General Practice Observed

Training for the Treatment-room Sister in General Practice

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Summary

A discussion group course for treatment-room nurses was organized in the spring of 1971 by the Thames Valley Faculty of the Royal College of General Practitioners. Twenty-eight nurses took part. Some were from local authorities but most were privately employed. Questionnaires were completed by participants. The course has had several consequences, and it is felt that some form of specific training for this branch of nursing should be established.

Introduction

During the past five years there has been a dramatic increase in the nursing work done in doctors' surgeries and health centres. This is reflected in the many medical publications during this period and is due partly to the increased use of attached local authority nurses. Yet in the discussions on the range and scope of these nurses' work there is little mention of training programmes for treatment-room activities. Moreover, though district nursing sisters are provided with refresher courses and in-service training by their local authority no such provision exists for nurses privately employed by general practitioners. Furthermore, in the case of the latter very little information is available on terms of service and conditions of employment.

With these conditions in mind the Thames Valley Faculty of the Royal College of General Practitioners decided to sponsor an experimental discussion group course for treatment-room nursing staff. The area covered by the faculty consists of the counties of Berkshire, Buckinghamshire, and Oxfordshire, with the city of Oxford and the county borough of Reading. There were 53 privately employed nurses in May 1971 in the area (figures supplied from the executive councils), and attachment schemes were also widespread.

Training Programme

A draft programme was drawn up and sent for comment to all county nursing officers in the area, the Royal College of Nursing, the Queen's Institute of District Nursing, and the Regional Medical Officer (Department of Health and Social Security). In the light of the comments received the programme was revised and circulated to all general practitioners in the area through their executive councils. The course (Table I) was held from January to March 1971. The speakers were drawn mainly from general practitioners and nurses in the area. The Royal College of Nursing kindly provided a speaker on the first day. Use was made of duplicated hand-outs describing procedures for immunizations, cervical smears, etc. The last afternoon was spent on evaluation. We were fortunate to be able to hold the course on the premises of the Oxford Regional Hospital Board in the mornings, and visits to health centres and surgeries occupied most afternoons. The accent throughout was on discussion and exchange of experiences, views, and methods between the nurses themselves. The introductory lectures each morning were designed only to encourage and structure the subsequent discussion. Twenty-eight nurses took part—20 were privately employed and 8 were from two local authorities. It was most encouraging that the various employers were prepared to release nurses for 10 full Wednesdays and, further, that the local authorities and almost all the general practitioners paid their nurses' expenses. The regional medical officer from the Department of Health and Social Security attended as an observer.

TABLE I—*Treatment-room Sisters' Course*

Day 1 (whole day*) ..	The practice nurse in primary medical care; legal aspects and terms of service; treatment-room organization and design
Day 2	Pathology and collection of specimens
Day 3	Special equipment
Day 4	Management of emergencies
Day 5	Immunization and vaccination
Day 6	Advice to patients and management of minor problems
Day 7	Basic physiotherapy
Day 8	Dressings, ear syringing, and other minor problems
Day 9	Minor operations and suturing
Day 10 (whole day) ..	Clinics for chronic disease and screening; course evaluation

* Most afternoons were spent visiting health centres and surgeries. The executive council and R.H.B. were included.

Course Project: Treatment-room Design

In order to give the course a competitive focus a short project was set with prizes for the three best results. The nurses were asked to write the architect's brief for their own treatment room in a proposed new surgery building. The approach to this project was expanded in writing and in one morning session of the course.

The project had two objectives. The first was to explore and develop the nurse's knowledge about her own relationship with her practice, its work, and probable future development. The second was to find out what the users of treatment rooms thought they needed in order to compare this with the

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suggestions for treatment-room design and equipment set out in *Buildings for General Medical Practice*[1] and the more recent detailed *Health Centres, a Design Guide.*[2]

An architect's brief is necessarily prescriptive in nature, but there is no evidence that the proposals for treatment-room design and layout in either of these two publications are based on empirical studies. In the event the composite brief arrived at by combining all 12 entries for the project (some of them multiple) was almost identical with that given in *Health Centres, a Design Guide*, and this coincidence should be at least reassuring if "design in use" studies have not, in fact, ever been carried out for treatment-rooms.

The best entries were difficult to separate for merit, and each one showed a comprehensive knowledge of the work of the practice and an ability to distinguish between the realities of present accommodation and future needs. There was a clear statement of job content and a categorization of the patients seen and the ideal design features for each kind of treatment-room task.

The conclusion was that this had been an interesting and useful exercise which had also allowed comparison of professional users' perceptions of their design needs with those held in the official publications.

Questionnaire Survey

The lack of information concerning treatment-room sisters prompted us to invite participants to answer a questionnaire. This was designed to obtain basic information about the sisters themselves, their tasks in general practice, and their training needs.

Of the 28 nurses attending 26 replied. Eighteen of these were employed by general practitioners and eight by local authorities. Only one of the sisters had been qualified less than three years and six had been qualified less than 10 years. Nineteen had been working in treatment-rooms for less than three years. Twenty-three of the sisters worked part-time and three full-time (42 hours a week). Before taking up treatment-room work seven of the sisters employed by general practitioners had been housewives and 11 had been employed as nurses. All the local authority sisters had previously worked as nurses.

Eighteen of those replying were members of the Royal College of Nursing (14 employed by general practitioners, 4 by local authorities); eight were not members (4 employed by general practitioners, 4 by local authorities). Eleven sisters employed by general practitioners had a letter of contract, seven did not. Of the 18 sisters employed by general practitioners 16 gave details of their pay—11 were paid within the scale recommended at that time (55 to 71p an hour), two were paid 75 and 76p, two were marginally underpaid, and one was seriously underpaid at 45p an hour. Altogether 21 sisters had full use of a treatment room, two shared it with other users, and three did not have a treatment room. Some of the tasks undertaken by the sisters are set out in Table II.

Twenty-one of the sisters said they would welcome written procedures for certain tasks. Nineteen recognized the need for training before taking up duties as a treatment-room sister and 22 recognized the need for inservice training. Opinions varied on the type of refresher course needed. One week a year was most favoured, with emphasis on discussion groups and learning practical techniques. The subjects in which further training would be useful were mentioned in the following rank order: taking electrocardiograms, suturing, taking blood, assessing casualties, cervical smears, haemoglobinometry, and immunization.

Comment

It was agreed that the course was a success and there were no major criticisms. There was much interest in the role of the treatment-room sister in relation to primary medical care. The afternoon visits to practices over a wide area proved difficult for all to attend, and this could have been reduced. It was interesting to note how close and friendly relationships developed between local authority and privately employed nurses. Inevitably the group tended to orientate its thinking around the privately employed nurse. These nurses often work on their own, with little contact with nursing colleagues, and rely on general practitioners to keep them informed of recent advances. It was felt for the first time that professional isolation was being overcome and status being established. The nurses subsequently made their own arrangements to continue regular meetings for educational and social activities.

Some more direct results are also apparent. Oxford City has altered its central sterile supply department packs for district nurses. Some hospital staff when communicating with practices now direct relevant letters to the nurses in the team. Moreover, Berkshire County Council has now planned a similar course in conjunction with this Faculty of the Royal College of General Practitioners for their attached nursing staff and for some private nurses.

The questionnaire provided some interesting information. Over three-quarters of the sisters had been qualified 10 years or more but had been doing this work for less than three years. This presumably reflects the relatively recent demand for nursing help on general practice premises and the appeal of the work to a mature nurse. The figures suggest that it might be easier for the housewife returning to nursing to accept employment by a general practitioner rather than employment by a local authority.

It was slightly disturbing to find that over one-third of privately employed sisters had no letter of contract and that one sister was being paid well below the recommended scale. Furthermore, eight sisters were not members of the Royal College of Nursing. Only members are entitled to insurance and assistance from the College in case of mishap or alleged negligence. Discussion on the legal position of both local authority and privately employed nurses featured in the course. At present the subject is under review, and we believe that urgent clarification is needed. We also consider that model letters of contract, and the recommended detailed pay scale for treatment-room sisters, should be distributed to all general practitioners and treatment-room sisters.

There appears to be wide variation in tasks assigned to treatment-room sisters—for example four sisters never took

TABLE II—*Frequency of Some Treatment-room Activities*

	Often	Seldom	Never	Not Stated
See patient as first contact to assess urgency	19	4	2	1
First person to see casualties	17	8		1
Suture wounds	3	10	12	1
Lay up for minor operations	11	5	9	1
Take blood for laboratory tests	19	3	4	
Check blood pressure	18	7	1	
Take cervical smears	8	3	14	1
Take electrocardiograms	11	2	11	2
Visit patients' homes as first contact	1 (L.A.)	5 (4 L.A., 1 G.P.)	20 (3 L.A., 17 G.P.)	
Visit patients' home after doctor has visited	7 (all L.A.)	2 (both G.P.)	17 (16 G.P., 1 L.A.)	

L.A. indicates sisters employed by a local authority. G.P. indicates sisters employed by a general practitioner.

blood. Though visiting patients at home was not discussed on the course it was felt that questions on this aspect of work would be of interest. Only one sister employed by a general practitioner visited patients at home as first contact and only two carried out follow-up visits. Both these activities occurred seldom, suggesting that there is no strong evidence that the privately employed sister is usurping the traditional role of the district nursing sister.

Discussion

This course would seem to be a step forward in our thinking on the training of the future community nurse. Though local authorities provide refresher courses for their staff much of this is orientated towards home nursing and, of course, the tendency now is for at least as much nursing work to be carried out in the treatment-room of the surgery as in the home. In view of the fall in home visiting and rise in surgery attendance by patients all over the country this trend in providing nursing care is likely to continue. In some counties individual nurses are able to attend a course only once every few years. The problem of privately employed nurses is more serious because of the complete lack of any training programme for them. A criticism has been levelled from professional nursing organizations that private nurses may be asked to perform work beyond their skill. With the large increase in numbers of these nurses and the difficult question of legal cover these problems must be faced. In our view some form of standardized training programme must be established.

We do not hold strong views on whether treatment-room sisters should be employed by local authorities or general practitioners. There is some advantage in the former, but as Dixon[3] pointed out six hours' treatment-room work a week is needed for every 1,000 patients at risk. Most local authorities have neither the finance nor the staff to provide this.

What is of fundamental importance is that community health teams should develop and define their nurses' roles and relationships. To assist this the nurses themselves will need training in the full range of techniques relevant to the 'seventies.

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References

[1] General Practice Advisory Service Ltd., *Buildings for General Medical Practice*. London, H.M.S.O., 1967.
[2] Department of Health and Social Security and Welsh Office, *Health Centres, a Design Guide*. London, H.M.S.O., 1970.
[3] Dixon, P. N., *British Medical Journal*, 1969, 4, 292.

Medical History

In Memoriam for Mr. Nash's "Ophthalmic Hospital"

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One hundred and fifty years ago the "Ophthalmic Hospital" was built in central London to the designs of Mr. John Nash. It was probably the most elegant eye hospital that the world has ever known. Four years ago its surviving wing was demolished, and before its memory fades into history it is fitting that we should do homage both to its noble design and to the altruism of Sir William Adams, who founded it.

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For just as the first eye hospital in the world was probably that built by Saint Louis for the soldiers who had returned from his disastrous crusade blinded by trachoma, it was the second great intrusion of Western Europeans into the trachoma-ridden Middle East that provoked the next great building of eye hospitals, in the wake of the Napoleonic wars. In rapid succession three London hospitals were erected —Moorfields Eye Hospital in 1805, the Royal Westminster Ophthalmic Hospital (subsequently incorporated with Moorfields) in 1816, and, in the same year, the York Hospital in Chelsea. The latter was founded by Sir William Adams so