Middle Articles

GENERAL PRACTICE OBSERVED

Group Practice Nurse: an Analysis and Comment on Six Months' Work

G. N. MARSH,* M.B., B.S., D.C.H., D.OBST.R.C.O.G.

Brit. med. J., 1967, 1, 489-491

Many articles have been written in recent years on the work of a nurse in the general practitioner's surgery. However, the object of this article is to analyse the work done and the cost involved of employing a nurse in a North Country group practice in the six months immediately after the Government's acceptance of the seventh report of the Review Body.

The practice is situated on the northern edge of Stockton-on-Tees. There are five partners. The premises have been recently improved and modernized and are functional in design. The total number of patients in the practice is almost 15,000. For many years lay ancillary help has been employed and at present this consists of one full-time secretary-receptionist, three full-time receptionists, and a part-time (evening) receptionist. By the early months of 1966 it had become increasingly apparent that much of the work that was being done by doctors in the practice did not really require a fully qualified practitioner for its performance. Accordingly, once the 70% reimbursement scheme had been accepted by the Government, it was decided to employ a part-time nurse. In spite of the financial "freeze" the date of her employment (May 1966) was such that the reimbursement scheme has operated in her case. Initially she was employed for six hours a week, but very soon after beginning it was decided to increase this to eight hours a week because of the amount of work she had to do. She works for a two-hour session on four days a week.

In the first instance there were four main principles which were to govern the work the nurse carried out:

1. She was not to do work that was properly the place of the lay ancillary help—for example, typing and secretarial work, patient-reception, making appointments, record-filing, urinalyses, weighing of patients, etc.—the present ancillary staff have a staff instructional course run by one of the partners and are therefore fully capable of doing this type of work.

2. She was not to do work which was properly the place of the district nurse—that is, work which at the time was being done by the district nurse and new work which it was felt could be better and more conveniently done at home rather than in the surgery.

3. She was not to introduce work which was at the present time not being done—that is, she was not to increase the total practice work load.

4. Essentially she was to do work which was at present being done by doctors.

Her main function was therefore to relieve the doctors of some of their work load.

Advertisement Response

The advertisement for the nurse was put in one of the local newspapers for three nights, and it stated that she would be

* General Practitioner, Stockton-on-Tees.

required to work only part-time. There were 18 applicants, and six of these were short-listed. These six were interviewed by all the partners jointly during the course of an evening and four were found to be excellent. The nurse who was employed had already been working in a group practice in Cambridge. We were therefore fortunate that she knew more of the possible work of a group-practice nurse than we did ourselves.

It was obvious from the response to the advertisement that a large pool of nursing help was available within a short distance of the group practice, yet these people were not able to work in hospitals. Mostly they were young mothers who were able to work a period of only two or three hours at a time. Hospitals cannot employ nurses for such brief sessions. The employment of group-practice nurses would therefore not appear to diminish the supply of nurses for the hospital service.

Total Work Carried Out

The nurse was given an appointments book identical with those used by the partners in the practice and she has seen all her patients by appointment. A detailed record of the work she has done and all the contacts she has made with patients was kept from the onset and the figures are used in this article.

The premises contain five consulting-rooms (one for each doctor), and her sessions were timed to run when only one (or at the most two) doctors were consulting. Even if both these doctors used two consulting-rooms each—that is, using one as an examination room—there was still one room available for the nurse.

Table I shows that in the first six complete months of her employment the nurse has made 1,818 patient contacts, and all this work had previously been done by the doctors in the practice. Working on a basis of as little as two minutes for each of these contacts (the majority of them injections), she has saved 60 "doctor hours." In effect, however, the nurse has worked to a much more leisurely time schedule (five- or ten-minute appointments), to the ultimate benefit of the patients.

TABLE I.—Monthly Nurse/Patient Contacts

	June	July	Aug.	Sept.	Oct.	Nov.	Total
No. of nurse/patient contacts ..	388	448	315	193*	233	241	1,818

* On holiday for one week.

Breakdown of Work Load

Therapeutic Injections

The therapeutic injections given by the nurse are detailed in Table II. It will be seen that they include only parenteral iron and

vitamin B₁₂. It is difficult for a part-time nurse working on only four days a week for a two-hour session to be of much help to the doctor in giving an intensive course of injections—for example, intramuscular penicillin—but vitamin B₁₂ and parenteral iron, which are given at most only two or three times a week, lend themselves

TABLE II.—Therapeutic Injections Given by Nurse

	Vitamin B ₁₂	Parenteral Iron	Total
June	50	0	50
July	48	3	51
August	70	0	70
September	50	9	59
October	53	10	63
November	60	7	67
Total	331	29	360

to administration by a nurse. There is no clinical need whatever for doctors to see their patients with controlled pernicious anaemia every three or four weeks to give the injection. Far better if the patients are seen yearly for a proper reassessment than fleetingly every three weeks more or less indefinitely. Similarly there is no need for the doctor to give each iron injection of a course of, say, six or twelve.

Prophylactic Injections

All mothers in the practice have their postnatal examination carried out by the partner who gave them their antenatal care. This applies whether the baby was born at the local general-practitioner maternity unit, at home, or even for the small proportion who had their delivery in the consultant hospital. The latter (16% in my series) are told routinely by the hospital service to attend for postnatal examination at six weeks. Whether or not the patient does this the partners in the practice still carry out a postnatal consultation on the grounds that any future obstetrical or gynaecological problem will be brought to them in the first instance.

Accordingly this postnatal attendance affords an opportunity for the doctors in the practice to instruct all mothers to bring their babies at the age of 3 months for their first triple antigen injection and oral polio vaccine. This is given by the doctor. It gives him an opportunity to examine the baby at 3 months to ensure that it is normal, is passing the early milestones correctly, and is fit for immunization. After this the second and third injections and the vaccination are carried out by the nurse, and any defaulters the nurse notifies to the secretary, who sends reminders. Consequently all babies in the practice are actively immunized against diphtheria, whooping-cough, tetanus, and poliomyelitis and are vaccinated against smallpox. The second column of Table III enumerates the extent of the work.

Two large notices hang in the waiting areas in the premises giving the immunization and vaccination programme which the partners recommend. Accordingly whenever parents of children under 12 attend the surgery they are reminded of the fact that immunization or vaccination may be due for their children. By displaying this notice a great deal of time is saved in explaining the details to each parent.

Nurses are not accustomed to giving prophylactic injections. Many of them do not know how to vaccinate against smallpox. It is therefore necessary to instruct and directly supervise the nurse in these procedures when she first starts, and to continue supervision until the doctor is satisfied that she can be relied upon to carry out the technique without supervision. In addition, the nurse was instructed not to administer prophylactic procedures without inquiring about the presence of minor illness—for example, infections of the upper respiratory tract—and in the case of vaccination never to vaccinate without inquiring about the presence of skin conditions. She was instructed not to proceed if any illness or skin disease was reported by the patient, until the doctor had considered the case and had authorized her to go ahead.

A letter from the Medical Defence Union reassured us that with this level of instruction and these precautions full Defence Union cover would operate for any doctor who had deputed a nurse to act on his behalf and from whose actions unfortunate and inadvertent sequelae had followed. It should be noted, however, that were a patient to sue the nurse in person none of the British defence organizations would be able to act for her and indemnify her, and

some form of professional indemnity such as that offered by the Royal College of Nursing is advisable. It is salutary to add that the doctors in this practice and their families receive their prophylactic immunizations and vaccinations from the nurse.

At these immunization and vaccination sessions the nurse is afforded an opportunity for listening to anxious mothers and discussing the various minor problems which they are meeting in the management of their young children—for example, feeding problems, constipation, napkin rash, etc. The mothers themselves often have minor health problems which the nurse can resolve. It is certain, therefore, that the work which the nurse is saving the doctor is not only the actual immunization or vaccination procedure but also the very many and varied problems which can be discussed at that time with the nurse and which otherwise might have necessitated a full doctor consultation.

Table III also shows the various adult prophylactic immunizations which were given.

TABLE III.—Prophylactic Injections Given by Nurse

	Triple Antigen and Oral Polio	Tetanus Toxoid	T.A.B.T.	Cholera	Influenza Vaccine	Vaccinations	
						No.	Checks
June	40	2	—	—	—	166	128
July	53	6	2	1	—	176	155
August	105	—	2	—	—	52	77
September	63	1	3	—	—	48	13
October	60	1	—	—	4	39	51
November	60	—	—	3	8	39	47
Total	381	10	7	4	12	520	471

Smallpox Vaccination.—The number of smallpox vaccinations carried out is high because during the summer months of 1966 it was necessary for British citizens holidaying abroad to be vaccinated against smallpox. All these vaccinations and checks were done by the nurse. The work load that the doctors were saved was therefore considerable (see Table III).

Other Work Done by the Nurse

Dressings.—These have never been a very great work load in this practice, since patients have been encouraged to do their minor dressings at home. If the dressings have been at all major the district nurse has been asked to call. This policy has not changed. It was not the intention to turn the premises into a minor dressing-station, and the nurse has done nothing to encourage this. Table IV shows how few dressings have been done, and the gradual increase probably denotes a better channelling of patients to the nurse as time has gone by.

Venepunctures.—It is apparent from Table IV that the number of venepunctures done by the nurse is extremely small. However, if she was working on a more full-time basis and while the doctors were consulting then obviously this work could expand greatly. Even with the present small number of hours, more forethought by doctors could have saved them much time in this procedure and

TABLE IV.—Other Work Done by the Nurse

	Dressings	Ear Syringing	Venepunctures	B.P. Readings	Suture Removals	Minor Operations
June	1	—	—	1	—	—
July	3	—	—	1	—	—
August	3	3	—	—	3	3
September	6	—	—	—	—	—
October	10	—	2	—	3	1
November	15	—	1	1	—	4
Total	38	3	3	3	6	8

considerably increased the nurse's work load. I have performed approximately 280 diagnostic venepunctures in the six months from June to November, and the vast majority of these could have been carried out by the nurse in the surgery.

Ear Syringing.—Opinions differ among partners in the practice about the safety of ear syringing. Hence this work has only very

occasionally been done by the nurse (see Table IV). However, there seems no real reason to expect that the nurse would cause ototrauma by this procedure any more than the doctor. The latter will presumably see the ear initially to establish the diagnosis and prescribe a softening preparation. The syringing could then be left to the nurse so long as she has been adequately instructed. The time saved would be considerable.

Blood-pressure Reading.—The number of blood pressures taken has been small (see Table IV). This is a dimension of the nurse's work which could be readily expanded. Controlled hypertensives could well have their routine check done by the nurse, and only if alterations outside a certain range were found would referral back to the doctor be necessary. The main reason that this routine has not been more widely adopted by the partners is that the doctors themselves, custom-hardened to taking hypertensives' blood pressures, have not made use of an available facility and referred such patients to the nurse for follow-up.

Minor Operations.—This work was the only exception that was made to the principles of employing a nurse which are enumerated above. Before we had a nurse sebaceous cysts, warts, and various skin nodules had all been put on the minor operations waiting-list at the hospital. Now, however, one of the partners conducts a minor surgery session about every six weeks. All the instrument sterilizing is done by the nurse beforehand in a small hot-air oven which was formerly used for sterilizing glass syringes. Each patient on the minor operations list is prescribed a "sterile dressing pack" (Vernaid) on Form E.C. 10. These dressing packs contain not only sterile dressings and cotton-wool and a sterile towel on which to dry scrubbed-up hands but also a sterile working surface on which sterile instruments can be placed before and during use. The nurse, having set the necessary sterile trays, prepares the patient, and assists as a "dirty nurse"—that is, not scrubbed up—at the operation. The minor surgery facilities offered at the group practice centre are therefore probably on a par with those available at the hospital. Though this is an added work load, it is greatly enjoyed by the partner concerned, who is thus able to satisfy his interest in minor surgery.

Cost to the Practice

Part-time nurses are paid by the hour (pro rata to the full-time scale) according to their number of yearly increments. Hence the hourly rate can vary from 6s. 3d. to 8s. if the practice decides to use the recognized hospital rates.

For her six months' work (mostly at eight hours a week) our nurse was paid £85, of which £51 was reimbursed by the executive council. Hence the nurse has made 1,818 official patient contacts (and countless other unofficial contacts) at a cost of £35 (including National Insurance stamp)—which seems reasonable value for money.

Future Work

Increase in Present Work

It is obvious from the figures in this article that the nurse could increase her work load in probably every item listed, with the exception of prophylactic immunizations, over which she has complete control. With increased hours of work therapeutic injections (penicillin, etc.) could be completely handed over to her, as could many venepunctures, blood-pressure checks, ear syringings, etc.

Expansion of Nurses' Work

Casualty Work.—For the first six months, with the exception of minor operations, the nurse has not increased the total work load of the practice. This was a principle of her employment. However, the group practice centre is developing an ever-expanding role in community health care, and it may well be that ultimately it will be necessary for it to perform the function of a minor extrahospital casualty centre. This would require facilities (casualty-room) not as yet available, but such facilities would need nursing staff.

Diagnostic Procedures.—Nurses could be trained to carry out haemoglobin estimations on a photoelectric haemoglobinometer, take electrocardiograms, to use a Vitalograph and other diagnostic instruments in a "procedures room." They could in fact be trained as "small-time technicians."

House Visits.—There may also be a place for the nurse to see patients at home on follow-up visits. This would necessitate her having a car. Though repeat visiting is becoming less common in view of the appointment system and the speed with which convalescing patients can get to and from the surgery, some repeat visits (especially those to the very young and the very old) are still necessary. Some of these could well be carried out by the practice nurse.

Telephone Advice.—If requests for visits received on the telephone before 10 a.m. were answered by a nurse a certain proportion of the calls could probably be translated into surgery attendances by appointment later that day without causing hardship to the patient and saving the doctor time.

Antenatal Care.—Finally, in the field of antenatal care the group practice nurse with her S.C.M. has a great deal to offer. In many areas local authorities are extremely reluctant to attach district midwives to group practices. The obvious immediate short-term answer is for the group practice to employ its own nurse-midwife, who would be able to carry out a proportion of the routine antenatal care in place of the doctor and also give general advice on hygiene, diet, etc. Playing her part at this stage in care of the mothers, she would be accepted automatically by them when the time came for her to carry out routine prophylactic procedures on the new babies. In many ways the group practice nurse-midwife may be of greater value to the group practice than an attached local authority district midwife in that the latter may be restricted by local authority rules and regulations and also would have outside commitments that might interfere with her work in the group practice centre.

Summary

This paper describes in detail the work carried out by a nurse in a group practice in the six months June to November 1966. During this time 1,818 patients were seen at a cost to the practice of £35.

Future expansion of the nurses' work is discussed.

Thanks are due to my partners, Drs. K. G. Wilmot, W. C. Moonie, A. C. MacDonald, and R. G. P. Hall, for permission to publish the practice figures and for their helpful comments during the preparation of the article. The figures have been collected and analysed by Miss Susan Hayton (practice secretary), and the work detailed in the article has been carried out with interest and enthusiasm by Mrs. Jennifer Claxton, S.R.N.