Surgery-attached psychogeriatric nurses: an evaluation of psychiatric nurses in the primary care team

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SUMMARY. Aspects of the work of five community psychiatric nurses are examined by means of a questionnaire completed by the nurses for a sample of 50 patients. Information sharing and a close working relationship with the general practitioner, skills relating to assessment and psychological support of patients, organization of care by other agencies, a detailed knowledge of community agencies, and a capacity for interdisciplinary working were all found to be important. Tasks relating to body care were reported in only a small number of cases. The nurses saw themselves as advising on the planning of patient management and the selection of medication in a substantial minority of cases. The original brief had been to care for psychogeriatric patients but a third of the patients fell into a younger age group. These findings are discussed in connection with their implications for the future training of nurses and the relationship between primary care teams and local psychiatric services.

Introduction

RECENT medical studies have emphasized the changing and expanding nursing role both in general practice and in psychiatry. Marsh and McNay (1974) and Kaim-Caudle and Marsh (1975) described the feasibility and acceptability of general practice nurses offering home visiting and surgery consultation in place of the general practitioner. Marks and colleagues (1973 and 1975) described the training of five registered mental nurses in the use of behavioural therapy with adult neurotic patients, the nurses achieving results comparable with those of psychologists and psychiatrists. Freeman (1968) identified domiciliary support, the needs of the elderly, and increased involvement of general practitioners as important factors in the development of a comprehensive community mental health service.

Arising from such considerations, three nurses were detached from St Crispin Hospital in 1969, and a further two in 1972, to work with 30 general practitioners in two towns in Northamptonshire as members of the primary care teams. The first three nurses had no special training; the last two attended courses in community nursing. All the nurses had a close liaison with the psychogeriatric wards of St Crispin Hospital and each group of nurses had the opportunity for regular administrative and clinical support meetings with psychiatric consultants.

It became clear that the nurses were developing close working relationships with their respective general practitioners and had become integral members of the primary care team. However, since most of their work lay outside the psychiatric network, it was difficult to get a clear picture of their function, and this led to the present study.

Aim

We sought to examine the role of five surgery-attached psychiatric nurses with a specific brief to care for psychogeriatric patients, defined as patients aged 65 and over in whom psychological symptoms were prominent, whether due to ageing, functional psychiatric disorder, or physical disease.

Method

Following consultation with the nurses involved, we designed a questionnaire with the following aims:

1. To examine a sample patient population.
2. To ascertain the working relationship with the general practitioner and other agencies in the community.
3. To examine the nursing skills which were being used.

The questionnaires were distributed in May 1974. With the permission of the relevant general practitioner, each nurse completed a questionnaire for 10 of his or her

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© *Journal of the Royal College of General Practitioners*, 1980, 30, 85-89.

patients selected randomly by us, giving a total of 50 patients from a case load of 321. We report on this sample population of 50 patients unless we state otherwise.

Results

Population

Most of the patients were female (88 per cent), about a third were under 65 years old (34 per cent), and a quarter were under 60 (24 per cent). A third were over 80 (32 per cent) and two of the patients were under 40. Fifty per cent of the patients lived alone, 36 per cent with their spouse, and 14 per cent with relatives.

Referrals

General practitioners (92 per cent) were by far the largest referral source of patients to the psychogeriatric nursing service; no referrals were received from community social workers. Among the reasons for referral (only 48 patients assessed) depression accounted for approximately half (52 per cent) of the cases though there was some overlap with dementia, and social and medical problems. There was a trend for social (44 per cent) and medical (10 per cent) problems to be found among the younger age group. A smaller proportion of the sample (27 per cent) were referred because they were dementing.

Length and frequency of visiting

The average length of care the patients had received before the study period was 36 months. Four fifths of the patients were visited more than monthly while most were visited weekly; only one patient was visited daily.

Relationship with general practitioner

Contact with the general practitioner was considered adequate in all but one case. In 46 per cent of the cases the nurse felt that the general practitioner regarded her as a member solely of the primary care team, in 24 per cent of the cases as a member of the psychiatric team, and in 30 per cent of cases as both. The decision to accept the patient after the initial visit was felt by the nurse to be a joint decision with the doctor in a high proportion (84 per cent) of cases.

Information sharing (84 per cent) and sharing the burden of care with the general practitioner (72 per cent) were strongly emphasized, while in 18 per cent of cases the nurse felt the doctor had used her to shed his load. In almost half the cases (46 per cent) the nurse felt involved in planning treatment policy and in 36 per cent the nurse offered advice on medication including the selection of drugs. The role perceived least frequently was that of diagnostician (12 per cent).

Nursing skills used with clients

In 86 per cent of cases the nurses felt their function was assessment and this was followed closely by advice-giving and psychological support (Table 1). Support for relatives was given to a lesser degree and medication was taken to the patient from the surgery in half the cases. A diagnostic function was exercised in over a third of cases; this is three times as often as it occurs in reporting to the doctor. For a small number of patients, nurses saw themselves as using physical nursing skills such as helping with body hygiene, problems of incontinence, and also with domestic chores. Three of the nurses noted that they saw themselves as providing education in self-care.

Table 1. Nursing skills used with patients.

Nursing skills	Number of patients	Percentage
Assessment	43	*86*
Advice giving	39	*78*
Psychological support	39	*78*
Supporting relatives	28	*56*
Supplying medication	25	*50*
Diagnosis	18	*36*
Education in self-care	7	*14*
Body hygiene	4	*8*
Dealing with incontinence	2	*4*
Domestic chores	2	*4*

Some of the categories overlap.

Provision of care

Direct care and organization of care by others occurred each in 34 per cent of cases while in 54 per cent care was shared with others.

Patient expectation

With regard to the nurse's perception of patient expectation, talking to patients was seen to be the most important function (82 per cent). This reflected not only the nurse's role of assessing and offering psychological support but possibly the patient's degree of loneliness and social isolation (half the patients lived alone). Connected with this, perhaps, is the fact that the nurse felt received as a family friend by over half the patients (56 per cent). In most cases (64 per cent) the patient saw the nurse as a link with his general practitioner. No patient expected the nurse to help with domestic chores, though in fact the nurse did so in two cases.

Role in practical arrangements

The fact that in slightly less than half the cases no practical arrangements were made (Table 2) may relate to the large number of clients under 65 years old. Similarly, the fact that only just over a quarter of the patients were demented may account for the fact that in only a fifth was psychiatric admission arranged. Otherwise a comprehensive span of community resources, both medical and social, were used.

Liaison with the general practitioner

Social workers were the most frequently involved professionals, while the district nurse, health visitor, and

Table 2. Practical arrangements made via the nurse.

Practical arrangements	Number of patients	Percentage
None	22	*44*
Home help	16	*32*
Hospital admission	15	*30*
Psychiatric	10	*20*
Geriatric	1	*2*
General	4	*8*
Local services	11	*22*
Laundry	3	*6*
Housing	3	*6*
Bathing	5	*10*
Meals on wheels	10	*20*
Volunteers	8	*16*
Day care	7	*14*
Local authority	3	*6*
Geriatric	2	*4*
Psychiatric	2	*4*
Social club	6	*12*
Part 3 accommodation	5	*10*

Some of the categories overlap.

psychiatrist were called upon in one third of the cases and the geriatrician in a quarter (Table 3). Consultations with voluntary organizations (20 per cent) resulted in practical arrangements in 16 per cent of cases (Table 2). Some splitting of organizing functions was seen: the general practitioner tended to work with the district nurse, health visitor, and geriatrician, while the psychiatric nurse liaised with home helps, meals on wheels helpers, and volunteers almost entirely alone.

Discussion

The findings regarding the nurse's perception of her relationship with the general practitioner suggest a satisfactory integration into the primary care team which allows the sharing of experience and exercise of special skills. Skills in planning and selection of drugs mark a departure from the traditional hospital role, pointing to needs in the surgery.

Hawks (1975) in a critical review of community care quotes several studies in which the general practitioners were not always willing to undertake the responsibility of caring for chronically mentally ill patients in the community or of co-ordinating the various services required. Our study presents equivocal evidence on this. In respect of the management and organizing functions of the nurse our results agreed with this view, in that the general practitioner tended to use resources within the primary care team and medical agencies outside it, while liaison with other resources was largely carried out by the nurse or in consultation with the nurse. On the other hand, only in less than a fifth of the cases did the nurse feel the recipient of load shedding by the doctor.

Hunter (1974) described the giving of injections, the supervision of established medication, the ferrying of drugs from the surgery, and the recognition of drug side-effects as well established tasks in community psychiatric nursing. Advice on drug selection seems inappropriate in terms of the basic nurse training, but the fact that it occurs is not surprising in view of an already deep involvement with matters relating to medication. May and Gregory (1968) and Johnson (1973 and 1974) have noted a lack of knowledge of the correct use of modern psychotropic drugs in a substantial minority of general practitioners; they found that knowledge of drugs was minimally dependent on undergraduate training and was gained from a variety of sources both formal and informal. This problem is also recognized in the report of the Working Party on the Continuing Education of Doctors in Medicinal Therapeutics (1975). It is therefore not surprising that the doctors in this study should 'pick the brains' of the nurses about medication.

The results show that of the nursing skills used, there was a much greater emphasis on an assessment function, psychological support, and diagnosis than on physical nursing. The first two relate to a considerable extent with the traditional hospital skills of sound observation and interpersonal working; whether diagnosis can be termed a new skill is open to debate.

Table 3. Professionals and agencies called upon.

	Initiated by general practitioner		Initiated by nurse		Initiated by both		Inadequate information received		Total	
Agency	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Social worker	3	*6*	8	*16*	10	*20*	—	—	21	*42*
Health visitor	7	*14*	4	*8*	4	*8*	2	*4*	17	*34*
Psychiatrist	1	*2*	4	*8*	10	*20*	1	*2*	16	*32*
Home help	4	*8*	10	*20*	0	*0*	2	*4*	16	*32*
District nurse	10	*20*	4	*8*	1	*2*	—	—	15	*30*
Geriatrician	10	*20*	0	*0*	2	*4*	—	—	12	*24*
Voluntary agency	1	*2*	9	*18*	1	*2*	—	—	11	*22*
Meals on wheels	2	*4*	8	*16*	0	*0*	—	—	10	*20*
Youth Action	2	*4*	1	*2*	0	*0*	—	—	3	*6*

Observation skills contain a diagnostic predictive component even if perhaps more tied to questions of immediate management than a medical prognostic model. The discrepancy between diagnostic skills used in consulting with the general practitioner (12 per cent) and with the patient (36 per cent) suggests either that the nurses are not working to a medical model or that this particular work is not fully expressed in interdisciplinary collaboration. A befriending function is listed in over half of the cases. It might be argued that this should be delegated to other workers, such as volunteers, to free the nurse for more 'professional' tasks. However, basic caring is a valuable and integral part of nursing practice; there is a danger of losing this if excessive emphasis is placed on the more specialized aspects of patient management.

Organizational skills were prominent, with organization of care by others as important as offering direct care; a large number of agencies were asked for practical help or advice. The lack of referral from Social Services Departments contrasts with the large referral to them; the implications of this finding are unclear but may suggest simply a lack of familiarity with the domiciliary scheme. In any event, the possibility of the psychiatric nurse in the primary care team exercising an early treatment and preventive function by organizing community resources (Caplan, 1964) is clearly stated.

It might be expected that some blurring of the age boundary was inevitable but the fact that a quarter of the patients were under the age of 60 years suggests that the original aim had changed and that the nurses had responded to a different need within the primary health care team.

May and Moore (1963) stressed the advantages of community psychiatric nurses retaining firm administrative and clinical ties with the parent hospital. While recognizing that this view continues to have strong support and that our special arrangement made it difficult for hospital-based colleagues to understand the work the nurses were doing, we nevertheless suggest that an institutionally centred scheme could restrict potentially useful developments at primary care level. The new development in this study suggests a need for the primary care teams and the district psychiatric service to examine jointly the implications of change to ensure harmony of effort and the proper preparation of nurses.

We consider that it would be helpful to have more detailed knowledge of the younger age group and its needs in assessing the likely demands to be made on the nurse. A comparison of patients referred to the nurse with an outpatient or day hospital sample would illustrate whether the nurse was dealing with a qualitatively different population from that met within the formal psychiatric network.

The low involvement of the psychiatric nurses in body care and the referral to the district nurse and health visitor (mainly by the general practitioner, and by inference for physical conditions) suggests a clear degree of specialization among the nurses. To what extent this is appropriate from the patient's point of view is open to question, since most patients place a high value on the psychiatric nurse as a non-technician and endow her with a befriending function. It would be surprising if this did not apply also to other nurses. The feasibility of offering psychiatric training to the district nurse or health visitor, with the psychiatric nurse occupying a consulting role, presents an alternative model which might be worth exploring.

This study underlines the helpfulness of training in community psychiatric nursing which is orientated towards psychotherapy, organizational skills, a detailed knowledge of local community agencies, and aptitude for interdisciplinary working. The training recommendations of the Briggs Report (Committee on Nursing, 1972) and the Post-Graduate Diploma Course of the Joint Board of Clinical Nursing Studies should help with this. Also, Hoyer (1973), amongst others, has pointed to the potential of behaviour modification techniques in the management of aspects of behaviour in the elderly. We have referred above to the possibility of behaviour therapy skills being acquired by nurses. The extent to which nurses can appropriately be involved in medication-related functions needs clarification. Apart from this, however, it is possible that psychiatric nurses working for long periods outside the psychiatric network may become 'stale' or develop idiosyncratic styles of working. Regular refresher courses and exchange postings back into the system are therefore essential. The establishment of a promotion gradient for community nurses, urged by Marks and colleagues (1975) in respect of nurse behaviour therapists, would ensure a skill-orientated structure of nursing management.

There is no clear answer to the most helpful way of integrating such a surgery-based scheme with the remainder of the psychiatric service. The main issue is perhaps less that of collaboration in particular treatment situations than more generally supporting the nurse and enabling her to maintain an appropriate clinical frame of reference. Also, there must be enough contact with the district psychiatric service to allow feedback upon which to base discussion about future developments.

Finally, the potential of family doctors to manage psychiatric resources at the primary care level requires exploration. Medical practitioners, in May and Gregory's study (1968), saw themselves as passive consumers rather than active participants in the psychiatric services. This study suggests that a high degree of interest and involvement results where practitioners have access to psychiatric resources in primary care.

Acknowledgement

We much appreciate the hard work and co-operation in the study by nurses Patricia Ingman, Rosemary Robinson, Alan Robinson, George Wilson, and the late Mary Hollins.

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Relationship between infant feeding and respiratory illness

The relationship between breast or bottle feeding and the incidence of bronchitis and pneumonia in the first year of life was examined in a birth cohort of nearly 2,000 children born in Harrow, England, between 1963 and 1965. Fewer episodes of acute bronchitis and pneumonia were reported in children who were breast fed than in children who were bottle fed. Firstborn children were more likely to be breast fed than subsequent children. Mothers who smoked were less likely to breast feed their babies. Although birth order and parental smoking have been shown to be associated with bronchitis and pneumonia in the same cohort, the association between feeding pattern and respiratory illness history persisted when these and other important factors were taken into account.

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