The clinical task

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This is the second of a series of articles focusing on the current tasks and functions of the primary health care team

In most practices the practice nurse is now an established member of the primary health care team, but this is a relatively new phenomenon. Any attempt to establish when practice nursing began is fraught with difficulty as there is an inevitable discrepancy between the official information and the experience of those who have worked in general practice without an official title or recognition. It is well known that the general practitioner's wife who had nursing qualifications was called on to use her bandaging and other nursing skills in between acting as receptionist, nanny, and chief cook and bottle washer to her overworked husband; and it may reasonably be supposed that the nursing duties were a forerunner to practice nursing as it is today.

Development of practice nursing

The chief factor in bringing about the change in practice nursing was the revision of general practitioners' terms of service in the mid-1960s, which not only introduced a 70% subsidy for employing a nurse in the practice but also specifically encouraged general practitioners to delegate tasks to nurses with the proviso that "reasonable steps are taken to ensure continuity of treatment..." and that the member of staff to whom such tasks were delegated was "... competent to carry out such treatment."

In 1968 the Health Service and Public Health Act allowed district nurses to treat patients in practice premises as well as in their own homes, opening the door for delegation of tasks to a wider client base. It rapidly became clear, however, that district nursing staff had insufficient time to take on this new role without compromising their domiciliary work. The door had been opened a crack, and it seems there were plenty of nurses waiting outside to push it open wider.

Department of Health figures indicate that in 1977 there were about 1500 practice nurses employed under the ancillary staff scheme. By 1984 the figure had reached 2000 whole time equivalents in England and Wales, and by 1986 it was 3700²; and with increasing numbers of nurses employed by local district health authorities to work in general practice the nurse was clearly an important part of the primary health care team. By 1988 the figure had doubled, and, with the advent of the new general practitioners' contract, by the end of 1991 there were about 18 000 practice nurses in post.

Strength in numbers alone is not sufficient to guarantee success, and those who work in unsatisfactory situations will find scant comfort in knowing they are not alone. To those nurses who feel isolated in their posts, unsupported, and perhaps misunderstood by their employing general practitioners it is only too evident that a disparate group of people who are working under one roof with the same group of patients do not become a team simply by being called one. However, nurses must ensure that they are suitably prepared for their delegated tasks. While there are nurses spending time carrying out tasks for which they have neither been trained nor employed (for example, dispensing) and general practitioners who remain unaware and unconcerned about the potential and limitations of practice nurses, for some practices

Tasks included in the developing role of the practice nurse

- Promotion of self care
- Follow up care after minor surgery in the practice
- Performing immunisations
- Giving vaccinations for foreign travel and advice on health care abroad
- Care of patients with chronic disease in the community
- Performing venepuncture
- Syringing ears
- Taking cervical smears
- The possibility of prescribing by nurses in the future
- Audit and self assessment

real teamwork will be nothing more than an interesting theory expounded in erudite medical journals.

Workload of the primary health care team

The 20 year period of growth in practice nursing has also seen considerable change in the workload and structure of the primary health care teams. Indeed there can be few "new" branches of a profession that have seen so many changes in their short life. Changes have occurred in response both to patients' (or clients') expectations and to government moves. It is perhaps fanciful to suggest that no aspect of life is deemed outside the scope of some member of the team. It is certainly true, however, that there is now a much greater emphasis on services provided to "the well." The promotion of self care is now deemed much more important than in the early days of the nurse in general practice, when the members of the team were all concerned with the sick and their families in either a supporting or remedial role.

One outcome of the transfer of patients to the community from institutions for mentally ill and handicapped people and earlier discharge from hospitals has been a blurring of the edges of the roles, and indeed the definitions, of primary health care and community care. The workload of both has increased and a jealously guarded territorial approach can no longer be countenanced.

ROLE OF THE PRACTICE NURSE

The workload of all team members includes considerable time spent treating patients with acute conditions, and the delegation of tasks such as changing dressings and removing sutures after trauma or surgery to the nurse is not a new phenomenon. This delegation has greatly increased, however, as general practitioners have undertaken emergency and minor surgery work in the practice which would previously have been done in hospital. The nursing tasks for such cases are now divided between the practice and district nurses on the basis of the patients' ability to attend the surgery. The presence of a practice nurse has also led to a change in self referral of patients both for treatment

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and for advice. In some instances the health visitor may previously have been seen as the person most appropriate to undertake this role. It should now be recognised that, provided adequate training has been undertaken, the practice nurse can make a valuable contribution in support of the health visitor and district nurse and is potentially always available to meet the demands of today's "instant" society.

IMMUNISATIONS

There has also been a movement towards the practice nurse performing immunisations. Targets for childhood immunisation are best met by an organised and consistent team approach, with all parties committed to maximum uptake. The health visitor's initial visit to the infant may be the beginning of the process, with the message reinforced by the general practitioner at the six or eight weeks' check. A combined clinic with the health visitor and general practitioner present to monitor progress and give support and advice as necessary and the practice nurse giving the immunisations may well be the most effective way of providing this service. Opportunistic immunisation of non-attenders at the clinic when they attend the practice can be carried out by the practice nurse. Adult immunisation and giving vaccinations for foreign travel and advice on health care abroad are now commonly delegated to practice nurses, enabling a flexible service.

Move to community care

Perhaps the greatest change for the primary health care team in recent years has occurred in the management of chronic diseases. For people with diabetes, asthma, or hypertension the pattern of diagnosis—hospital referral and outpatient follow up, with the general practitioner prescribing drugs and giving support between visits—has been broken, and care in the community has become the norm for all but the most complex cases. For most patients at the very least this is considerably more convenient, and at best they receive personally tailored, systematic care locally from professionals with whom they already have a

rapport and in whom they have confidence. Sadly this confidence is sometimes misplaced, as the introduction of payment for health promotion clinics has been responsible for "road to Damascus" experiences for some general practitioners who were previously unwilling to delegate such work to practice nurses, unhappy with the extension of their role beyond anything but task orientated handmaiden.

The move to community care has also given scope for enthusiastic but untrained and unaware nurses to take on roles for which they have had no suitable preparation, and the inevitable loser is the patient. A golden opportunity to review the care of patients with chronic diseases in a team setting, with each team member taking advantage of further training and development and sharing in the drawing up of protocols, has in too many cases been lost. In the best provided for centres, however, there will be access to a community dietician, physiotherapist, chiropodist, and social worker, with referrals made directly by the general practitioner, health visitor, district nurse, and practice nurse.

Accountability

But how have these changes affected those who are providing the care? For the general practitioners there are not only the issues of keeping themselves updated in all aspects of care for all conditions, issues which affect all of the members of the primary health care team, but there is the added concern of clinical responsibility. If general practitioners are to delegate specific tasks to other members of the team they must do so with a clear knowledge of their fellow professionals' capabilities, a knowledge which includes awareness of the content of the training they have undertaken, so that there is no ambiguity about the limitations as well as the extent to which their role can reasonably be extended. Also, all parties concerned must recognise that tasks should be delegated or undertaken only by agreement, with an acknowledgment of individual accountability and where this begins and ends. Professional indemnity is relevant to all concerned, and the terms under which this is applicable are unambiguous and immutable. A nurse undertaking responsibilities for which she has not been trained and assessed as competent is not protected, and no amount of goodwill from her employer will alter this fact.

Communication is a fundamental part of the processes of both delegation and role extension, and there need be no barrier to developing the role of the practice nurse if this is mutually respected. The evidence that this is both possible and successful is widespread, and the Georgian Research Society's pilot study of general practitioners' attitudes towards practice nurses suggests that most practitioners favour the extension of the nurses' role.³ It has even been suggested more recently that an increase in the number of nurse practitioners could, in conjunction with optimum participation by all members of the primary health care team, enable practitioners to increase their list size relatively painlessly.⁴ (Self referral by the patient to a nurse practitioner for diagnosis and treatment of certain conditions to an agreed medical protocol, with referral to the general practitioner of those outside this protocol, is now the chief difference between the nurse practitioner and the practice nurse, and there is obviously scope for developing this role to the benefit of all concerned.)

PRESCRIBING BY NURSES

The issue of nurses prescribing looks set to rumble on for some time. This should allow all parties concerned to examine the issues carefully as such

The practice nurse is potentially always available to give treatment or advice

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a radical move raises at least as many questions as it answers. The practice of nurses selecting and administering a treatment (such as applying a dressing) but requiring a general practitioner's signature on the prescription form may be seen as demeaning,⁵ and prescribing by nurses would promote greater professional independence in this respect. But accountability issues remain, and there is a need for a considerable training and education programme for those nurses for whom prescribing is proposed. Few nurses currently in post will be equipped for this without a great deal of support, and it is not surprising that employing general practitioners have reservations. Before prescribing is undertaken by nurses it could be beneficial to all parties to discuss aims and objectives, and a locally devised protocol and limited list would ensure that everyone concerned may embark on this new development with confidence.

Audit

This system of evaluation can be effectively applied in other spheres of activity, and indeed audit is a requirement for general practice. This seems entirely reasonable and is an integral part of improving the service and quality of care offered to patients. Audit is most effective if it is undertaken by individual members of the primary health care team, with regular feedback in both directions. Unfortunately it does not come easily to everyone. As many of us trained in an atmosphere where initiative was frowned on, and our work was principally task orientated, the tasks being

laid down by the consultant or tradition, it is perhaps understandable that the prospect of self motivation and assessment is a daunting one. Audit need not, however, be seen as a negative and potentially threatening activity. Indeed, it is encouraging to be able to demonstrate both to yourself and to other team members that aims and objectives have been achieved, or that change has begun to take place, and if audit is regularly undertaken any inefficient procedures and systems can be amended before they become too deeply ingrained.

For practice nurses working with team members who are unsure about extension of the nurse's role audit presents an excellent opportunity for nurses to show how successful their position is. Nurses are particularly good at organising, and the organisation of accurate records is fundamental to the audit process. Team audit and feedback may lead to redistribution of tasks and reassessment of systems, and with a cohesive team approach this can only be beneficial, not only in terms of professional development for the team members but most importantly for the patients.

This series has been edited by Dr Mike Pringle.

- 1 Statutory Instrument 1966 No 1210. NHS Eng & Wales Gen Med & Pharm Serv. Reg. 1966.
- 2 Department of Health. *Statistics for general medical practice in England and Wales, 1979-89*. London: DoH, 1990.
- 3 Beaton S, Campbell D, O'Sullivan J, Robinson G, Sedgwick J, Tanner S, et al. The attitude of general practitioners towards practice nurses: a pilot study. *Br J Gen Pract* 1991;41:19-22.
- 4 Marsh GN. Caring for larger lists. *BMJ* 1991;303:1312-6.
- 5 Crown JM. *Primary Health Care* 1991;1:30.

ANY QUESTIONS

Does the routine use of aniline dyes as currently used by leather workers carry an appreciable risk of carcinogenesis?

Nine reported studies have looked at the relation between leather work and bladder cancer (more correctly urothelial cancer, as most of the urinary tract may be affected). Reported relative risks have varied from 1.49 to 6.3.¹ Unfortunately, the term "leather worker" embraces a wide range of occupations and it is difficult to attribute risk to any particular chemical. Study is further confused by the inability to distinguish between occupational and natural tumours and their long latency, typically more than 40 years.

A causal link between bladder cancer and the manufacture of the aniline based azo dyes, auramine and magenta, has long been known, and the condition was called aniline cancer. Research subsequently showed that the carcinogens were naphthylamine and benzidine, present as impurities in quantities up to 15%. They are structurally different from aniline, having two benzene rings rather than one. It has been suggested that these carcinogens could be liberated from azo dyes, either during decolouring of misdye fabrics by reductive dye stripping or by the action of tissue or gut flora azoreductases on such dyes. Support for this theory has been adduced from research showing that rodents and dogs fed with certain azo dyes developed bladder tumours.² Such an association has never been proved in humans, and dye stripping is not used in the leather industry.

Regardless of these uncertainties, advances in dye technology have dramatically reduced the risk of urothelial cancer. Azo dyes are seldom used in the leather industry nowadays, and those that are contain quantities of potentially carcinogenic impurities a thousand times lower than the presumed safe levels permitted by European law.³—ALAN SCOTT, senior employment medical adviser, Health and Safety Executive, Nottingham

- 1 Alderson M. *Occupational cancer*. London: Butterworth, 1986:135-9.
- 2 Clayton DB. Bladder cancer. In: Parmeggiani L, ed. *Encyclopaedia of*

occupational health and safety. 3rd ed. Geneva: International Labour Office, 1983:293.

- 3 Sykes RL. *Safety aspects of some chemicals used in the leather industry*. Northampton: British Leather Manufacturers Research Association, 1981:15.

How old should children be before they are taken swimming? Does timing bear any relation to immunisation status, and does it differ for swimming baths and the sea?

A paediatrician's first response would be that childhood drownings account for many more deaths than do water based infections in developed countries, and child safety is the first priority. Assuming that suitable precautions have been taken, what of the risk of infections? In Britain there is a popular belief that babies should not be taken to their local swimming baths until they have had their first immunisation. I am not sure of the origin of this belief, which is not apparently held in North America or Australia. It has no logic, given the scant protection provided by the first as opposed to the second and third immunisations¹ and the high degree of sterility of most chlorinated pools. It is yet another myth about immunisation, and we should not put restrictions on age for swimming in public pools.

In many countries pollution of the sea is far more a problem, and untreated sewage may be discharged near the beach. During an outbreak of poliomyelitis in Finland in 1984-5 poliovirus type 3 was common in sewage and seawater.² Recommendations on swimming in the sea should reflect local levels of pollution, but if there is doubt about the cleanliness of the water it would be wise to wait until after a child's second dose of polio vaccine.—DAVID ISAACS, head of department of immunology and infectious diseases, Sydney, Australia

- 1 Halsey N, Galazka A. The efficacy of DPT and oral poliomyelitis immunisation schedules initiated from birth to 12 weeks of age. *Bull WHO* 1985;63:1151-69.
- 2 Hovi T, Cantell K, Huovilainen A, Kinnunen E, Kuronen T, Lapinleimu K, et al. Outbreak of paralytic poliomyelitis in Finland: widespread circulation of antigenically altered poliovirus type 3 in a vaccinated population. *Lancet* 1986;ii:1427-32.