Practice Nurse Handbook

Fifth edition

Gillian Hampson
RGN, RCNT, DN, PN/Dip HE in Community Health Care
Independent Practice Nurse

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Contents

Preface to the Fifth Edition vii
Acknowledgements viii

1 Teamwork in General Practice 1
The National Health Service 1
Teamwork 7

2 General Practice Nursing 16
Historical background 16
Nurse employment in general practice 20
Networking for support 22
Practice nurse education 24
Identifying good practice 25

3 Practice Organisation 31
Information about patients 31
Protocols, guidelines and clinical pathways 36
Policies and procedures 37
Meetings 39
Public involvement 39

4 Management of the Nurses' Rooms 42
Design and furnishing 43
Health and safety 44
Control of infection 47
Supplies and equipment 54
Training in emergency procedures 55

5 Nursing Treatments and Procedures 59
Injections 59
Wound care 60
Wound healing 60
Eye treatment 68
Ear care 68
Assisting with minor surgery 72

6 Diagnostic and Screening Tests 79
Laboratory tests 81
Investigations and tests within the practice 91

7 Emergency Situations 104
General principles 104
Collapse 105
Asphyxia 109
Management of other emergency situations 112
Respiratory problems 119
Haemorrhage 120
Poisoning 123
Pain 124
Trauma and minor injuries 124
Stings and bites 127
Eye problems 129
Foreign bodies 130
Emergency midwifery 131

8 Common Medical Conditions 134
Medication 135
Upper respiratory tract infections 136
Ear conditions 138
Headache 139
Insomnia 140
Gastrointestinal disorders 140
Urinary problems 144
Vaginal discharge 145
Infectious diseases 147
Human parasites 150
Other skin conditions 151

9 Health Promotion 160
National Service Frameworks and Quality and Outcomes Framework 160
Inequalities in health 160
Cultural diversity 161
Education for practice nurses 161
Terminology 161
Health promotion and the primary healthcare team 163
Health promotion in general practice 164
Dietary advice and monitoring 170
Smoking cessation 175

10 Child Health, Childhood and Adult Immunisation 180
Child health promotion 180

Safety 183
Child abuse 184
The Children Acts (1989 and 2004) 185
Childhood immunisation 185
Adult immunisation 191
Conclusion 196

11 Travel Health 200
Nurse education 200
Advice for travellers 202
Immunisation for travellers 211

12 Sexual Health 219
Sexual identity 219
Relationships 220
Education for nurses 220
Fertility and fertility control 221
Termination of pregnancy 233
Sexually transmitted diseases 234

13 Women's Health 239
Menstruation 239
Cervical cytology 241
Breast awareness 243
Preconceptual care 244
Infertility 245
Pregnancy 246
Hysterectomy 249
The menopause 249
Osteoporosis 251
Bladder problems 252
Information for patients 254

14 Men's Health 258
Morbidity and mortality 258
Male patients in general practice 261
Well-man checks 262
Testicular cancer 263
Prostate disease 264
Erectile dysfunction 269
Conclusion 271

15 Mental Health 275
The historical background to the development of mental health services 275

Mental healthcare in general practice 277
Self-awareness in the caring professions 289

16 Supporting Patients with Chronic Diseases 292
The expert patient 292
Clinics in general practice 293
Asthma 294
Chronic obstructive pulmonary disease 300
Diabetes mellitus 304
Hypertension 312
Coronary heart disease 316
Conclusion 317

Appendix 1 Examples of the clinical equipment needed in the nurses' rooms 321
Appendix 2 Emergency equipment 325

Index 327

Preface to the Fifth Edition

Throughout this new edition I have aimed to provide the type of information I really needed as a new practice nurse and have used the same format that I used in the previous edition. I have included practical information and emphasised the legal aspects of the work. I have also stressed the need for education and have provided information about useful courses and qualifications. I have spent long periods each day searching the internet and have recommended some of the more reliable websites.

At times, I have felt overwhelmed by the need to make sense of all the changes in the National Health Service. Hardly a day goes by without some new target or directive from above. I have not included details of the health service structures and legislation of the other countries in the United Kingdom in the interests of brevity. Many of the documents produced by the English Department of Health have their equivalents in Scotland, Wales and Northern Ireland. I apologise to readers in those countries for supplying mainly English references.

Gillian Hampson

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Chapter 1
Teamwork in General Practice

This chapter outlines the background to the work of practice nurses so that the role can be considered within the context of the whole primary healthcare team.

THE NATIONAL HEALTH SERVICE (NHS)

In 1948 the National Health Service was established on the basis that everybody should have free access to medical care irrespective of financial status. At that time, it was assumed that the demand for care would decrease once the unresolved 'pool' of illness in the population had been treated. In the light of experience, it has become clear that the amount of treatable illness is small compared with both chronic conditions, which cannot be cured, and problems created by environmental and personal stress, the underlying reasons for many consultations in general practice.

Developments in general practice

Prior to 1948 most general practitioners worked independently, usually from their own homes. Patients who were unable to afford private medical care belonged to a doctor's panel. The cost was supported by various insurance schemes and hospital beds were endowed especially for 'the poor'. The hospitals were nationalised in 1948 but general practitioners, dentists, retail pharmacists and opticians stayed as independent businesses with contracts to supply specific services to NHS patients. Executive councils were set up to administer these arrangements. The local authorities employed the district nurses and health visitors.

The early days of the NHS were a catalogue of disasters, with neither doctors nor patients really knowing what to expect of the new system. Patients had been led to believe that everything was free so extra demands were made upon doctors, who were themselves unprepared for the organisational and practical difficulties created by the new system. Between 1948 and 1956, expenditure in the NHS had risen by 70%.[1]

The Family Doctors' Charter

The British Medical Association, through its General Medical Services Committee, has always been responsible for the political aspects of general practice, including terms of service and remuneration. The College of General Practitioners, established in 1953 (to become the Royal College in 1966), was mainly concerned with educational issues. The effects of these two bodies on government policies brought about the so-called *GPs' Charter* in 1966, in response to the threat of resignation by disillusioned doctors.[2] The Charter radically altered the way in which GPs were paid and gave them incentives for having better premises and reimbursement for ancillary staff salaries. Nurses were included among these ancillary staff.

NHS reorganisation

The structure of the NHS was reorganised in 1974, when management first assumed a specialist function. Executive councils became family practitioner committees (FPCs) and community nurse employment was transferred from local authorities to the health service. Area health authorities were abolished in 1982 and their powers devolved to district health authorities. However, 1990 saw a more radical change to the NHS. The introduction of the internal market created a separation between the purchasers and the providers of services. Hospitals were invited to become self-governing trusts and GPs in group practices were encouraged to become fundholders to purchase secondary services on behalf of their patients. FPCs were changed to family health service authorities (FHSAs) with greater managerial responsibilities in relation to general practice.[3] FHSAs later merged with health authorities and some of their functions were devolved to primary care agencies.

The GPs' Contract of 1990 required them to provide a range of screening and health promotion services. Many practice nurses were employed at that time to undertake the extra work.[4] In that same year, the government introduced targets for reducing disease and disability through its *Health of the Nation* strategy for England. The Labour government replaced this with 1997's strategy on saving lives.[5] Similar strategies were produced in the other countries of the United Kingdom.

The change of government in 1997 led to the development of *The New NHS*.[6] Fundholding was abolished and instead of being in competition, all the practices in a locality became part of a primary care organisation. These were subcommittees of health authorities, with a devolved budget to purchase services on behalf of the local community and a remit to monitor and improve the quality of services (clinical governance) and promote improvements in health (health improvement programmes). The pace of change became relentless, with a stream of targets to reduce waiting lists and National Service Frameworks (NSFs) to specify the standards for services for the common diseases and patient groups.

The National Institute for Clinical Excellence was established to make recommendations on the use of new drugs and treatments in order to end the 'post-code lottery', whereby patients in one health authority area could be denied treatments available elsewhere. The Commission for Health Improvement (rebranded as the Healthcare Commission in 2004) was established to inspect health authorities and trusts (including general practices) and to monitor performance. In 2001 a special health authority, the National Clinical Assessment Authority, was set up, in the wake of several medical scandals, to provide a rapid investigation into the performance of certain doctors and dentists.[7–9] The functions of the NCAA were transferred in April 2005 to the National Clinical Assessment Service, a division of the National Patient Safety Agency.

The NHS Plans

In the year 2000 the government published an ambitious plan for investment and reform of the NHS to take place over ten years.[10] The plan outlined the intention to provide extra beds, hospitals and staff, as well as modernisation of general practice, new doctors' contracts and a greater role for nurses. The role of patients in the modernisation process was also stressed. The 2004 *NHS Improvement Plan* contained even more ambitious promises, with less emphasis on reducing waiting times and more on improving the care of people with chronic conditions and the local control of services.[11] The involvement of the independent sector was included and the full extent of such proposals became clear in the contracting guide produced by the NHS Confederation on alternative providers of medical services.[12] Community nurses began to feel concern about their future employment status.

Primary care organisations (PCOs)

Enlarged PCOs became autonomous providers of general practice and community nursing services and commissioners of secondary care. As many of the functions of the health authorities were devolved to PCOs, health authorities were merged into larger strategic regional bodies. Proposals were also contained in *The NHS Plan* for PCOs to merge with social service departments to form care trusts, with budgets to provide integrated health and social services.

Care in the community

Other changes accelerated within the community from April 1993 as a result of the NHS and Community Care Act (1990). Social service departments assumed new responsibilities for assessing the needs of and providing tailor-made services for vulnerable people. Hospitals had to ensure that the appropriate

services were in place before such patients could be discharged home. More resources were needed to provide effective community care and plans were made to modernise mental health services.[13] The National Service Framework for Mental Health, published in 1999, was intended to address some of the failings of care in the community (see Chapter 15).

Health service structures

Although politics can seem remote from direct patient care, it is essential to keep abreast of developments in the NHS, which is a highly politicised organisation. The endless change can seem daunting but nurses have a key role to play in the changing NHS and in developing innovative services and ways of promoting health for the public.

The NHS structures for Scotland, Wales and Northern Ireland have always been slightly different but space does not allow for more than a general overview. All nurses should be aware of their own country's health service management structure and policies.

General practice as a business

Unlike hospital doctors, who are salaried, the majority of GPs have always been independent contractors, with the same contract with the NHS for providing general medical services (GMS). This had a very complicated system of remuneration and *The Statement of Fees and Allowances* (known as the Red Book) provided details of all the payments which GPs could receive from the NHS. Some practices employ salaried GPs but this is still uncommon.

Personal medical services (PMS)

The Primary Care Act of 1997 permitted a departure from the national GMS contract.[14] PMS practices (the first pilots started in 1998) demonstrated new ways of providing general practice services, through local contracts with health authorities (later with primary care organisations). Nurses who employ salaried GPs to provide medical services to their practice populations have led some pilots. The majority of nurse-led schemes have tended to provide services for specific population groups, such as the homeless, refugees and asylum seekers or people in underdoctored areas.

New general medical services (nGMS)

From April 2004, GPs not covered by PMS accepted a new standard GMS contract, administered by local primary care organisations. *The Statement of*

Financial Entitlements, a 250-page document which specifies how payments to practices should be calculated, superseded the Red Book.[15] Practices are paid a global sum to cover the provision of services to patients, staff costs and locum payments. The nGMS Contract (known as the Blue Book) specifies how services should be provided in general practice.[16] Three types of services are identified.

- *Essential services* – the diagnosis and treatment of illness, including terminal illness, and the management of chronic diseases.
- *Additional services* – including cervical screening, contraception, some immunisations, child health surveillance, maternity services excluding interpartum care, basic minor surgery such as curettage, cautery and cryocautery of warts and other skin lesions.
- *Enhanced services* – are commissioned by the PCO and might not be provided by all practices. These services could consist of higher standards of essential or additional services, e.g. advanced minor surgery, or deal with specific health needs, provided by practitioners with special interests and expertise. There are three forms of enhanced services.
  1. **Directed enhanced services** – specified and priced nationally. They include childhood and influenza immunisations, improved access, services to support staff dealing with violent patients, quality information preparation and advanced minor surgery.
  2. **National enhanced services** – specified and priced nationally but not directed. These include anticoagulant care, insertion of IUDs, intrapartum care, specialised care of patients with depression, enhanced care of the homeless, services for drug and/or alcohol misusers, immediate and first response care, minor injury services or more specialised sexual healthcare.
  3. **Local enhanced services** – agreed locally between the practice and the PCO.

Quality and Outcomes Framework (QOF)

This part of the contract deals with the quality of services provided in general practice and is voluntary. Payment is made for the achievement of specified quality indicators on a points system in four domains: clinical, organisational, patient experience and additional services. The clinical domain consists of: CHD, stroke/TIA, hypertension, diabetes mellitus, COPD, epilepsy, mental health and asthma. Each of these has a number of quality indicators, which have to be achieved in order to receive payment. The contract specifies several principles regarding the QOF.

- Indicators should, where possible, be based on the best available evidence.
- The number of indicators in each clinical condition should be kept to a minimum number compatible with patient care.
- Data should not be collected purely for audit purposes.
- Only data useful to patient care should be collected. A consultation should not be distorted by an overemphasis on data collection.

- Data should never be collected twice, i.e. data required for audit purposes should be data routinely collected for patient care and obtained from existing practice clinical systems.[17]

Education for general practitioners

Qualified GP trainers provide placements in approved training practices for doctors who wish to become GPs. Consultations are sometimes video-recorded, with the consent of the patient, for teaching and assessment purposes. Postgraduate training was introduced on a more formal basis in the 1970s, followed by various parliamentary regulations. Legislation allowing the free movement of doctors within Europe has been in place since 1986. New regulations came into force in 1998, outlining the training required for all doctors working in general practice in the NHS.[18] Vocational training is overseen by the Joint Committee on Postgraduate Training for General Practice, the body which sets the standards of general practice training, approves GP trainers and training practices, as well as issuing the certificates required for doctors to work unsupervised in general practice.

Revalidation and appraisal

The GMC plans for revalidation have been in existence for several years, in order to demonstrate a doctor's fitness to practise. However, the plans are undergoing further consideration in the light of the Shipman Inquiry.[19] Doctors currently keep folders about their professional practice for use at annual appraisals, which may form part of their revalidation procedures. Nurses are already accustomed to keeping professional profiles and to re-registering every three years. All staff are required to have personal development plans and to undertake an annual appraisal.

Practice population profiles

The changes within the NHS necessitate the identification of the particular health and social needs of local populations in order to provide appropriate services. Such profiles should cover: age/sex ratios, ethnic groups, family structures, numbers on the child protection register, social class, poverty levels, employment, housing, vulnerable groups, morbidity and mortality, environmental hazards and amenities. Since April 2000 practices have also been required to identify all informal carers registered with them, whether or not the person for whom they care is registered at the same practice.[20] Practices have a duty to ensure that carers are offered the support and help to which they are entitled.

TEAMWORK

The explosion of work within general practice highlights the need for good teamwork but just being together in one place will not create a team. All teams share certain characteristics, whatever their functions:

- A shared purpose or goal
- A sense of team identity
- An understanding of the role and valuing of the contribution of individual team members.

Teamwork needs some committed hard work to succeed. It can be hindered by ineffective leadership, divided loyalties, when members belong to more than one team, or sabotage by disaffected members.

The historical background to the different professions means that modern-day, independent-minded nurses and GPs accustomed to assume authority may have very different perceptions of the same situation, which can lead to conflict. The importance of team building has been recognised for many years in the commercial world and many of their methods are being adopted in the health service.

Primary healthcare

Primary healthcare refers to health promotion, treatment and care within general practice and the community, as compared with secondary care provided by hospitals and specialist services. The government is keen to promote primary care services.

Primary healthcare teams have been around since the 1960s in one guise or another but in reality, there are often two types of team involved with general practice.

The practice team

A practice team tends to incorporate all those people based within the practice, most of whom are either partners or employees of the GP. Apart from the doctors, practice teams include the following.

The practice nurse(s) (see Chapter 2)

The title *practice nurse* has always been generally understood to apply to a qualified nurse employed by a GP or GP partnership. However, it is becoming more common for practice nurses to be employed directly by primary care organisations. Some practice nurses are partners in their practices, while others are self-employed as independent nurses. A practice may also include a nurse practitioner in the team, although the Nursing and Midwifery Council does not

yet protect the qualification and title and the work undertaken is subject to wide variations. Healthcare assistants are being employed by many practices to undertake basic tasks, in order to allow time for practice nurses to utilise their skills more effectively.

The practice manager

A practice manager has responsibility for organising the systems which allow the practice to run smoothly, as well as for financial and personnel management, staff development and liaison with all the staff and the PCO. A modern practice manager will usually have had the specific management training needed to cope with the demands of running a busy practice, which can include a university degree in business management. The specific role may differ from practice to practice but the success of each organisation can depend on the effectiveness of the manager. Many practice managers are members of the Association of Medical Secretaries and Practice Managers, Administrators and Receptionists (AMSPAR).

The receptionists

The receptionists are the first point of contact with the public. They must be able to stay calm in the face of conflicting demands from patients, other staff and the telephone. Receptionists frequently act as gatekeepers to the doctors and nurses by prioritising appointments or controlling the number of telephone calls put through. A very fine line exists between efficient organisation and the denial of a patient's right to consult a doctor or nurse.

Apart from running the appointment system and taking telephone messages, there is plenty of administrative work. Most practices are computerised and registration data have to be processed. Data entry clerks type data into the computers. Some receptionists organise repeat prescriptions. Training for receptionists often takes place in-house but recognised courses are also available. Practice receptionist training, organised by some PCOs and colleges of further education, leads to a qualification from AMSPAR.

The medical secretary

A medical secretary needs office skills and knowledge of the terminology used in medical correspondence. In smaller practices, secretarial duties may be combined with reception or administrative work but large practices usually employ a qualified medical secretary to deal specifically with referral letters, reports, office administration and the practice correspondence.

Paramedical staff

Larger practices may employ or facilitate access to other professional staff – dietitians, physiotherapists, counsellors and chiropodists – to increase the range of services available for patients. Pharmacists are joining many practices to help

with more effective prescribing. Alternative therapists such as acupuncturists, aromatherapists and masseurs are also being welcomed into some teams.

Phlebotomists

Larger practices often employ a phlebotomist to take routine blood tests. In some areas, a member of the clerical staff will be trained in phlebotomy in order to free up valuable nursing time. This potentially risky work calls for adequate training and assessment as well as immunisation against hepatitis B (see Chapter 10).

The primary healthcare team (PHCT)

When group attachment was introduced, it was thought to allow better communication between the professional groups than when nurses work in geographical patches. District nurses, health visitors, community midwives and community mental health nurses also relate to teams in their own specialities, which may have different aims and priorities from those of the practice. Practice nurses have traditionally been unique among NHS nurses in being employed by a GP and not by a community or hospital trust. However, sometimes practice nurses, district nurses and health visitors are all employed by the same local primary care organisation.

Integrated nursing teams

The idea that community nurse attachment to GP practices would lead to integrated primary care teams has only rarely been fully realised. There have been a number of teams created in recent years consisting of district nurses, public health nurses and practice nurses.[21] The success of such teams often seems to rely on the degree of self-direction and budget control permitted, as well as on the personalities of the team members themselves. The need to avoid duplication or gaps in the service is leading to a radical rethink of the way nursing services are delivered. The Department of Health has spelled out how nurses can help to deliver *The NHS Plan*.[22]

Specialist community nurses

In 1994 eight branches of community nursing were accorded equal recognition by the United Kingdom Central Council, now the Nursing and Midwifery Council (NMC). Modules in common core subjects as well as discipline-specific modules in each of the specialities lead to a BSc or Honours degree in one of the eight specialist fields:

- General practice nursing
- Community mental health nursing
- Community learning disabilities nursing
- Community children's nursing

- Public health nursing/health visiting
- School nursing
- Community nursing in the home/district nursing
- Occupational health nursing.

The expansion of specialist nursing and the roles of autonomous practitioners and nurse consultants resulted in a consultation exercise by the NMC on establishing a standard of proficiency for advanced nursing practice.[23]

District nurses

A district nurse is responsible for providing skilled nursing services in the community by:

- Assessing the care needs of patients and their families
- Formulating individualised care plans and revising them as necessary
- Implementing the care or delegating to other members of the district nursing team
- Monitoring patients' progress and reassessing care needs
- Supervising the care given by other members of the district nursing team.

Liaison with other PHCT members, social services and voluntary agencies is often as important as direct care giving. The role also includes providing support to carers and teaching patients, other nurses and medical students. District nursing teams work in a similar way to hospital ward teams, with mixed skills and grades. Most district nursing care takes place within the patients' homes, although some district nurses also run clinics within health centres or general practices, e.g. leg ulcer clinics.

Health visitors (specialist community public health nurses)

Despite the new title, the term 'health visitor' still tends to be used and understood. The role of health visitors is in a state of change. Health visiting evolved in the Victorian era to promote the welfare of mothers and children. Many health visitors still devote a high proportion of their time to work with the under-fives and to child protection work. However, the role can encompass health promotion with people of all ages and the importance of the public health role has also been reasserted in recent years.[24]

Community midwives

Midwives have statutory responsibilities for the care of women during pregnancy, confinement and post partum. Community midwives organise antenatal and postnatal care and run antenatal and parentcraft classes. A community midwife will attend a home confinement and be responsible for a DOMINO

scheme or delivery within a GP hospital maternity unit. The midwife will care for a mother and baby in the postnatal period and notify the health visitor when they are discharged. A wider public health role has been proposed for midwives in recent years.[25]

Other community nurses

Other nurses may be considered as peripheral members of the PHCT. Each has a specific contribution to make but the links with general practice are often more tenuous.

Community mental health nurses (CMHNs), previously called community psychiatric nurses (CPNs), are registered mental health nurses who have undertaken postregistration studies in their field of expertise. The service developed out of hospital-based psychiatric nursing and most CMHNs continue to be based in hospitals within community mental health teams. CMHNs carry out mental health assessments, support patients and their families within the community, and offer a range of therapeutic strategies (see Chapter 15).

School nurses have a major role in health promotion for school children, as well as in dealing with their health problems at school. The role has expanded significantly since the days of the 'nit nurse' and school nurses are expected to have expertise in all aspects of child health and wellbeing.[26] School nurses carry out wide-ranging immunisation programmes for school-age children and play a key role in helping to reduce the number of teenage pregnancies through sex education and the provision of practical advice. Practice nurses may have most contact with school nurses through the care of children with asthma or other chronic conditions.

Community children's nurses care for children with acute and chronic illnesses in their homes and provide valuable support for families. The children's nurse role ranges from teaching wet wrapping for eczema to managing a terminal illness at home. Their degree of contact with the practice nurse can depend on local arrangements.

Community learning disability nurses help people with learning disabilities to maximise their potential for independent living within the community. They help clients and carers to deal with physical, mental and social problems, including challenging behaviour, and liaise with a range of support services.

Hospital and community-based specialist nurses are a valuable resource for advice and teaching on their individual subjects, e.g. diabetes, continence, stoma care, HIV/AIDS and infection control. Macmillan nurses provide a palliative care service for patients with cancer and support them and their families.

Community matrons

This new breed of nurse was mentioned in the *NHS Improvement Plan* and it is proposed that by 2008, the NHS will have 3000 community matrons using case management techniques to care for patients with complex needs.[27]

Social services

Referrals can be made on behalf of patients who require home care, meals-on-wheels, occupational therapy or other social service support. However, relatively few practices have an attached social worker and referrals for social services are usually made by telephone or letter. Social workers are expected to make a full needs assessment of the patients referred to them, although the National Service Framework for Older People requires health and social services to work together to ensure that single assessments of needs are carried out.[28]

Public health nurses and GPs are sometimes involved with social workers on child protection issues. Also, an approved social worker is needed when a patient is compulsorily detained under the Mental Health Act (see Chapter 15).

Voluntary services

A huge number of voluntary services, self-help groups and charities exist. They provide financial and practical assistance, as well as information, advice and research funding. Some are organised locally to help people in need in that community, while others are organised nationally to help sufferers of a specific illness or disability. Patients and their carers can benefit from the knowledge of a practice nurse who can tell them whom to approach for help. A database of contact addresses and websites can be useful but it needs to be regularly updated. The internet is a good way of finding out about support groups and there may be a directory produced by the local Council for Voluntary Service.

Some larger practices have a League of Friends, who organise voluntary transport, collect prescriptions, visit elderly or bereaved patients and even raise funds to buy special equipment for the practice. This type of voluntary work can provide significant help in both urban and rural communities.

Involvement of the public is one of the key elements of the plan for modernising the NHS. PCO boards have several lay non-executive members and practices are expected to seek the opinions of patients about the quality of their services. Patient participation is a key factor in the government's plan for the NHS.[29]

Suggestions for reflection on practice

- How much do you know about the way your local NHS is run? Who are the nurse leaders?
- What sort of contract does your practice have? What services does your practice provide? Could they be improved?
- How integrated is your primary healthcare nursing team? What changes could be made to improve the service to patients?
- What statutory and voluntary services are available locally? How do you find out?
- How much involvement do patients have in the organisation of your practice? What changes could be made?

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USEFUL ADDRESSES AND WEBSITES

Department of Health
Richmond House, 79 Whitehall, London SW1A 2NS
Website: www.dh.gov.uk

NHS Institute for Innovation and Improvement
University of Warwick Campus

Coventry CV4 7AL
Telephone: 0800 555 550
E-mail: enquiries@institute.nhs.uk
Website: www.institute.nhs.uk

National Primary Care Development Team
Gateway House
Piccadilly South
Manchester M60 7LP
Telephone: 0161 236 1566
Website: www.npdt.org

Healthcare Commission
www.chi.gov.uk

Chapter 2
General Practice Nursing

One of the attractions of practice nursing is the flexibility it allows. Progressive nurses have blossomed in the atmosphere of general practice and some have become nursing celebrities through their innovations in health promotion and chronic disease management. However, herein lies a dilemma, because that same flexibility can also lead to a diversity of standards. Clinical governance is intended to iron out variations in quality. It is the modern term for the framework covering all the activities which contribute to a high-quality service. This includes: education, risk assessment, evidence-based practice and audit, as well as patient feedback and the analysis of critical incidents and mistakes. The Healthcare Commission has a statutory responsibility for assessing the performance of healthcare organisations.[1]

HISTORICAL BACKGROUND

Practice nursing evolved over time, partly from the work of those GPs' wives who were nurses and partly from district nurse attachment to general practice. More practice nurses began to be employed by doctors in the early 1970s when it became apparent that district nurses were unable to spend as long in the surgery, undertaking tasks such as dressings and injections, as the doctors wanted them to do. One solution to this was for doctors to employ nurses directly. After 1966, when salaries could be partially reimbursed, practice nurses were classified with secretaries and receptionists as ancillary staff on the Family Practitioner Committee returns. Even as late as 1992, when asked by the Social Policy Research Unit to furnish the names of practice nurses for the National Census, some family health service authorities could not identify all the nurses in post.[2]

Neighbourhood nursing

The Cumberlege Report in 1986 caused outrage among many practice nurses when it was suggested that all community nurses should be employed in

neighbourhood nursing teams.[3] Practice nurses did not receive this concept of integrated nursing with great joy. The proposal led to a new sense of group identity as practice nurses came together to fight for the right to continue being employed within general practice. The apparently illogical preference for members of one profession to be employed by members of another owed more than a little to the negative attitudes of many practice nurses towards inflexible management in the NHS at that time.

Practice nurse education

The 1990 GP Contract led to a huge increase in the number of practice nurses employed. This phenomenon caused a stir in nursing circles and concern at the lack of professional control over such a large group of nurses. Practice nurse education finally began to receive serious attention. Practice nurses were suddenly overwhelmed by educational opportunities from a variety of sources but there was no simple way of assessing the quality of the education. The amount of study leave granted to practice nurses varied from one practice to another.

Project 2000 changed the traditional nurse training into a higher education system comparable with that of other disciplines.[4] Initially it was expected that this would equip nurses to work in any setting but it became obvious that more education would be needed for work in the community. From 1996, the United Kingdom Central Council decision on community education gave qualified practice nurses and other community nurses equality with district nurses and health visitors as specialist practitioners. Future postregistration qualifications are currently being debated by the Nursing and Midwifery Council, which replaced the UKCC in 2002.

Nursing in general practice

The diversity of work undertaken by practice nurses makes a precise description of the role very difficult. A study in Sheffield found both a seasonal variation and a wide range in the nursing activities and the time spent on them by individual nurses.[5]

Treatment room nurses to healthcare assistants

Treatment room nurses were originally employed by the NHS for nursing work within health centres. They were not employed directly by the general practitioners. Few treatment room nurse posts exist nowadays but healthcare assistants (HCAs) are being employed in many practices. They perform some of the basic administrative, organisational and treatment room work previously

undertaken by practice nurses. HCAs are able to study for national vocational qualifications (NVQs) to equip them for the role. They allow a practice to make the best use of the time and expertise of all its nurses.

Practice nurses

Practice nurses usually have a wide remit, although some practice nursing still contains an element of treatment room work. Practice nursing can be considered under several headings.

1. *Management*, which could include:
   - Organising the nurses' rooms and work, including call/recall for health promotion
   - Supervision of subordinate staff
   - Ensuring clinical stocks and supplies are maintained
   - Collaboration on organisational and professional issues, including policies, protocols, quality standards and educational needs.
2. *Clinical*, which could include:
   - Assessing patients' care needs
   - Nursing procedures
   - Performing tests and health screening
   - Immunisation
   - Assisting with minor surgery
   - Chronic disease management.
3. *Specialist services*, such as family planning.
4. *Communication*, which could include:
   - Giving information, support and advice to patients and carers
   - Counselling
   - Health promotion
   - Teaching patients, other nurses and students
   - Liaison with other members of the practice team, the primary healthcare team, social services and other agencies
   - Telephone consultations.
5. *Audit and research*, which could include:
   - Evaluation of care given
   - Compiling statistics and reports on nursing activities
   - Identifying ways to improve nursing practice.

The need for up-to-date knowledge is increased because the work of practice nurses is so varied and challenging. Many practices have a practice library, which should include a nursing section. There are journals relevant to practice nursing and the internet provides an easy way of accessing information. Many websites provide links to support for practice nurses.[6,7] The NMC, Department of Health and nursing organisations, such as the RCN and CPHVA, are all accessible on-line.

Nurse practitioners

Nurse practitioners are experienced nurses who have undertaken further specialised education at degree level to be able to work autonomously in a variety of settings. Examination skills and the management of injury or diseases, traditionally the prerogative of doctors, are among the subjects taught on nurse practitioner courses. However, because the title is not yet protected by the NMC, there is nothing to stop a nurse calling her/himself a nurse practitioner by virtue of experience, without having undergone a recognised course and examination. Consultation is in progress to establish a recordable qualification of Advanced Nurse Practitioner, possibly at Master's degree level.[8]

Nurse practitioners originated in the United States. The first one in the UK, whose background was in health visiting, took up her post in Birmingham in 1982. Since then the numbers have grown considerably. Some nurse practitioners undertake work with neglected, underprivileged groups in the community; others work in hospitals, general practice or walk-in centres. There can be an overlap with some of the work of practice nurses and the titles may still be used rather indiscriminately. It is not unusual to see job advertisements specifying the experience required, which could apply to either type of nurse. Conflict can arise in a practice which employs a nurse practitioner and a practice nurse, both of whom have qualified at degree level and expect to be accorded the same level of respect. It is essential that a clear understanding be reached, so that the patients benefit from the expertise of all the nurses.

Skill-mix

Skill-mix is the system for identifying the knowledge and expertise needed to perform any job, so that the most appropriate person can do it. The reform of services in general practice has made delegation inevitable.[9] Any practitioner who wishes to review her/his role can consider each activity in turn and list the knowledge, skills and education needed to perform it effectively. It will become apparent which activities could be delegated and a case can then be made, on economic grounds, for utilising nursing skills most effectively. Phlebotomy is a case in point, for while it can reasonably be argued that practice nurses may deal with other important issues while taking blood, it would be hard to justify the routine use of a highly trained nurse in such a role.

The nurse practitioner, healthcare assistant and nurse triage roles could be considered as examples of skill-mix, using nursing expertise most effectively. Nurse prescribing has also increased the autonomy of nurses in general practice (see Chapter 8).

Triage

Historically, this term arose from the assessment of trauma victims in order to prioritise treatment. Nurse triage was introduced in general practice as a way of

managing requests for urgent appointments. Triage could be by telephone or in face-to-face consultations and be carried out by an experienced practice nurse. NHS Direct nurses deal with telephone encounters by using computerised algorithms to assess patients but they may take longer and cost more than practice-based triage.[10]

NURSE EMPLOYMENT IN GENERAL PRACTICE

Medical training has traditionally been concerned with the diagnosis and treatment of patients, with little time left over for management and issues of human resources. It follows that while some GPs are excellent employers, there are others who are less so. This can leave an inexperienced nurse vulnerable to exploitation. The terms and conditions agreed at the job interview are binding but employees are entitled to receive a written contract of employment within two months of starting work.[11] Employees' rights were enhanced by employment legislation in 1999, which established new rules for fair treatment of employees and the right to trade union representation.[12] A new Employment Act in 2002 introduced more family-friendly policies.[13] Part-time workers have the same rights as full-time staff.[14]

Nurses accustomed to pay and conditions being negotiated nationally may never have had to negotiate on their own behalf before. Not all nurses are naturally assertive, so it is important to know what to ask at the interview and how to present a good case when negotiating for a change in conditions or salary. The Royal College of Nursing (RCN) and other trade unions have produced guidelines on the employment of practice nurses. The following points should be considered in relation to employment.

Job description

A job description should specify the job title, the key activities and responsibilities, the conditions of employment, clinical grade/band and salary and to whom the employee is accountable. A comprehensive job description also provides a tool for appraisal at a performance review.

The RCN guidelines on employment for practice nurses specify the type of work and the responsibility suitable to each grade, although all NHS employees are currently undergoing a job evaluation exercise called Agenda for Change (AfC).[15] Practice nurses, unless directly employed by a PCO, are unlikely to be included so will have to make their own case with their employers. The RCN has published advice about AfC for members not employed by the NHS.[16]

Job descriptions can prevent misunderstandings if everyone involved knows what they are required to do. When all staff members have a job description, it will become apparent if the responsibility for those small tasks necessary to the

smooth running of a practice has not been specified. Unnecessary conflict can be prevented if such issues are resolved promptly.

Contract of employment

A statement of terms of employment should cover the following:

- Salary and incremental dates, plus rates of pay for overtime hours
- The normal hours and times of work plus expectations of overtime to cover the absence of colleagues
- Holidays, study leave, sick pay, maternity/parental leave and compassionate leave entitlements
- Pension arrangements
- Period of notice for the termination of the employment.

In addition, the contract should set out the disciplinary and grievance procedures. Any health and safety hazards in the place of employment should also be included. If home visiting is part of the job description, then a mileage and car allowance should be negotiated. Practice nurses are strongly advised to seek a contract which guarantees pay and conditions of service in line with those of other NHS nurses.

Pensions

Pensions need careful consideration. Since 1997, practice employees have been entitled to contribute to the NHS pension scheme and to receive an employer's contribution. The practice manager will be able to provide advice on NHS pensions and any additional voluntary contributions, which may be paid. Many people wait until middle age before considering pension arrangements but it is worth getting independent advice as soon as possible about the best ways of maximising income after retirement.

Insurance

National Insurance contributions, deducted at source from the salary, together with contributions made by the employer, pay for sickness, maternity and unemployment benefit and for the state pension. GPs have indemnity insurance to cover vicarious liability for injury caused by their employees. However, personal indemnity insurance is essential because nurses, as individuals, could also be sued. The Royal College of Nursing, Medical Defence Union, the Community Practitioners' and Health Visitors' Association (CPHVA) and Unison provide indemnity insurance and give legal advice to members if needed.

Accountability

Accountability for one's actions is one of the hallmarks of a professional person. Ultimately, nurses are accountable to their patients, via the NMC, for the standards of nursing care provided. Among other things, the Code of Professional Conduct requires all nurses to only undertake practice and accept responsibilities for activities in which they are competent.[17] Many aspects of practice nursing go far beyond what is taught pre-registration and nurses may sometimes feel pressurised to take on work for which they are not adequately prepared. Assertiveness training can be helpful in dealing with difficult situations, but it is up to every nurse to ensure that she/he practises safely.

Professional registration

Current registration with the NMC is required in order to practise as a nurse. The registration fee and notification of the intention to practise are sent every three years. Each registered nurse is issued with a plastic card, bearing a personal identification number (PIN). Evidence of continuing professional development needs to be available in a personal professional profile as part of the requirements for re-registration. A minimum of five days (35 hours) of learning in three years must be undertaken in subjects relevant to the area of work. Many practice nurses already achieve much more than this, but arrangements are needed to help those who do not. Formal study days are not necessary, as long as the learning and its influence on nursing practice are documented. In addition, a minimum of 100 days (750 hours) of clinical practice must have been worked, or an approved return to practice course have been successfully undertaken.[18]

Appraisal and professional development

It is now common practice for staff to have a regular performance review, which should help to identify the strengths and weaknesses in their work, identify their learning needs and contribute to their professional development. All practitioners are expected to have a personal development plan and be able to demonstrate when their personal objectives have been met. Appraisal interviews should never be confused with disciplinary procedures.

NETWORKING FOR SUPPORT

Traditionally, it has been thought that practice nurses work in greater isolation than other groups of nurses but while this may be true in some instances, there

is a large support network stretching out for those who look for it. The loss of public confidence in elements of the health service, as a result of various scandals in recent times, calls for all practitioners to be able to demonstrate their competence. The use of support networks is vital to achieve this aim.

Local support

Clinical supervision

Although not a new concept, clinical supervision was slow to develop among practice nurses because of their unique employment status, but is now considered to be essential as a means of support and of promoting high standards.[19] Various ways have been suggested for organising clinical supervision, either in groups or on a one-to-one basis, and every nurse should be able to access the form of clinical supervision to suit her/himself.

Practice nurse groups

Local practice nurse groups developed spontaneously across the country as practice nursing spread but as other educational and support opportunities arose, local groups sometimes became redundant. However, there is still a need for groups of nurses to meet to share ideas and listen to speakers on topics of common interest.

The valuable support of the primary care facilitator was lost in many areas as health authorities prepared to devolve responsibility to primary care organisations. So, although some practice nurses were left in limbo for a time, the new PCOs have usually appointed practice development nurses with a remit to look after the interests of practice nurses. At the present time, few of these practice development nurses have a direct managerial responsibility for practice nurses but all professional staff are required to meet agreed standards of practice as part of clinical governance.

Regional support

Some local practice nurse groups are affiliated to regional associations, which can often lobby for change more effectively than small groups and individuals. The National Practice Nurses Conference and Exhibition is planned and organised by a different regional group each year, either alone or in conjunction with other organisations or professional conference organisers. About 500 nurses attend the three-day event, which provides an opportunity for social contact with colleagues as well as topical lectures and seminars.

National support

The RCN Practice Nurse Association is active on behalf of its members and all the specialist groups within the RCN run study days and conferences. The Community Practitioners and Health Visitors' Association and Unison also offer membership to practice nurses and publish helpful literature.

The internet is an ideal way for nurses to network. Practice nurse e-groups allow nurses to contact colleagues from all areas in order to seek or provide information. Protocols can be shared and contributors often provide web addresses of other useful internet sites.

PRACTICE NURSE EDUCATION

When the UKCC policy on community nurse education came into operation in 1996 (see Chapter 1), transitional arrangements were made for experienced practice nurses to acquire a recordable qualification in line with the automatic use of the title given to district nurses and health visitors, who qualified under the previous system. Most areas have experienced practice nurses in post with teaching qualifications, who act as practice nurse teachers. Training practices are also being designated, where a practice nurse who has a nurse education qualification provides supervision and support for nurses in training. Since September 2001, a new system for educating nurse teachers has been in place. Mentors, practice educators and lecturers have become the only recordable nurse teaching qualifications.[20]

CATS, APEL and APL

Credit accumulation and transfer (CATS) is a way of evaluating the academic content of different courses so that points can be collected towards an academic award. Three levels of credit are awarded in England and Wales:

- 120 credits at level 1 = certificate level
- + 120 credits at level 2 = diploma level
- + 120 credits at level 3 = degree level.

Scotland has four levels of credits (SCOTCATS).

Assessment of prior experiential learning (APEL) is a way of awarding credits for previous learning. Life experiences, professional knowledge and skills are assessed and credited towards a relevant academic course. A professional profile needs to be prepared, which outlines previous learning experiences and how they have influenced practice. Colleges usually charge for these assessments, which are complex to administer.