Practice Nurse Handbook

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Fourth edition

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Contents

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CHAPTER 3
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CHAPTER 4
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CHAPTER 11
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Preface to the Fourth Edition

So many changes have happened in practice nursing and within the National Health Service since writing the last edition in 1994, that it was difficult to decide how to proceed. The nursing journals frequently contain articles about the pioneering work of individual practice nurses, which make other experiences seem humble by comparison. In deciding what information to include, I tried to think of those things I most needed to know when new to practice nursing. I adopted the same objectives as last time. Namely: to give as many practical hints and pointers as possible, to draw attention to the legal pitfalls, and to indicate ways that practice nurses can develop their role. The emphasis throughout is on the need for on-going education.

The Internet has been invaluable in verifying facts and seeking new information. I have included many of the web sites which were particularly useful. The sheer scale of the information available and the volume of Government documents online, has meant that this book has assumed a rather Anglo-centric nature. I hope that readers in other parts of the United Kingdom will forgive this.

Gillian Hampson

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Nesta Jones also generously gave her time to provide constructive criticism about other chapters and helped with finding reference material, even while she was studying successfully for her BSc degree in practice nursing. Her assistance was greatly appreciated.

Chapter 1
Teamwork in General Practice

This chapter outlines the background to the work of practice nurses so that their role can considered within the context of the whole primary health care 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 their financial state. It seems naive now, to realise that 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 either chronic conditions which cannot be cured, or the 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. District nurses and health visitors were employed by the local authorities.

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. This includes 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 in 1966 the so-called *GPs' Charter*, 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, which may account for some of the attitudes subsequently displayed towards nurses employed in general practice.

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 fund-holders 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 (PCAs).

A change of government in 1997 led to the development of *The New NHS*[4]. Fund-holding was abolished and instead of being in competition, all the practices in a locality became part of primary care groups. 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 unremitting, with a stream of targets to reduce waiting lists and national service frameworks (NSFs) specifying standards for services for the common diseases. The National Institute for Clinical Excellence was established to make recommendations on the use of new drugs and treatments in order to end the 'postcode lottery', whereby patients in one health authority area could be denied treatments available elsewhere. The Commission for Health Improvement was established to inspect health authorities and trusts (including general practices) and to monitor performance. The National Clinical Assessment Authority was set up

to provide a rapid investigation into the performance of certain doctors, in the wake of several medical scandals[5–7].

The NHS plan

In the year 2000 the Government published an ambitious plan for investment and reform of the NHS to take place over ten years[8]. 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.

Primary care trusts (PCTs)

Primary care trusts quickly replaced PCGs; becoming autonomous providers of general practice and community nursing services and commissioners of secondary care. As many of the functions of the health authorities have been devolved to PCTs, health authorities have started to merge into larger strategic bodies akin to the old regional health authorities. Proposals are also contained in the NHS plan for PCTs to merge with social service departments to form care trusts, with budgets to provide integrated health and social services.

Health Service structures

Although politics can seem remote from direct patient care, it is essential to keep abreast of developments in the organisation of the NHS. 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 structures for Scotland, Wales and Northern Ireland were always slightly different but there are likely to be more significant changes now that parliamentary devolution has taken place. The NHS Policy Board decides the overall strategy for the NHS. The various directorates and branches of the NHS Executive (NHSE) are responsible for the operation of the service in terms of effectiveness and value for money.

The 'New' GP Contract

In 1990 the Government imposed a new contract on GPs; requiring them to provide a range of screening and health promotion services. Many practice nurses were employed at that time to undertake the extra work[9]. Apart from the medical services already offered to patients, the new contract required GPs to be responsible for:

- Child health surveillance – developmental checks up to the age of five for which a single fee may be claimed
- Registration health checks – for all patients aged 5–75 (a fee can be claimed)

- Annual health checks for patients aged over 75 years
- Health promotion clinics (clinic fees were replaced in 1993 by target payments for specific health promotion activities)
- Minor surgery – by doctors accepted onto the minor surgery list (fees can be claimed for 15 minor operations per GP each quarter).

Health targets

In that same year, the Government introduced targets for reducing disease and disability through its *Health of the Nation* strategy for England. This was replaced in 1997 by the Labour Government's strategy document *Saving Lives: The Nation's Health*[10]. Similar strategies were produced in the other countries of Great Britain.

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 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[11]. *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).

General practice as a business

Unlike hospital doctors, who are salaried, GPs have always been independent contractors, with the same contract with the NHS for providing general medical services (GMS). This has a very complicated system of remuneration and *The Statement of Fees and Allowances* (known as the Red Book) gives details of all the payments which GPs may receive from the NHS. Payments include:

- Basic practice allowance – towards the costs incurred in providing medical services to NHS patients.
- Capitation fees – for each patient registered. Higher rates are paid for patients aged over 65 and over 75 years of age, to reflect the increased healthcare needs of older people. Higher rates are also paid for the extra work generated in areas of social deprivation (calculated using the Jarman Index of Deprivation[12]).
- Item of service fees – can be claimed for additional services, e.g. family planning, registration health checks, some immunisation. (Payments for cervical screening and childhood immunisation may sometimes only be

made when overall targets are reached.) Maternity care, night visits and emergency treatment can attract fees.

- Other payments
  - Budgets include partial reimbursement for ancillary staff salaries and training costs.
  - Other diverse activities, such as teaching medical students or dispensing, may earn payments.
  - The postgraduate education allowance (PGEA) is paid to doctors who provide the required evidence of professional updating. The system for managing PGEA is being updated.

Apart from payments by the NHS, GPs are entitled to charge for activities not covered by their contract, such as writing reports, private medical certificates and examinations, or for treating non-NHS patients privately. PCTs may now give additional incentive payments for effective prescribing and meeting clinical governance and HlmP targets, or provide money for practice development schemes.

Personal medical services (PMS)

The Primary Care Act of 1997 permitted a departure from the national GMS contract[13]. PMS pilot practices (the first wave started in 1998), demonstrated new ways of providing general practice services, through local contracts with health authorities (later with primary care trusts). Some pilots have been led by nurses, who employ salaried GPs to provide medical services to their practice populations. The majority of nurse-led pilots have tended to provide services for specific population groups, such as the homeless, refugees and asylum seekers; or people in under-doctored areas[14].

Education

Postgraduate training for general practice was introduced on a more formal basis in 1973, followed by the Vocational Training Act in 1981. It is now impossible to become a principal in general practice without three years specific postgraduate education, which includes one year as a registrar in an approved training practice. However, many changes are in the offing for all professional education. Multi-professional education, whereby members of different professions learn together and are able to switch more easily between career pathways has been strongly advocated by the Department of Health[15]. Workforce development confederations have taken the place of the local medical workforce advisory groups and the education consortia in order to bring all the branches of health-related professional education under one umbrella. The inclusion of patients in education for the professions is a welcome part of the move to involve the public more closely in the running of the NHS.

Revalidation

The General Medical Council has instituted a process of appraisals for GPs, who will be required to develop personal learning plans and to demonstrate their fitness to practice. Revalidation at regular intervals may also be required[16]. Practice development plans are a way of ensuring all practice staff reach their full potential and that lifelong learning underpins the work of everybody. Nurses are already accustomed to keeping professional profiles and to reregistering every three years. The terminology used for development varies from area to area, so the use of abbreviations can be misleading. In some areas personal development plans may be confused with practice development plans if both are called PDPs.

Beacon practices

Practices which have demonstrated particular expertise or have developed innovative ways of working can be registered as beacon practices, which members of other practices can visit to learn about their successes and problems[17]. A booklet is available listing the beacon sites and the reason beacon status was awarded.

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[18]. 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.