LETTERS

Patients' awareness of streptokinase treatment after thrombolysis for acute myocardial infarction

Streptokinase, a bacterial enzyme, is the most commonly used thrombolytic agent in the United Kingdom. It is highly antigenic, and current recommendations, based on studies of antibody titres after streptokinase treatment^{1,2} are that it should not be reused within one year. A substantial minority of patients receiving thrombolysis for myocardial infarction will have a further coronary event within one year,³ and as thrombolysis is usually carried out urgently effective patient education about the need to avoid inappropriate reuse of streptokinase is important.

We conducted an audit on the efficacy of patient education in this hospital. Twenty patients given streptokinase for myocardial infarction were contacted at home by telephone within a week of discharge and questioned about their recent admission (group A, table). Although all had been counselled and given a streptokinase alert card in the casualty department, only one still possessed the card after discharge and no patient was aware that he or she had been given a drug that should not be reused in the following year. Three patients were not aware that they had had an infarct.

In response to these poor results we introduced a leaflet containing information about the dangers of reuse of streptokinase, emphasising that alternative agents likely to be more effective are available if required. The leaflet also contained a description of the "clot dissolving" mechanism of action, which seemed from our earlier audit to be the most memorable aspect to patients. The leaflets were initially intended for use by the junior medical staff, but combined audit showed that this was not sufficiently reliable and that patients were still leaving

the hospital without a satisfactory level of awareness (data not shown). Involvement of the ward pharmacy staff, who agreed to distribute and explain the leaflets and alert cards to all relevant patients, resulted in an appreciable improvement in patient awareness and possession of an alert card (group B, table).

These results indicate that patient education about streptokinase cannot be assumed to be effective without monitoring. The use of leaflets may help to increase patients' retention of information, as has been shown in other settings.⁴ Our results also suggest that pharmacy staff are a more appropriate source of information than medical staff, and they should become more involved in this important aspect of drug safety in other hospitals.

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- 1 Jalil S, Morris GK. Antistreptokinase titres after intravenous streptokinase. *Lancet* 1990;335:184-5.
- 2 Lynch M, Littler WA, Pentecost BL, Stockley RA. Immunoglobulin response to intravenous streptokinase in acute myocardial infarction. *Br Heart J* 1991;66:139-42.
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- 4 Dodds LJ. Effect of information leaflets on compliance with antibiotic therapy. *Pharmaceutical J* 1986;236:48-50.

Advanced cancer: aiming for the best in care

Irene Higginson¹ should add another item to her list of standards, audits, and checklists for care of patients with advanced cancer. The Association of Chartered Physiotherapists in Oncology and Palliative Care has also produced guidelines for good practice.² They cover communication and team work, knowledge and skills, assessment and goal setting, documentation, environment, occupational stress, patients with AIDS, and patients with motor neurone disease, and they cross refer to the Chartered Society of Physiotherapy's standards of physiotherapy practice³ and rules of professional conduct.

The role of physiotherapy is developing for patients requiring palliative care. Physiotherapy helps to restore function with exercise programmes, gait re-education, assessment for and provision of walking aids, and assessment for and instruction in the use of wheelchairs. It helps patients with transient peripheral neuropathies with re-education of balance and muscle action and advice on drop foot splints. Chest physiotherapy may be required to treat acute infection or to make patients more comfortable in the terminal stages of their disease. Massage, transcutaneous nerve stimulation, acupuncture, hot and cold therapy, and

relaxation can be used for palliation of pain. Lymphoedema can be treated with compression bandaging, massage, skin care advice, exercises and compression therapy. Physiotherapists can offer advice to carers and health care professionals on the best method of lifting and transferring a patient. Recognition of this role is increasing, and hospices are now seeking to employ physiotherapists, whom they should ensure are "chartered," as the title is not yet protected.

When aiming for the best in care a truly multidisciplinary input must be outlined clearly. There are set standards in many clinical areas of physiotherapy. Physiotherapists are contributing equally in aiming for the best in care.

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- 1 Higginson I. Advanced cancer: aiming for the best in care. *Quality in Health Care* 1993;2:112-6.
- 2 Association of Chartered Physiotherapists in Oncology and Palliative Care. *Physiotherapy in Oncology and Palliative Care Guidelines for Good Practice*. London: ACPOPC, 1993.
- 3 Chartered Society of Physiotherapy. *Standards of physiotherapy practice*. 2nd ed. London: CSP, 1993.

BOOK REVIEWS

Obtaining the Views of Users of Primary and Community Health Care Services. McIver S. (102 pp; £9.50). London: King's Fund Centre, 1993. ISBN 1-85717-056-6.

Shirley McIver's overview of the research on obtaining users' views and preferences in their dealings with the primary and community health care services will come as a godsend to anyone who has newly had this responsibility thrust upon them and would like to avoid reinventing the wheel. Would be readers that spring to mind include family health services authority staff in their new, more managerial role; health and local authority purchasers, who cannot do their job properly without obtaining information about the health needs and priorities of local people; and frontline staff across the range of nursing, professions allied to medicine, and staff in residential and community care.

Having learnt about the difficulties of obtaining reliable patient feedback the hard way over the past 10 years (during which the College of Health has developed a range of techniques we call "consumer audit"), I would greatly have appreciated such a concise manual of practical guidelines, avoidable pitfalls, and examples of good practice back in 1983 when the notion of asking patients how they perceived services was still novel, even within the acute sector. The "useful address" and reference sections alone would save anyone new to the subject hours of desk research.

Patients' recall of information about streptokinase and possession of an alert card before and after distribution of an explanatory leaflet. Figures are numbers of patients

No of patients	Before distribution (group A)	After distribution (group B)
Total	20	20
With understanding of diagnosis	17	19
Given an alert card	1	19*
Knew interval for reuse	1	14†
Knew dangers of reuse	0	16‡
Knew mechanism of action	6	14§

* $\chi^2 = 28.9$; $p < 0.01$

† $\chi^2 = 15.4$; $p < 0.01$

‡ $\chi^2 = 23.4$; $p < 0.01$

§ $\chi^2 = 4.9$; $p < 0.05$

(χ^2 values obtained by comparing the numbers of correct and incorrect replies in the two groups of patients for each point).

Such a reader will quickly appreciate a too-unhealthy reliance on the "tick box" type of questionnaire which reflects the mindset of those providing a service rather than that of those at the receiving end. This too often ignores two factors that bedevil virtually any attempt to find out what people really think about caring services. Firstly, there is the gratitude factor. People who think they are lucky to be getting a service at all or who perceive the caring staff as being overworked and underpaid, are often very reluctant to voice concerns they see as being beyond the control of the staff who look after them from day to day. Then there is the vulnerability factor. This comes out most clearly in the section devoted to the community health services. Users who are totally dependent on these for their continuing care and wellbeing, especially those in residential care, may be afraid to be critical.

The section on community care is particularly useful in that it goes beyond the practicalities of how to elicit users' and carers' views, and addresses the most effective ways of ensuring that they are actually involved in planning and evaluating future delivery of services.

Beginners start here, and I promise your learning curve will be reduced!

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An Analysis of Instruments and Tools used in Psychiatric Nursing Audit. Bond S, Balogh R, Simpson A, Quinn H, Dunn J, Wilkinson A, *et al.* (28 pp, £5). Newcastle upon Tyne: Centre for Health Services Research, 1993. ISBN 1-870399-56-0.

Despite the title this is not a report of great depth. Rather it is a "Cook's tour" of six (there are at least ten) audit systems used to appraise the quality of care in mental health. Four of the systems analysed are targeted at nursing, with the remaining two having a multidisciplinary focus. In the main the report consists of tables where each of the six systems are examined against a range of evaluative criteria. These include for each tool details of psychometric qualities, spheres of application, training requirements, data collection procedures, data sources, presentation of results, ownership of results, and how results are to be implemented.

At £5, the report may seem inexpensive, but with twenty eight pages (which I read in fifteen minutes) it is by no means a bulky tome. Furthermore, it does not provide an in depth exploration or discussion of each audit system nor does it inform readers which system is best for their care setting. In fact a caveat is inserted in the introduction explaining how, in the authors' opinion, it is the local circumstances that influence the adoption of an audit as much as the system itself.

After reading the body of the report I was looking forward to a concluding section of discursive text where the authors would pull together (and perhaps analyse!) the wide variations that exist between these audit systems. There isn't one; the report ends abruptly, and one is left with the impression that this analysis

was undertaken as an organisational checklist for a research literature review. However this does not mean that it is not a useful resource for those interested in audit. It does provide evaluative criteria which can usefully be applied to any audit tool. It also presents the beginnings of a conceptual framework which should support further discussions on audit.

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Change and Teamwork in Primary Care. Pringle M. (120 pp, £7.95). London: BMJ Publishing Group, 1993. ISBN 07279-0779-4.

General practice is now in a "managed health service." The changes in private industry are now being applied to public utilities like the NHS, and especially general practice. *Change and Teamwork in Primary Care* is a timely appraisal of the environment; it informs readers of the state of practice teams, where they have come from and where they may wish to go, but it does not guide them how they might get there. A valuable review of the current situation, it also flags up important issues. Its style is consistent and should be acceptable to members of the primary care team, which is a refocused group and an area of renewed interest for primary care managers; for both parties this book is essential background reading.

The book has two parts: managing change in general practice and partners in practice; the chapters have a user friendly format, aided by powerful drawings and clear summary boxes. Undoubtedly, people are a valuable resource, and the key message is that they and their skills be valued, but to deliver primary care in the future the competencies and training of general practitioners will also need to be reviewed. More could have been said in learning from the past about the individual in change, and how people may sometimes respond to change by elation followed by denial, burnout or by rationalisation and acceptance. There is a need for empathy with colleagues, to "walk in their shoes," as they will naturally ask what is in it for them and if the change is threatening will wish to maintain the status quo. In the chapter "strategies for success" I was hoping to read about a business plan and appraisal of strengths, weaknesses, opportunities, threats in general practice. Similarly, mapping the environment and reflecting on the external and internal environment was not mentioned. The key question is "What business are we in?"

Most people are clear on the need for change, and it was pleasing that leadership received due attention, with the visions of strong leaders such as Sir John Harvey-Jones documented. Visions, goals, and objectives are important targets. General practitioners should dream and share those dreams with their primary care teams. Little was said about education; hospitals and managers in the NHS have done better since 1985, with the NHS training agency, but we need better management, better health in primary care initiatives too.

The development of primary health care teams is well recorded. The work of the practice nurse is explained, but what about understanding the work of other primary care team members? If staff are properly trained and empowered there is a risk they may leave because of the limited ability in the NHS for financial reward. Recruitment and retention of key staff is therefore very important. Educational needs are important, but is there a robust method of identifying them and, more importantly, how are resources freed to meet them and from whom? Quality was mentioned throughout the book; why not involve some patients as non-executive members of the primary care team to ensure that the people who really matter are not forgotten?

For some people much in this book will be new. For others it may be a refresher, but they may be disappointed that the book does not go far enough. I believe the authors do not want to be prescriptive. That is good as it permits further ideas and thoughts. It's up to primary health care teams to find ways of making them a reality.

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Communication Audit Tools. Ambulatory Care Programme, Centre for Health Services Research. (74 pp, £12.00). Newcastle upon Tyne: Centre for Health Services Research. ISBN 1-870399-53-6.

An audit likely to yield useful results commonly develops from recognition of a problem in clinical practice. However, between that recognition and the final outline of an audit plan lies a vast amount of work including literature searches, consultation, negotiation, and consensus development about the exact nature of the problem, the data needed, and how the audit might be done.

Communication Audit Tools is a specific compilation of information and resources for audit of communications between hospital and general practice. A brief literature review and useful bibliography is followed by an overview of current interface audit activity, based on a survey of medical audit committees and medical audit advisory groups in Northern region, which may provide new ideas. On the basis of previous (referenced) work, the authors describe an audit tool which they have used to audit GP referral letters and consultants' replies. The method is described in detail for the administrative details (such as names, dates, and postcodes), which are obviously easier to score as present/absent, but the same methodology is also applied to the clinical content. Without actually piloting the tool it is difficult to know whether the clinical details can be so reliably scored in the same way, but the method seems simple, logical, and adaptable. The final section describes an (unreferenced) questionnaire which the authors have used to facilitate discussion between hospital staff and general practitioners about possible differences in their expectations. As part of that process it is likely to provide useful material, although it is not intended as an end in itself.