



Identifying barriers and facilitators to improving prehospital care of asthma: views of ambulance clinicians

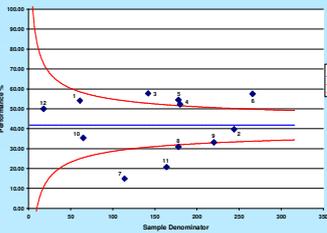
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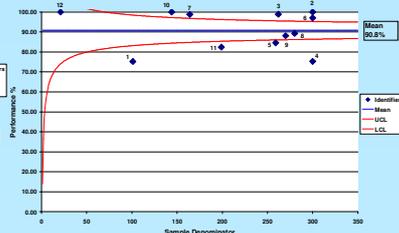
Background

- 2008/09 there were nearly 80,000 emergency hospital admissions for asthma.¹
- Current UK guidelines emphasise the importance of evidence-based prehospital assessment and treatment of asthma for improving patient outcomes and reducing hospitalisation, morbidity and mortality.²
- National benchmarking of ambulance clinical performance indicators for asthma have revealed important unexplained variations in care across ambulance services.³
- Little research has been undertaken to understand the reasons for poor levels of care.

National Ambulance Asthma CPI March 2010
Peak flow recorded (before treatment) by Trust



National Ambulance Asthma CPI March 2010
SpO2 recorded (before treatment) by Trust



Objective

- To gather data on ambulance clinicians' perceptions and beliefs around prevailing and best practice for management of asthma.
- To identify the factors which prevent or enable better asthma care in ambulance services.

Methods

- We used a phenomenological qualitative approach, which addresses how individuals use their experiences to make sense of their world, focusing on participants' experiences of care delivery for asthma.
- We used two focus groups of 5 to 8 ambulance clinicians to gather data on barriers and facilitators to better asthma care.
- Recordings and notes were taken, transcribed and then analysed using QSR NVivo 8.
- A coding framework was developed based on a priori concepts but with emergent themes added during the analysis.

Results

- A number of preliminary themes and sub-themes were identified.
- The study identified issues relating to clarity of ambulance guidelines, conflicts between training and guidance, misconceptions about the importance of objective assessment and over reliance on non-objective assessment.
- Some practitioners believed hospital staff were not interested in prehospital peak flow assessment

Relevance, appropriateness and clarity of ambulance guidelines

'...they are guidelines, they are not specific set down protocols, we have to be aware they are there for us as guidelines.'

The guidelines seem to be more set for hospitals than anything else. And being out on the road ... we haven't got 6 people to go round grabbing pieces of kit to help us out...'

I think the algorithms where you've got the box and then an arrow down to the next thing, then answer "yes" or "no", and then the line drops to the next bit. Where it's easy and quick to follow rather than a load of text that you have to read through ...'

Prioritising treatment over assessment

'For those of us that understand [peak flow] is the most important reading the respiratory unit require and yet the majority of staff don't do it.'

'Also, if we're honest all clinicians want to crack on with the treatment and see that [peak flow] as a pointless numbers exercise rightly or wrongly. ... I'm not saying this is what we do but I'm saying this is what crews will do.'

'... a lot of them won't do a pre but I always do a post. Sometimes you can do it and sometimes you can't but generally I do because that's another reason why you would leave them at home because if their peak flow come back at 150 you would be dubious to leave somebody at home in case they deteriorated further.'

'You know fine well they're not going to have a very good peak flow if they're not putting a sentence together.'

'What do you think the expectations of the patient are?'
'Treat me now.' 'Yes. I can't breathe do something now.'

Lack of feedback from hospital staff

'I've never had a doctor ask for a peak flow.'

'...we usually do a pre-alert so you usually have a doctor standing by to take over straight away. But no they very rarely ask [for a Peak Flow].'

Conflict between training, ethics and guidance

'With these it always starts with airway, breathing and circulation. They always say if you can't get past the first couple you treat those first couple. So the rest of the guidelines basically go out of the window...'

'...if we do the peak flow prior to...we are withholding treatment really so that isn't really a priority for us. It's the airway and breathing that is.'

'We don't do because the patient physically hasn't got time, because they are getting very exhausted. If they get too exhausted sometimes it's game over.'

Conclusion

- Our findings will inform improved systems of care for asthma
- The effect on indicators will be measured using time series methods.
- This approach could be used more widely to improve management of specific clinical conditions where quality of care is demonstrated to be suboptimal.

References

1. Asthma UK: http://www.asthma.org.uk/news_media/media_resources/index.html accessed 29 August 2010
2. British Thoracic Society, Scottish Intercollegiate Guidelines Network, British Guideline on the Management of Asthma, A National Clinical Guideline. London: British Thoracic Society, 2009. <http://www.brit-thoracic.org.uk/Portals/0/Clinical%20Information/Asthma/Guidelines/sign101%20revised%20June%2009.pdf> Accessed 30 August 2010
3. Siriwardena AN, Shaw D, Donohoe R, Black S, et al. Development and pilot of clinical performance indicators for English ambulance services. Emerg Med J 2010;27: 327-331.