Minimum data set necessary to promote the care of the elderly in general practice

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SUMMARY. A preliminary data set was designed to allow uniform information collection, to initiate structured intervention and thereby to promote anticipatory care of the elderly. A questionnaire inviting comment on the data set was sent to 116 general practitioners in training practices and 40 consultants in geriatric medicine in the northern region and also to the 18 professors in general practice in the United Kingdom. The response rates from the three groups were 76%, 55% and 67% respectively.

There was good agreement between the three groups regarding the content of the data set suggesting that it may be possible to introduce uniform information collection which in turn would standardize records of the elderly and aid computerization.

The need for periodic screening of the elderly was considered necessary by 37% of general practitioners, 59% of consultants and 33% of professors. The cause of such low interest in screening and its effect on computerized care and surveillance of the elderly are discussed.

Introduction

THE care given to old people in the community is unstructured and crisis oriented,[1] and such demand-based service is considered to be unsatisfactory and ineffective.[2] In order to promote anticipatory care and to permit appropriate intervention several different information gathering systems have been proposed[3-7] but they have proved difficult to implement on a wide scale.

In the light of the Korner report[8] and reports of inadequacies in the information about patients collected in hospitals[9] and in general practice[10,11] in the United Kingdom an attempt has been made to define a commonly acceptable minimum data set to assist in planning services for the elderly in general practice. All the general practitioners in training practices and the consultant physicians in geriatric medicine in the northern region were invited to comment on a proposed minimum data set for older people in the community. The questionnaire was also sent to all professors of general practice in the United Kindgom for their comments.

Method

A preliminary data set was designed to include those items of information required by the primary health care team to identify vulnerable elderly people in the community. The information included in the data set was designed to minimize unnecessary duplication of activities and to promote sharing of information among the team. The information was initially grouped in two categories, similar to those described in the Korner minimum data set:[8] (1) basic information in general practice records; (2) data to be specially collected. However, data available in the general practice records are neither satisfactory nor standardized.[10,11] The data available in the patient records were therefore divided into two further groups giving three groups: (1) general patient information from the records; (2) clinical information from the records or to be collected; (3) additional information to be specially collected.

A questionnaire asking for comments on the data set was then sent to 116 general practitioners in training practices and 40 consultants in geriatric medicine in the northern region and also to the 18 professors of general practice in the United Kingdom. The questionnaire also asked about the need for periodic screening of the elderly.

Results

Eighty-eight general practitioners (76%), 22 consultants (55%) and 12 professors (67%) responded to the questionnaire. Details of their comments on the three sections of the data set are given in Tables 1–3. All three groups of respondents found the data set acceptable and they agreed on the content of the information. Table 4 gives their opinions on the need for periodic screening of the elderly. Only 37% of general practitioners and 33% of professors were in favour of screening compared with 59% of consultants.

Table 1. Number of respondents who regarded patient information as necessary for the care of elderly patients.

	Number (%) of respondents		
	Professors ($n=12$)	Consultants ($n=22$)	General Practitioners ($n=88$)
Name	12 *(100)*	22 *(100)*	88 *(100)*
Date of birth	12 *(100)*	22 *(100)*	88 *(100)*
Sex	12 *(100)*	22 *(100)*	88 *(100)*
Occupation	8 *(67)*	21 *(95)*	85 *(97)*
Marital status	12 *(100)*	22 *(100)*	88 *(100)*
Address	12 *(100)*	22 *(100)*	88 *(100)*
Other occupants of home	12 *(100)*	22 *(100)*	88 *(100)*
Key support	12 *(100)*	22 *(100)*	88 *(100)*
Next of kin	11 *(92)*	22 *(100)*	82 *(93)*
Attends hospital, day centre, lunch club, and so on	12 *(100)*	22 *(100)*	84 *(95)*
Receives home help, meals on wheels, and so on	12 *(100)*	22 *(100)*	83 *(94)*
Visited by bath attendant, nurse, health visitor	11 *(92)*	22 *(100)*	83 *(94)*
Admitted to hospital in past year	10 *(83)*	22 *(100)*	69 *(78)*
Additional information suggested	Shopping and housing arrangements	Telephone number	Heating arrangements

n = total number of respondents.

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Table 2. Number of respondents who regarded clinical information as necessary for the care of elderly patients.

	Number (%) of respondents		
	Professors (*n* = 12)	Consultants (*n* = 22)	General practitioners (*n* = 88)
Medical problems	12 *(100)*	22 *(100)*	84 *(95)*
Medical treatment	12 *(100)*	22 *(100)*	84 *(95)*
Risk factors	11 *(92)*	22 *(100)*	83 *(94)*
Medical follow up	11 *(92)*	22 *(100)*	82 *(93)*
Social follow up	11 *(92)*	22 *(100)*	78 *(89)*
Additional information suggested	Drug allergy and sensitivity		

n = total number of respondents.

Discussion

The response from participating clinicians in this study was comparable to other postal studies[12,13] and sufficient to obtain a consensus of the information needed to promote anticipatory care of the elderly in general practice. The numbers of consultants and professors participating in the study were too small for statistical analysis of the differences in their opinions.

The data set was found to be acceptable to the participating general practitioners, consultants and professors and the three groups appeared to agree about the content of the information. It would therefore be possible to design a standardized information collection system which would ensure uniformity in recorded information and would also aid computerization of the information to assist in the surveillance of vulnerable elderly patients in the community.

The whole of the primary care team should be involved in the collection of the information described here and should share the information. The details listed in Table 1 could be obtained by the administrative staff of the practice with support from the team. The general practitioner would need to be involved in maintaining the information listed in Table 2. The information contained in Tables 1 and 2 would assist the clinician in planning the care of the elderly and mobilizing appropriate resources to support them. Such an exercise was also suggested by the Korner report: 'data should be collected largely as a by-product of operational procedure'.[8]

The practitioner interested in screening the elderly could use the details listed in Table 3 or modify the details according to the needs and resources of the practice. The information could be easily collected by the primary care team or by a nurse practitioner.[6,14]

In this study, only 37% of general practitioners favoured screening of the elderly while 51% were not in favour. In the north-west of England, 11% of the members of the Royal College of General Practitioners strongly favoured screening of the elderly while 23% were strongly opposed.[15] The lack of interest in screening may be due to problems with workload, time and finance[15] and the fact that the existing primary care team could not undertake the commitment.[16] The lack of interest also suggests that screening is still considered to be limited to the identification of unreported treatable illness at an early stage,[17] such illness rarely being detected during routine screening of the elderly.[18]

In order to successfully implement screening, it is necessary to clarify its interpretation. The response from the participants of this study suggests that they feel the data set would promote quality of care but that screening is a separate additional activity the value of which is questionable. However, it has been shown that collecting information in itself provides comfort and a sense of well-being to the elderly.[19,20]

The factors contributing to the low interest in screening demonstrated by this study need to be reviewed. Advocates of screening[21,22] must define proposed exercises clearly, describe the deficiencies in existing demand-led care and demonstrate the effectiveness of the planned interventions.

A computerized screening programme based on our study has been developed in order to promote the care of the elderly. It is, however, difficult to obtain funds to introduce the system.

Table 3. Number of respondents who regarded additional information as necessary for the care of elderly patients.

	Number (%) of respondents		
	Professors	Consultants	General practitioners
Height	8 *(67)*	19 *(86)*	88 *(100)*
Weight	10 *(83)*	19 *(86)*	86 *(98)*
Blood pressure	12 *(100)*	22 *(100)*	78 *(89)*
Vision	12 *(100)*	22 *(100)*	85 *(97)*
Hearing	12 *(100)*	22 *(100)*	83 *(94)*
Mental state	12 *(100)*	22 *(100)*	84 *(95)*
Social rating	12 *(100)*	17 *(77)*	74 *(84)*
Physical disability	12 *(100)*	22 *(100)*	86 *(98)*
Disability factor	12 *(100)*	22 *(100)*	83 *(94)*
Additional information suggested		Mobility Incontinence	Mobility Urinalysis

n = total number of respondents.

Table 4. Number of respondents who agreed that there was a need for periodic screening of the elderly.

	Number (%) of respondents			
	Professors (*n* = 12)	Consultants (*n* = 22)	General practitioners (*n* = 88)	Total (*n* = 122)
Agreed	4 *(33)*	13 *(59)*	33 *(37)*	50 *(41)*
Disagreed	6 *(50)*	5 *(23)*	45 *(51)*	56 *(46)*
Response not known	2 *(17)*	4 *(18)*	10 *(11)*	16 *(13)*

n = total number of respondents.

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Psychoactive drug use by doctors in the USA

Random samples of 500 practising physicians and 504 medical students in a New England state were surveyed during 1984–85; 70% of the physicians and 79% of the students responded. Fifty-nine per cent of the physicians and 78% of the students reported that they had used psychoactive drugs at some time in their lives. In both groups, recreational use most often involved marijuana and cocaine, and self-treatment most often involved tranquillizers and opiates. In the previous year, 25% of the physicians had treated themselves with a psychoactive drug, and 10% had used one recreationally. Although most of the use was experimental or infrequent, 10% of the physicians reported current regular drug use (once a month or more often) and 3% had histories of drug dependence. More physicians and medical students had used psychoactive drugs at some time than had comparable samples of pharmacists and pharmacy students. The results suggest a need for renewed professional education about the risks of drug misuse.

Source: McAuliffe WE, Rohman M, Santangelo S, *et al.* Psychoactive drug use among practicing physicians and medical students. *N Engl J Med* 1986; **315:** 805-810.

INFECTIOUS DISEASES UPDATE

Pertussis and *Mycoplasma pneumoniae* infections

Both these infections cause outbreaks at approximately three to four year intervals. We are currently coming to the end of a pertussis epidemic but mycoplasma is on the increase. The recent pertussis epidemic appears to have been slightly smaller than the last, probably owing to greater use of vaccine. We would expect few cases now until the next outbreak starts in around 1989. *Mycoplasma pneumoniae* typically causes fever, cough and a patchy pneumonia without the severe toxicity usually associated with pneumococcal or legionella infections. Erythema multiforme or a 'glandular fever' like illness are alternative presentations. More cases occur between epidemics than with pertussis. Most virus laboratories can now look for specific IgM on a single serum sample which confirms the diagnosis.

Meningococcal infection

Over the last 12 months there has been, throughout Britain, an increase in notifications and laboratory reports of meningococcal infection to approximately double the 'usual'. The last national epidemic (as opposed to local outbreaks) was in around 1975. The combination of an acute febrile illness with purpura (sometimes very scanty) should suggest the diagnosis. Parenteral penicillin given before transfer to hospital, if any delay is anticipated, can be lifesaving.

Searching for nasal carriage of meningococci among contacts or looking for the source of infection are of little practical value in preventing secondary cases since there is a high rate of carriage in the normal population. Giving rifampicin or minocycline to close contacts (for example, family and playgroup friends) as recommended in the *British national formulary* may be helpful.

HIV infection

General practitioners are increasingly requesting blood screening for patients concerned about human immunodeficiency virus (HIV) infection and for those who are in high risk groups. It is, however, important for general practitioners to be ready to respond to positive tests because of the implications for the patient and the need for counselling those infected so as to prevent further spread. Facilities vary from region to region and local community medicine specialists should know what clinics or specialist advice is available.

Rabies vaccination

A recent case of 'imported' rabies contracted following a dog bite in India is a reminder that a human diploid cell vaccine, largely free from side effects is now available. It is effective if used before or after exposure. Travellers may wish to be protected before departure especially if intending to be 'off the beaten track', although they should note that boosters plus hyperimmune rabies immunoglobulin should still ideally be received after a suspect bite. The vaccine is obtained from Merieux UK Ltd (telephone 02816 2566) and costs around £20 for a 1 ml dose. Three injections of 1 ml deep subcutaenously (at four week and 6–12 months intervals) is the standard recommended schedule. Intradermal injections of 0.1 ml can be used. They must be truly intradermal and their effectiveness is as yet less well documented.

Further information about these subjects can be obtained from the contributor: Dr E. Walker, Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow G20 9NB (telephone 041-946-7120).