THE USE OF A NURSE IN GENERAL PRACTICE

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IN THE SUMMER OF 1964, the partners in the practice described in this article found themselves taking stock of their position and considering what might be done to meet the impact of an increasing work load, caused partly by a tendency for patients to seek advice more readily and partly by the anticipation of an increase in numbers on the practice list. The volume of this increase was completely unknown, depending as it did on the amount of new housing about to be built.

The possibility of assuming a fifth partner was considered but, as the ultimate size of the practice was not possible to foresee and as such a partner could not be provided with a consulting room owing to shortage of space, this was decided against and we considered the possibility of employing a nurse.

The local authority in this area provides health visitors, midwives and district nursing sisters in adequate numbers. They are charming and competent and work very closely with all the doctors and attend a fortnightly meeting in the practice consulting rooms to discuss common problems. The medical officer of health, however, has not found it appropriate to attach nurses or other local authority staff to the practice and we were therefore reluctant to ask the nursing sisters to undertake work in the surgery. In addition to that, the demands we made on them for domiciliary visiting were often sufficient to occupy their time to the full.

We therefore advertised for a nurse and we received some 22 replies, a few from outstanding applicants. We were fortunate to obtain the services of Miss Ferguson, R.G.N., S.C.M., Q.N.S., who had recently completed a year as district nursing sister with a neighbouring local authority.

Once the decision to employ a trained nurse had been taken, we felt it most important to try and define her duties. The principle reason for this was to ensure that she did not find herself acting as an extra receptionist. It was therefore made clear to her and the rest of the staff that she was employed solely as a professional person and that it was not part of her duties to file record envelopes or make routine appointments. In order to emphasize her professional status, she would be required to wear her uniform. In retrospect, we believe these decisions were correct because not only has the nurse’s professional position been maintained, but the presence of a uniformed nurse on the premises has raised the

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status of the practice in the eyes of the patients.

This is a semirural practice in a small town ten miles south of Edinburgh. There is no other practice in the town. The nearest doctor lives four miles away and he visits patients in the town but has no consulting room there. Owing to a considerable scheme of private building, the numbers of patients on the practice list has increased steadily from approximately 9,800 at the beginning of this study to approximately 10,500 at the end.

In November 1964, there were four principals whose experience in the practice ranged from three to 30 years. In addition to the doctors, there was a secretary who had been with the firm for 19 years, two half-time receptionists working staggered hours, and thus providing full-time cover and a resident caretaker-receptionist who took messages and made appointments out of hours, and undertook some duties during consulting hours. There was also a daily cleaner.

The practice premises are in a detached house, converted for the purpose, situated on the main road at a convenient 'bus stop. The upper storey has been converted into a self-contained flat with separate access by an outside stair as well as an inside one. This flat is occupied by the caretaker and her family.

The ground floor, which has been extended for the purpose, contains four consulting rooms, an examination room, a waiting room, a room with a reception counter, and a large office and a toilet.

All consultations are by appointment. Surgery sessions, which are limited to one hour at a time, are from 9–10 a.m., 11–12 a.m., 2–3 p.m., 4–5 p.m. and 5.30–6.30 p.m. Two doctors are on duty at each session. Although, owing to the flexibility of the appointment system, consultations may be going on in any of the surgeries at any time, there is usually one unoccupied surgery. We therefore decided that the nurse should use the vacant room. As this meant that she would be using a different room at different times, it was decided to purchase a dressing trolley, equipped to her own requirements, which could be pushed from room to room. Although this was a second best arrangement, as we could not give her a room of her own, it proved reasonably satisfactory.

Neither we nor she had any experience of this type of work and this is one of the reasons that lead us to attempt to define the sphere of her activity. However, we started hopefully feeling our way, and it was soon apparent that we had a lot to learn about how best to make use of the nurse's services, and during the first month she was not given enough to do. In one respect this was fortunate because she immediately set about getting the surgeries put to rights. Before she came we thought we had a good organization but by the time she had cleaned out and tidied the cupboards, re-organized the stock, prepared sterile instruments and adequate supplies of dressings, we began to realize that our arrangements had fallen far short of what they should have been. Almost at once our standard of work in the surgery began to rise. Not only did we find it easier to carry out procedures by reason of the fact that dressings, instruments and facilities for taking specimens and so on were ready for
immediate use but the very presence of a competent nurse kept us on our toes.

In due course, we were able to examine the work done by the nurse and it seemed to fall into certain categories:

1. Maintenance of equipment. This includes routine care of instruments, dressings and drugs; keeping all supplies, including vaccines, pathological specimen containers, dangerous drugs, disposable towels and syringes, etc., up to date; maintaining the accident bag and midwifery bag ready for instant use.

2. Carrying out procedures in support of a consultation with the doctor, e.g., applying dressings, estimating haemoglobin, etc.

3. Carrying out regular procedures after the patient has first been seen by the doctor until the treatment is finished or the nurse needs further instruction, e.g., gynaecological treatment, daily dressing of wounds, or dressing of warts. With the help of the receptionists, she has developed her own appointment system.

4. Carrying out procedures in which the doctor is not involved, e.g., routine immunizations and minor accidents attending without appointment or when there is no doctor immediately available.

With regard to the fourth category, it soon became known that the nurse was available for doing immunizations and she was obliged to set aside an hour for this purpose each week. Treatment of minor accidents can be time consuming and they disrupt a full session of appointments. With nurse available, she takes the patient into the surgery and cleans the affected part and prepares everything for treatment. It then takes the doctor only a few seconds sometimes to instruct her as to what treatment she shall carry out. Miss Ferguson was asked to keep a record of the amount of work she did. In addition to all the time spent on maintaining the equipment, she saw an average of 84 patients per week.

She herself feels that she could do more than this and would like to do so, particularly if she had a room of her own, and I am sure it would be possible to make better use of her services by delegating more work to her.

Discussion

There have been several references in the literature to the use of a nurse in general practice, and there have been different ways of using her services. In one method, a local authority district nurse is seconded to a practice but does domiciliary visiting only. In another method, the district nurse is seconded to the practice and, in addition to doing her domiciliary work, also works in the surgery. In the method referred to in this paper, the nurse works in the surgery only, full-time. Lea and Forman describe examples of this kind. The above-mentioned papers refer to the use of a full-time nurse, but examples of the use of a nurse for limited periods are also described. Whichever method is used, the almost universal observation is that the doctors and the nurses all like it, and in every case the standards of practice are improved. Adverse comments are rare and I think these probably apply to practices where the nurse is employed more as a receptionist than a professional ancillary helper.

The question arises as to what is the best method of making use of a nurse's services in general practice. Not all doctors would use a nurse's
services in the same way and different kinds of practice require different kinds of assistance. It seems to me, however, although my experience is limited, that there are certain advantages in the arrangements described here. First, the nurse is employed solely by the practice and therefore her duties can be planned, and her loyalty is to the practice only and is not shared with the local authority. There is also the advantage of having a nurse available at the surgery all day, which is much appreciated by the patients and which enhances the status of the practice.

Whatever method is adopted, one thing is abundantly clear and that is that, provided a nurse is employed in a professional capacity, the standard of practice of the doctors who employ her is immediately and permanently raised to a new level.

REFERENCES

FIFTEEN YEARS IN GENERAL PRACTICE

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THE RECENT PUBLICITY GIVEN TO THE working conditions of the general practitioner has brought to the fore the question of ancillary help in general practice.

An interesting series of articles recently appeared in the Nursing Times (June and July 1965) on this subject, in which reference was made to papers published by Dr Forman of Barnstaple, during recent years. (A nurse in general practice and Ancillary help in general practice). Dr Forman and his partners must have been one of the first group practices to employ a full-time nurse to work with them; as I have recently left them after 15 years they suggested that a review of the progress made during this time might be of interest to others.

The beginning of August 1950 brought me into a completely new field of nursing—there were no footsteps to follow, and the pattern of my work

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