PRACTICE OBSERVED

Organising a Practice

Organising and training staff

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One important change in general practice in the past 15 years has been the emergence of the "team concept." There are many different interpretations of what this phrase means, whether the idea works, how it should be organised, and so on, but virtually all our patients now come into contact with a variety of people with different training and different skills. These are usually organised into two groups: a community health care team of health visitors, community nurses, nursing assistants, and midwives; and a surgery team of receptionists, secretaries, perhaps a practice manager, treatment-room nurses, and sometimes other skilled workers. The divisions are not quite as hard and fast as this implies, and there are considerable variations in the patterns of employment and work.

There is about one whole-time equivalent worker in each group per doctor, but as most doctors work in groups and most workers are less than full time each doctor and his patients have to relate to four or five people. This often produces problems of communication and continuity of care, which are compounded by great variations in training and skills. Overcoming these difficulties is an important part of organising a good practice and has a direct bearing on the quality of care provided to patients. It is an anachronism that the front line in general practice is manned by the least trained troops, causing it to become an area that generates the most dissatisfaction from patients. Rudolf Klein[1] has shown that at least a third of all grumbles about us arise for this reason, and Ann Cartwright and Robert Anderson[2] have shown that between 1964 and 1977 we did not get much better in the way we handle these things. It is a truism that no matter how brilliant we are at diagnosing esoteric conditions if the patient cannot reach the doctor through the system then all is wasted.

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Training

General practitioners do not have much to do with training the community health care team. The team's formal training is the responsibility of the health authority, and even though the members often work closely with general practitioners neither side knows much about the other's training. A recently qualified health visitor had one hour of contact with a general practitioner during one year of training. The gulf that exists between general practitioners and social workers might be lessened if each side understood the training and aspirations of the other, and the problems that sometimes arise between community nurses and doctors might be eased in this way.

The training of the surgery team is usually the responsibility of the doctor. Under section 52 of the Statement of Fees and Allowances a general practitioner can claim reimbursement of 70% of the salaries paid for up to two whole-time or equivalent part-time staff per doctor. Now an average of one staff member a doctor is employed. The employee must work on a regular basis for at least five hours a week at one or more of these qualifying duties: making appointments; receiving patients; nursing and treatment; secretarial or clerical; and dispensing. Receiving and passing messages also qualifies if the person is employed mainly for one of the other qualifying duties, and the employer's National Insurance contribution and sometimes the pension contribution is also reimbursed. Reimbursement at the same rate of 70% of the costs incurred in training staff can be obtained, and if the course is organised by the health authority, education authority, Royal College of General Practitioners, or Association of Medical Secretaries, Practice Administrators, and Receptionists then 70% of travelling costs and subsistence also applies. Despite all this most staff do not have formal training.

About 100 colleges of further education provide training for secretarial and reception staff. Nearly all their courses are designed for school-leavers, post-"O" level or in some cases "A" level, and they last for one or two years. All students do field work training in hospitals and general practices, but most,

although trained in both, start work in the hospital, where they work more regular hours and are less isolated. Some general practitioners indeed express a desire to employ older people, but there is some evidence that it is more difficult to alter attitudes—an important requirement for staff—in older employees.

There is no national scale of salaries for staff employed by general practitioners, but a suggested scale, linked to hospital grades, can be obtained from the Association of Medical Secretaries, Practice Administrators, and Receptionists, BMA House, Tavistock Square, London. Adherence to this scale has the advantage that incremental or annual pay awards can be agreed without personal hassle.

Most staff, however, arrive untrained and learn either by "sitting with Nellie" or by "picking it up as I went along." This is highly undesirable. Nellie's bad habits are just as easily learnt as her good habits, and the doctor's often misguided idea of what goes on over the reception desk or in administration is a poor basis for learning.

Like most education, training for staff can be divided into preservice and in-service, and the last can be seen as either introductory or continuing education.

As I have already said, it is unusual to employ staff who are specifically trained for the job. Even treatment-room nurses usually have had only standard training and no preparation for many of the tasks that they might be asked to do, so preservice training consists of no more than identifying the skills, attitudes, and knowledge that the applicant has acquired before coming to work for you.

How to hire

Doctors, it is said, employ staff either because they like the look of them or because they are sorry for them—a potential recipe for disaster. The laws relating to employment make it much easier to acquire staff than to discharge them.

A detailed job specification must be drawn up setting out what is required, and from this a detailed advertisement can be produced. The skills and attributes required of a secretary might include: typing, shorthand, medical terminology, knowledge of medical work and ethics, simple book-keeping, handling confidential papers, ability to work with others, sensitivity to patient's requirements, compassion, reliability, tidy appearance, imperturbability, and good health. Suitable lists can be prepared for a receptionist, a practice manager, or a treatment-room nurse. Giving as much detail as possible in the advertisement will save wading through replies from unsuitable applicants, and if a standardised form is drawn up listing what is being looked for the job of interviewing becomes much easier. References should always be taken up, and employers have to know what their obligations are under the Contracts of Employment Protection Act 1975, schedule 16, part II, and the 1978 Employment Protection (Consolidation) Act. These specify the contract that has to be given to staff not later than the thirteenth week after starting work and the rules about the amount of notice that has to be given.

Given that you have interviewed and agreed to employ someone with the right previous experience and training, have taken up the references, and found them to be satisfactory, what is the next step?

On the job

The amount of in-service training required by a new employee obviously depends to a large extent on experience. Let us assume that a receptionist or secretary has the skills and attitudes necessary for the job but has had no previous specific training. If she is replacing someone who is leaving it will obviously be helpful if the appointments overlap for at least a week. This will allow some of the important aspects to be observed from the side lines, but remember that bad habits are picked up as well and that you cannot claim reimbursement of salary for overtime, so it is possible only if you do not already employ your full quota of staff.

This introductory period should include meeting all other members of staff to find out what they do and when they do it. New staff should learn the geography of the building and find out where important things are kept. They should watch each of the other workers at work, have an opportunity to ask them questions, and find out the "chain of command."

STANDING ORDERS

Two documents that should be kept in the surgery for new employees to study and learn are a set of "standing orders" and a check list for teaching. Standing orders should contain clear instructions for: security of the building and contents; "rules" about confidentiality; "rules" about personal behaviour relating to smoking, dress, hygiene, personal sickness, etc; guidelines about what to do if they have problems with patients or other staff; guidelines about what to do if faced with an emergency—how to get hold of a nurse or doctor, and so on.

Such a set of "standing orders" should not be seen by staff as an authoritarian control but as a method of increasing their confidence and can be written in a way that accentuates this aspect. For example, "A no smoking rule applies in the premises—this is because much time is spent by doctors trying to persuade patients not to smoke and this aspect of health care is undermined if they see us smoking."

The check list is an educational tool that many doctors are familiar with in training practices. It contains a list of possible duties that the new employee can work through until she is satisfied that she can perform them. A check list for a new receptionist would include, for example: registering a new patient; making an appointment; dealing with incoming mail; taking a request for a new visit. Each of these would have a number of subheadings, so registering a new patient would include a new baby, a person new to the district or changing address, a transfer from a practice without changing address, a person who has left HM Forces.

The preparation of standing orders, check lists, and, indeed, the introduction of in-service training should not ideally be the doctor's job. The senior secretary or practice manager is the proper person—given guidance and support—to carry such a job out. Moreover, this clearly establishes a line of communication that may avoid later problems.

Staff should have available to them sources of information. These are listed at the end of this article.

Check lists are particularly important when training staff who will help in clinical work, such as treatment-room nurses. Before a doctor delegates any job to a nurse he has to be satisfied about her competence to carry out the task. Standard nurse training may not have covered skills such as taking cervical smears, and other skills such as venepuncture, syringing ears, and taking blood pressures may have been taught so long ago that they have faded with time and lack of experience. Your legal protection may depend upon being able to show that you have satisfied yourself about the competence of clinical staff.

Meeting colleagues

Group practices are introverted organisations. Just as doctors need to learn from their colleagues working in different specialties, so do staff. They should be given a chance to see and meet their opposite numbers from other practices by visiting them at work and they should visit other important organisations with which they have to work. In my list of essential visits I include: the family practitioner committee; the outpatient and medical records department of the local hospital; the social services department; the x-ray department and laboratory.

A useful list of "do's and don'ts" can be constructed to smooth out problems and oil the wheels of communication. This sort of education takes place much more easily if one or two doctors locally take it upon themselves to provide leadership and guidance—not to tell people what to do but to give moral support. Often the local representatives of pharmaceutical firms will provide the "tea and biscuits" support that helps so much. Some health authorities have laid on courses for practice nurses that are open to staff employed by the authority and by doctors. If they have not yet done so, the regional training officer can be approached about it.

Morale in a team is of vital importance. Happy staff mean happy patients, and this generally means better patient care. The rules of the game are fairly simple and stem from the tone the doctors set in the way they do their work and conduct their relationships.

These relationships have to be developed between the doctors in a partnership and then spread down to all the staff.

(1) Make the "ability to work with others" a high priority when appointing staff.

(2) Do not allow your staff to become isolated from you. The office area or treatment room should be a place in which doctors can see their staff and be accessible to them.

(3) Support staff in front of patients, and deal with problems in privacy later.

(4) Listen to what your staff say, and encourage good ideas for improved patient care.

(5) Pay your staff a proper wage, and stick to the rules about contracts and holidays.

(6) Have formal practice meetings at which staff are present. Keep proper minutes, and take action when it is agreed.

(7) Look after their working conditions. They need decent tools and proper space.

(8) See that tasks are appropriately and evenly distributed.

(9) The social niceties—practice parties, Christmas presents—are important, but appreciation of good service need not be confined to the occasional festive gathering.

Staff relationships do need care. Organising staff well, seeing that they are well trained, and keeping them happy may make a much more important contribution to patient care than many other more esoteric aspects of clinical medicine that occupy our time.

References

1 Klein R. *Complaints against doctors*. London: Knight, 1973.
2 Cartwright A, Anderson R. *General practice revisited*. London: Tavistock Publications, 1981.

Reading list for staff

Drury M. *The medical secretary's and receptionist's handbook*. 4th ed. London: Baillière Tindall, 1981.
Jones RVH, Bolden K, Pereira Gray DJ, Hall MS. *Running a practice*. 2nd ed. London: Croom Helm, 1980.
Owen H. *Administration in general practice*. London: Arnold, 1975.
Pritchard P. *Manual of primary health care*. London: Oxford University Press, 1978.
National Health Service—General Medical Services. *Statement of fees and allowances payable to general medical practitioners in England and Wales*. London: DHSS, Welsh Office.
In practice. Supplements from *General Practitioner*, 1978 and 1979.
Pulse blue book. Supplement from *Pulse*, 1979 and 1980.

Practising Prevention

Hypertension

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Preventing stroke and heart failure depends on identifying rises in blood pressure in the asymptomatic stage. This requires systematic detection and follow-up of patients in general practice. A method for doing this and classifying patients into one of three groups is described.

The case for anticipatory care is nowhere better proved than in the treatment of hypertension. To wait for the patient to present with symptoms today is simply bad medicine. The "rule of halves" indicates that for every patient identified with seriously raised blood pressure there is another in the community who is unidentified. A middle-aged man came down to the medical centre to have his ears syringed. My partner noticed a circular disc on the record envelope and asked him whether she might take his blood pressure. His diastolic pressure was 170 mm Hg. Apart from his deafness he felt very well. All practices that do not screen for hypertension will have patients with seriously raised pressures who are not on treatment, and nine out of 10 will visit the medical centre over a period of three years. The need is obvious. How is it to be met?

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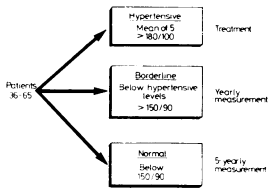
First screen the records

The Achilles heel of much work in practice is the records system. It is a disheartening and difficult place to start. But unless the records have some semblance of order most of the information that is collected for ongoing care will be lost. Many patients, particularly women, will already have a record of blood pressure in their notes as part of a routine examination for issuing the pill or for menopausal symptoms. Measuring and recording the pressure, however, is not always followed by taking appropriate action. We found not a few cases in which unacceptable levels of blood pressure had been recorded and not followed up—both in the continuation notes and in hospital letters. Other patients had been established as hypertensive in the past and started on treatment but had failed to continue

with it. A 56-year-old man with a right partial hemiparesis from birth who had been on treatment for severe hypertension had not attended the surgery for three years. When sent a card he came along readily, and when asked why he had not attended said he felt quite well and thought he had been cured. Had he really not got the message or were his tablets giving him unpleasant side effects which he did not feel like owning up to? Or was he just a "don't care" type? It was difficult to be sure, but such cases are very common. New patients will be joining the practice list and as their records arrive this is a good time to see whether there is a satisfactory record of blood pressure. We start looking systematically for hypertension at the age of 35, and this means that one new section in the age/sex register comes under surveillance each year and those patients should have their cards examined.



Recording ongoing information in the same place in the envelope is obviously very useful. We use the reverse side of a problem list card, but there are many variations on this theme. For the past year we have employed a nurse-receptionist whose role is to perform a "Forth Bridge" type maintenance operation on the practice records. She sorts and weeds letters, arranges continuation cards in order, and, if blood pressure checks are required, draws them to my attention. If there is no record whatever of blood pressure (especially in the case of middle-aged men) or if there are hypertensive levels recorded, I ask her to send the patient a card asking him to attend the practice nurse for blood pressure examination. Most come. If the situation is less urgent she writes "Take Blood Pressure" on the next line of the continuation card. I find this less likely to be ignored than stickers on the front of the envelope.

Starting from the medical record in this way a continuous screening programme may be planned with the object of recording the blood pressure of every patient on the practice list at least every five years between the ages of 35 and 65.

Classifying blood pressure

At this point the problem of the variability of blood pressure raises its ugly head. Some patients will be found with what look like treatable levels but which, on repeat takes, seem to return to normal over a few weeks. In others the pressure hovers around a level such as 160/95, where we may not feel it justifiable to subject the patient to treatment but do not want to leave the matter for five years without review. These constitute an important borderline group, and we review them yearly. We define the group in terms of at least one pressure over 150 mm Hg systolic or 90 mm Hg diastolic but not high enough to warrant treatment. At first we simply asked them to book an appointment in a year's time but most forgot. We now keep a card index file of these patients and send for them in rotation to attend a clinic run by the practice nurse in the evenings. When the clinic was held during the day large numbers of working patients failed to turn up.

Patients with borderline rises in blood pressure will be additionally at risk if they have other risk factors. Smoking and obesity can be tackled at this stage. A bad family history or diabetes may lower our threshold for treatment. I recently waited too long in a 52-year-old patient with diabetes who, after being followed up for some years at the borderline clinic, was found to have a mean blood pressure over five readings of 187/109. He did not attend for six months after these readings so he was sent for with the object of starting him on treatment. When he attended his pressure was 146/90. At the same time he had some new vessel formation in the right eye and was referred to an ophthalmologist. He was reluctant to have blood pressure treatment and asked if he could try weight reduction and come again for review. Six weeks later he had not managed to reduce his weight and his pressure was 186/100. He was also due to have an operation for an inguinal hernia and again asked me to defer a decision on treatment while he made fresh efforts to reduce weight. I agreed, but unfortunately two months later he had a major right hemiplegia. This case shows well the difficulty of making decisions and of sticking to them in the face of pressures from patients who often fear long-term treatment.

It is worth asking patients with borderline rises about salt intake and alcohol consumption. Heavy salt users will readily admit to this on questioning and should be told that it pushes up the pressure and to try to get used to food without adding salt at table. Patients who drink more than six pints of beer a day or the equivalent are also increasing their blood pressure and should be counselled, though this habit may be difficult to alter.

Patients on treatment

The decision to put patients on treatment for hypertension is a serious one for the patient and the doctor. It should not be made in a hurry, and it should be accompanied by a very full explanation. Because of the natural variability of blood pressure, sufficient base-line readings should be obtained. I use a minimum of five. These are done by the practice nurse who refers the patient for consideration if the mean systolic pressure exceeds 180 or the diastolic 100 mm Hg. A separate card-index file is kept for treated hypertensives. This is examined every three months to make sure that patients are attending. Tagging age/sex register cards or computer recall systems can be used for the same purpose. If no system is used sooner or later patients will stop attending.

Conclusion

Classifying patients into three groups or "boxes," as shown in the figure, enables follow-up of blood pressures to be organised rationally in a practice. The key to the whole operation is the education and motivation of the nurse. It is she who will be doing most of the blood pressure estimations and maintaining the card-index files and ensuring that patients continue to attend. Ultimately it will be with her that they will develop the close rapport that is essential for the prevention of disease in symptomless patients.

ONE HUNDRED YEARS AGO The Metropolitan Board of Works have determined that, in all Bills seeking powers for fresh underground railway construction, if power be sought to make openings in the public thoroughfares for the ventilation of the tunnels, they will, in their official capacity, oppose the passing of such Bills. It is satisfactory, says the *Globe*, to note that the Metropolitan Board of Works have realised it to be their duty to interfere, so that boards of railway directors may be compelled to give attention to the health and comfort of the community, as well as to the achievement of large dividends. Probably Dr Neale could help them. (*British Medical Journal*, 1882.)