglycate to treat this. When the nurse took over the running of the clinic she was able to consult one of the partners for this purpose, asking them to endorse the decision and sign a prescription for the medication required.

Later the clinic underwent two significant changes. First, it was held in the treatment room and, second, it was made available every day of the week. Thus it became a service offered by the nurse in the treatment room. This also meant that it was possible to teach the appropriate skills to other members of the nursing staff.

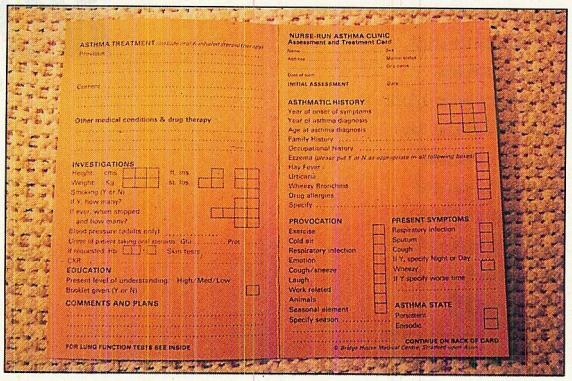
Audit of care

It is vital to establish whether factors such as the number of acute attacks, the number of night calls required for asthma-related emergencies and the number of days off sick from school and work are reduced by an asthma clinic.[5] It would also be very interesting to know whether there was any reduction in the time from onset of the first symptom to diagnosis. (One study has suggested that up to 48 consultations can be required before a diagnosis is made.[6])

As yet no formal studies have been done on the efficacy of our clinic, although much work has been done on the original model in Stratford-upon-Avon. Judging by the level of use, however, it did seem to be fulfilling a very important role, especially in education and assessment — both time-consuming areas for the busy GP. Certainly it was felt that holding the clinic daily was useful as the number of patients attending increased, from around five to about 20 per week.

It was also found that prolonged follow-up was unnecessary, most patients acquiring the skills necessary to continue on their own within six months. In many cases this included buying their

The Bridge House Medical Centre asthma card.



own peak flow meter, to use when they suspected their asthma was getting worse.

A considerable number of our patients were children, most with a parent involved in the supervision or administration of treatment and monitoring. There was almost universal appreciation of this usually new level of control over their child's illness.

Problems

The biggest initial problem was getting the doctors in the practice to use the clinic. Although self-referral was allowed, the clinic only started being used fully when doctors referred patients. However, these two functions were interdependent, as patients who referred themselves were sent on to GPs, who then began to realize the value of the screening function of the clinic. As time went on the number of self-referrals decreased. Without further research it would be difficult to know whether or not this was due to the success of the clinic.

Difficulties experienced at the clinic included teaching younger patients how to use their inhalation devices. In older patients the main problem was one of compliance, the predominant attitude being that they had 'managed so far' and they did not see why they should use 'new-fangled' techniques in order to improve their health!

Recommendations

From my experience, the most important element in setting up a clinic is the enthusiasm of a key person. It is also important to assess the overall enthusiasm in the practice: if the GPs are not going to be willing to use the service its chances of success will be low. The overall attitude of the practice to clinics needs to be looked at; for example, how have other clinics fared in the past? If enthusiasm is lacking a clinical meeting on recent advances in asthma, perhaps inviting a speaker who espouses similar views to your own, might help to stimulate some interest.

'Pros and cons' of a nurse-run clinic

The main advantages in the nurse running the clinic appear to be:

- that he or she probably has more time to spare than the doctors
- many patients feel the atmosphere in the treatment room is less threatening than that of the doctor's surgery
- the nurse is able to offer an approach unbiased by individual doctors' management methods.

The clinic can be set up so that the level of autonomy granted to the nurse matches the requirements, not only of the practice as a whole, but of any individual GPs. For example, one GP in a practice may be happy for the nurse to do a full 'work-up' and refer only problem cases, whereas another may be unhappy with this approach and may prefer the nurse simply to carry out educational functions or monitoring.

Obviously a nurse is unable to prescribe without consultation with the GP, but this need not be a major practical problem. There is a theoretical possibility of not detecting other respiratory illness in a self-referring patient but, again, this is not a practical problem since a patient found not to have evidence of asthma on screening but still having a respiratory problem would be referred to his or her GP.

DO WE NEED YET ANOTHER CLINIC?

The tendency towards the establishment of 'miniclinics' in general practice is well known, and it has been seized upon as a 'good thing' by the government in its current health reforms. But some doctors have argued that hiving off separate disease entities into 'mini-outpatients in the surgery' detracts from the doctor–patient relationship and the management of the individual as a whole person. However, while many clinic activities could equally well be carried out in the GP's surgery, the relative lack of time or commitment needed makes nurse-run clinics seem like a useful option. In fact, in our practice not only was a clinic set up, but this led to a clinical meeting to refresh the practice's knowledge about recent advances in the treatment of asthma, and my interest in the subject prompted a trainer–trainee group meeting in which we discussed the ways in which asthma was treated in different practices.

I believe that the balance achieved between the GP's autonomy and the nurse's educational, screening and monitoring role worked well for our practice and enhanced, rather than detracted from, the doctor–patient relationship. It also fitted in well with the diabetes and hypertension clinics run along these lines, which were the only other 'illness' clinics within the practice.

Whether or not one should add to this complement by having various 'well person' clinics is perhaps a more moot point.

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