Open access to the practice nurse

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SUMMARY. The work of practice nurses to whom patients are allowed 'open access' was analyzed. The attendance rate for the population registered with the doctors was 964 per 1,000 patients per year. It was found that in nearly half of the attendances the nurse was the person of primary contact for the health care team and that she dealt with three quarters of these cases without referral to a doctor. Further research is required into the management of these patients by the nurse. Although it is the opinion of the practice doctors that the nurses' care was adequate, open access presents them with such a wide range of problems that their work has moved ahead of the legal restrictions placed on general practitioners concerning the delegation of work.

Introduction

THE work of practice nurses is gradually changing. Reedy (1972) has given an account of the extensive range of tasks they perform. Their role is gradually extending into areas of primary contact and management. They may make first visits to house calls (Smith and O'Donovan, 1970) and help to run family planning and 'well women clinics' (Marsh, 1976). Studies of the work of nurses in the treatment room (Dixon, 1969; Hasler *et al.*, 1968; Bain and Haines, 1974) have also shown that nurses are involved in primary contact and management of patients. These surveys have shown that this primary contact mainly involves minor casualty and skin conditions.

Aims

In the study practice the patients have open access to the practice nurses. This means that the practice nurses are involved in primary contact with patients. The aim of this study was to see, given such a system, what range of problems presented to the nurses and how they were managed.

Method

The practice consists of five doctors, caring for 12,200 patients in a semi-rural area. The premises were purpose built 10 years ago and contain one treatment room for the use of the nurses. Five part-time SRN nurses are employed by the practice. They staff the treatment room and help run the various clinics: family planning and well women clinic, children's immunization clinic, obesity clinic and venepuncture clinic.

The treatment room is open between 9.00 hours and 12.30 hours and between 14.00 hours and 18.30 hours on Monday to Friday, and between 9.00 hours and 12.00 hours on Saturday. During this time, except for one and a half hours while the nurse runs the obesity clinic, there is open access for the patients. Patients can make an appointment to see a nurse in the treatment room, particularly for lengthy procedures where she is assisting the doctor, such as in sigmoidoscopy or ligation of haemorrhoids, but most patients are seen without an appointment. The other clinics are held in other parts of the building so as not to interfere with the open access and require a further eight hours per week of nursing time—family planning and well women clinic, four hours; immunization clinic, three hours; venepuncture clinic, one hour. These clinics are run by appointment.

There are a number of different ways by which the patient may come to consult one of the nurses:

1. The patient may be referred by one of the doctors.
2. The patient may ask to see a nurse.
3. Where certain tasks have been delegated to a nurse, the patient may be asked to see the nurse rather than the doctor.
4. Patients attending without an appointment may be asked if they would like to see a nurse.
5. Patients may be referred to a nurse from outside agencies: school, hospital, work.

During 1977 the nurses were asked to keep a record of every patient contact, making a note of the problems presented and their management of each patient. They

Table 1. Distribution of all problems presented to the practice nurses.

Problem		Number	Percentage of all problems
Dressings		443	*14.7*
Traumatic lesions		289	*9.6*
Family planning and well women clinic		266	*8.8*
Ears—syringing	113		
—otitis media	55		
—others	52		
Total		220	*7.3*
Therapeutic injections		212	*7.0*
Desensitizing injections		184	*6.1*
Immunizations		177	*5.9*
Inflammatory skin lesions		140	*4.6*
Venepuncture clinic		136	*4.5*
Children's immunization clinic		130	*4.3*
Skin disorders and rashes		129	*4.3*
Obesity clinic		125	*4.1*
Surgical procedures			
—removal of sutures	54		
—others	67		
Total		121	*4.0*
Medical problems		108	*3.6*
Upper respiratory tract infections		104	*3.4*
Eye problems		81	*2.7*
Investigations		56	*1.9*
Warts		56	*1.9*
Advice		30	*1.0*
Specific infectious diseases		9	*0.3*
Total		3,016	*100*

Table 2. Distribution of problems where the nurse was the primary contact.

Problem		Number	Percentage
Traumatic lesions		261	*18.9*
Ears—syringing	60		
—otitis media	53		
—others	43		
Total		156	*11.3*
Children's immunization clinic		130	*9.4*
Skin disorders and rashes		113	*8.2*
Inflammatory skin lesions		110	*8.0*
Medical problems		104	*7.5*
Upper respiratory tract infections		104	*7.5*
Family planning and well women clinic		101	*7.3*
Immunization		86	*6.2*
Eye problems		63	*4.6*
Surgical procedures			
—removal of sutures	53		
—others	2		
Total		55	*4.0*
Dressings		33	*2.4*
Warts		33	*2.4*
Advice		25	*1.8*
Specific infectious diseases		9	*0.7*
Total		1,383	*100*

were also asked to indicate those contacts where they were acting as the person of primary contact for the health care team, i.e. categories two to five mentioned above. If a patient required follow-up by the nurse, only the initial visit was indicated as a primary contact. In the case of these primary contacts the nurses were also asked to record whether they referred the patient to a doctor, either at the time of the consultation or to a subsequent surgery. If the nurse obtained a prescription for the patient without the doctor seeing the patient, this was counted as management by the nurse without referral to a doctor.

A three-month period of these records was then analyzed. If the problem as recorded by a nurse appeared to be one which by its nature was not capable of being managed by a nurse, it was recorded as a medical problem. Any problems which appeared ill-defined by a nurse were also considered medical problems.

Results

During the year there were 11,756 attendances to see the nurses, giving an attendance rate for the population registered with the doctors of 964 per 1,000 per year.

During the three-month sample period there were 3,016 attendances and in 1,383 (46 per cent) of these attendances one of the nurses was acting as the primary contact for the health care team. Of these primary contacts the nurses referred 341 (24 per cent) to a doctor.

Table 1 shows the problems the 3,016 attendances presented. It shows the nurses acting in their traditional role—dressings, traumatic lesions and injections accounted for 31.3 per cent of the attendances. However, it also shows that they have become involved in a very wide range of problems. These included family planning and well women clinic problems (8.8 per cent of contacts) and medical problems (3.6 per cent of contacts).

Table 2 shows the list of problems the 1,383 patients presented to the nurses when they were acting as the primary contact for the health care team. Again it shows a very wide range of problems: 18.9 per cent with traumatic lesions, 16.2 per cent with skin problems, 11.3 per cent with ear problems and 7.5 per cent with medical problems. Of the 7.5 per cent of primary contacts considered to be medical problems, 32 presented with pains in muscles or joints not associated with injury. Thirty patients presented well-defined medical problems (Table 3) and 42 patients presented ill-defined problems, e.g. lethargy, headache, dizziness, sensitive penis, discomfort in the throat.

Table 4 shows the number and percentage of the 1,383 primary contacts who were referred to a doctor. The rate of referral varied with the problem. Of patients presenting for immunization (outside the children's immunization clinic) only 1.2 per cent were referred, whereas 56.7 per cent of patients presenting with a medical problem were referred. The number of

Table 3. Medical problems referred to a doctor where primary contact was with a nurse.

Problem	Number	Number referred to a doctor
Cystitis	6	5
Abdominal pain	4	4
Ganglion	3	3
Deafness	2	1
Insomnia	2	1
Constipation	1	0
Parotitis	1	1
Blood per rectum	1	1
Diarrhoea	1	0
Asthma	1	1
Epistaxis	1	0
Urticaria	1	0
"Collapsed" at work	1	1
Bleeding per vaginam	1	1
?appendicitis	1	1
Right inguinal hernia	1	1
?pregnant	1	1
Bell's palsy	1	1
Total of well-defined problems	30	23
Ill-defined problems	42	20
Pain in muscles or joints	32	16
Total	104	59

Table 4. Distribution of all problems referred to a doctor where primary contact was with a nurse.

Problem	Primary contacts	Referred to doctor Number	Percentage
Traumatic lesions	261	66	*25.3*
Ears—syringing	60	2	*3.3*
—otitis media	53	18	*34.0*
—others	43	9	*20.9*
Children's immunization clinic	130	23	*17.7*
Skin disorders and rashes	113	34	*30.1*
Inflammatory skin lesions	110	34	*30.9*
Medical problems	104	59	*56.7*
Upper respiratory tract infections	104	38	*36.5*
Family planning and well women clinic	101	21	*20.8*
Immunization	86	1	*1.2*
Eye problems	63	19	*30.2*
Surgical procedures			
—removal of sutures	53	4	*7.5*
—others	2	1	*50.0*
Dressings	33	1	*3.0*
Warts	33	5	*15.2*
Advice	25	1	*4.0*
Specific infectious diseases	9	5	*55.6*
Total	1,383	341	*24.7*

each particular medical problem referred to a doctor is shown in Table 3. The average referral rate to a doctor was 24.7 per cent.

Discussion

The results show that, by allowing open access, a large number of patients (964 per 1,000 patients per year) attended to see a nurse, and that in 46 per cent of these attendances the nurse was acting as the person of primary contact for the health care team. Jones and colleagues (1978), in their report of practice nurse activities for 1977, give a similar attendance rate of 1,118 per 1,000 patients per year. Bain and Haines (1974) reported a slightly lower attendance rate of 704 per 1,000 patients per year where there was self-referral to the practice nurse, but a similar self-referral rate of 51 per cent. Dixon (1969) reported an attendance rate of only 448 per 1,000 patients per year with only 15 per cent self-referrals, but this was a new health centre and he reported an increasing number of casual attenders during the study period, which he thought could have been due to the local population gradually learning that advice and treatment was readily available.

The large number of attendances at the open access clinic presented the nurses with a wide variety of problems; and in the family planning and well women clinic the nurses also assisted the doctor in inserting and removing coils and in taking the preliminary history of new patients presenting for contraception. Primary contacts by the nurses at this clinic involved pill checks, repeat prescriptions for the pill, advice, cervical smears and breast examinations. In the children's immunization clinic the nurses and health visitor again acted as primary contacts for the health care team, administering immunizations according to criteria laid down by the doctors.

Among the primary contacts were 7.5 per cent who presented problems which were considered medical, including some potentially serious conditions such as abdominal pain. Bain and Haines (1974) reported that 9.9 per cent of their self-referrals presented with miscellaneous problems which included ill-defined symptoms. Dixon (1969) reported that the nurse felt that 23 per cent of the self-referrals needed to be referred to a doctor. Although the problems presented are not listed, as the patients were casual attenders, it is probable that they included a number of strictly medical problems.

Clearly, in this open-access practice, and presumably in the practices mentioned above where there was self-referral, nurses are being presented with medical problems. In this situation some safeguards are necessary (Hasler *et al.*, 1968) in the way practice nurses are supervised. In our practice the following safeguards were built into the system, which had evolved over a number of years, so that the nurses had become accepted as a source of primary medical treatment and advice for certain conditions:

1. The nurses must be experienced and competent.
2. The nurses must know that they have immediate access to medical advice.

3. The doctors must be flexible in their manner of working so that they are ready to give immediate help and advice to the nurses when asked.

4. There should be regular meetings between the doctors and nurses to discuss how the system is working and any problems which are arising.

5. The patient must not be forced to see a nurse instead of a doctor, rather the patient should want to or accept seeing a nurse because the patient realizes that she is capable of dealing with their particular problem.

It is probably the last of these safeguards which accounts for the low referral rate of these patients to a doctor. Most of the patients had correctly decided that their problem was suitable for management by a nurse.

Now, although this paper shows that the nurses felt capable of managing nearly three quarters of their primary contacts without reference to a doctor, it may be asked whether this management was adequate.

There was continual observation of the nurses' work and when a new nurse was appointed it was noted that she would refer a greater percentage of her patients until the doctor and nurse both had confidence in her diagnosis of certain conditions, e.g. otitis media; at practice meetings the management of well-defined topics, e.g. immunization and family planning, was discussed; there was continual observation and education of the nurses through joint consultations with those patients the nurses had asked the doctor to see immediately; all the nurses' patients were also patients of the doctors so any serious mistakes or complaints would become known to the doctors.

Further research is required to audit the management of patients by nurses when patients have open access to them; but over a number of years, during which the nurses have seen many thousands of patients, it was the opinion of the doctors that the management given by the nurses was adequate. We also felt that the nurses were capable of picking out those patients who urgently required a doctor's opinion.

Hodgkin (1978) in his book, *Towards Earlier Diagnosis in Primary Care,* discusses the conflict between community and individual needs as one of the main dilemmas of primary care. The doctor's ability to provide an effective personal service to each patient conflicts with the wishes of all those patients who are kept waiting while such a service is given. In this context, the practice doctors feel not only that management of those patients seen by the nurses was adequate, but also that the care of all the patients belonging to the practice is improved through open access. This is because the doctors are relieved of many consultations which the nurses can deal with adequately, leaving the doctors time to help patients who require their skills. The scope and interest of the work of highly trained nurses is also increased and, through joint consultations between doctor and nurse, the nurses' knowledge of general practice is extended.

However, open access to practice nurses raises legal problems. A doctor is allowed to delegate only those functions which he knows a nurse is competent to undertake. As this paper shows, with open access such a wide variety of problems are presented to the nurses that it would be impossible to say that they had been taught to deal with every particular problem. On the other hand, the doctors still felt confident about delegating this work as in their opinion the nurses had shown themselves competent to do it. In particular, they were capable of picking out those patients who urgently required a doctor's opinion.

In conclusion, it is our opinion that, although further research into open access to the practice nurse is required, it leads to improved care for the total community served by the practice. We also believe that open access has led to the work of the practice nurse moving ahead of the legal restrictions placed on general practitioners concerning the delegation of work, and that this problem must be resolved.

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