The Practice Nurse

A Guide to Nursing in General Practice

The Irish College of General Practitioners
Coláiste Dhochtúiri Teaghlach Éireann

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Introduction

This guide to practice nursing should be welcomed, not just as an introduction to a landmark development in primary medical care, but as an important reference for anyone wishing to understand and work with practice nurses – still a relatively new and exciting addition to the nursing profession. It is intended for a wider readership – not just practice nurses and GPs.

General practice (as opposed to GPs) has developed rapidly, particularly in the last decade. It has become clear that in practice there are at least three overlapping areas of diagnosis and management: patients with chronic illness, patients with undifferentiated symptoms and complaints, and asymptomatic patients requiring the prevention and early detection of a range of serious illnesses.

Historically general practice was single-handed, with minimal reception staff often involving the doctor’s family.

Since 1970 increasing numbers of GPs began to recognise the invaluable contribution a dedicated practice nurse could make to the quality of patient care. I expect that the evolution of the role of the practice nurse will continue.

It is important for practice nurses and GPs to be clear about their respective roles. It is unfair to expect any medically qualified person to undertake tasks outside their scope of practice other than in an emergency situation. It is therefore essential to work towards a mutual understanding of each other’s scope of practice from the outset and particularly in advance of any clinical crisis. Given the fact that both professions are continuing to refine and define their discipline, this will continue to be a dynamic process.

Already much collaborative work is being done in areas of chronic illness. Asthma, for example, should involve patient education, and participation by patients in their own care and dose adjustment. It may include learning to recognise the onset of an acute attack and to know when urgent nebuliser treatment is required. It also involves ongoing education about trigger factors, correct use of inhalers etc. Doctors and particularly practice nurses are doing this very effectively, since they are the ones seeing the patient repeatedly in good times and bad.

Chronic illness management for cardiovascular disease, diabetes, COPD, and a variety of other serious long-term conditions can be revolutionised by using the ‘Heartwatch’ model. Based on the principles of secondary prevention patients are recruited using clear criteria. A defined data set of essential risk factors and measurements are recorded at regular intervals and related to targets for risk reduction. In the case of the Heartwatch Programme, the ‘Prevention of Coronary Disease in Clinical Practice Programme’ of the ‘Second Joint Task Force of European and other Societies on Coronary Prevention’ was used. It included guidelines for pulse, BP, smoking status, BMI, etc. Computerisation of the care process and the pooling of anonymised information nationally provides proof of the benefits –
translating into substantial numbers of deaths postponed (81 over the initial 33 months) and further ‘heart attacks’ prevented.

From the outset it became clear that the role of the practice nurse in the delivery of care to Heartwatch patients was crucial to success. The relationship developed over repeated visits between patient and nurse produced steady improvement in the most important risk factors.

More recently it has been recognised that many patients suffer from multiple chronic illnesses at the same time. General practice, because it is defined by the patients who attend rather than by the clinical specialty of the doctor or nurse, is naturally patient-centred. The focus is not primarily on the illness but on the person with the illness. Generalist doctors and nurses will develop an intimate knowledge of patients, all their illnesses, their family circumstances, their current employment, and their attitudes and beliefs.

Doctors and nurses working together must be complementary if they are to be effective. Duplicating the work of colleagues is not only a waste of precious time but could appear to be an attempt to review their performance.

Communication with the patient must be consistent. If the doctor and nurse are offering conflicting advice the patient will be at least confused and often not inclined to believe either. This will require a change in the way we all work — much of the innate knowledge we have must be made explicit and even perhaps committed to paper.

Much confusion persists about the future shape of the ‘Primary Care Team’. In the care of patients the general practice will continue to be the location for the delivery of approximately 18 million consultations per annum. There the practice doctors, nurses, and management staff will serve populations ranging from 2,000 to 12,000 patients.

General practice should welcome public health nurses as part of core primary care teams. A limited number of other health professionals may attend the practice for weekly/monthly sessions. But other ‘Primary Care Team’ professionals will find it more effective to offer their specialist services on referral at clinics based in HSE centres, operating in much the same way as hospital outpatient clinics.

General practitioners fought hard and eventually successfully in the 1980s for the recognition by the Medical Council, of general practice as a medical specialty in its own right. Specialist recognition enabled the establishment of GP based training programmes, GP teaching practices, and a GP membership examination to qualify GP specialists be put in place.

Practice nurses deserve and need similar recognition. Suitably trained practice nurses are entitled to be regarded as ‘Clinical Nurse Specialists’. To enable them to achieve that status funded training programmes based in general practice should be put in place as a matter of urgency. Established experienced practice nurses should be the trainers in such a programme. Secondment arrangements and placements in suitable practices would be required. This issue has been discussed for more than a decade.

For the GP, relating to practice nurses both as colleagues and team members, and as their employer can be problematic. However, it may become easier as the range of employed professionals increases. Thus the practice manager, the administrators, some of the doctors, and other allied health professionals may all be salaried members of the practice staff. The challenge then is for those GPs who are the partner/owner directors to ensure that their status does not interfere with their clinical role as team members in the practice.
At a time of unprecedented upheaval in the Irish Health Services there must surely be an opportunity to place practice nurse development, education and training high on the list of reforms of primary care.

While health reform continues, day-to-day practices continue to provide health care to patients. This guide will support both practice nurses and general practitioners in this care delivery.

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July 2006.
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Developing Nursing Services in General Practice

1.1 Benefits of a Nursing Service in General Practice

The changing healthcare climate has resulted in increased pressure on general practice. The type of care provided in general practice has become more complex with the shift of many health issues from secondary to primary care. The growth of a practice is dependent on the services it can provide for its patient population. Establishing a nursing service in general practice or developing an existing service has the potential to benefit patients, practice and clinicians. These services have the potential for financial return, which facilitates the economic growth of the practice.

Benefits for Practice Population

**Increased Choice of Clinician:** Patient choice is enhanced with patients sometimes preferring to consult with the practice nurse for health screening, health promotion and other nurse-led services.

**Increase in Services Offered:** Potential for new services e.g. chronic disease management, health screening, coronary risk prevention, cryotherapy, phlebotomy, wound care and specialist clinics etc.

**Chronic Disease Management:** Many practices provide chronic disease management in primary care for conditions such as diabetes, asthma, COPD, heart disease and hypertension. Primary care if properly resourced can provide quality efficient chronic disease management. Accessibility, continuity of care and the development of a therapeutic relationship with the practice nurse and GP increase patient satisfaction and improve clinical outcomes. A new GMS contract is currently under negotiation and chronic disease management in primary care is expected to be part of this contract.

**Coronary Heart Disease Management:** Evidence from the pilot phase of the Heartwatch Programme i.e. Secondary Prevention of Cardiac Disease in Primary Care, has demonstrated an improvement in the modifiable risk factors of patients enrolled in the programme with the aim of reducing morbidity and mortality. Practice nurses implement this programme with support from the general practitioner using agreed continuing care protocols.

Read More


A systematic review of randomised trials of secondary prevention programmes in coronary heart disease concluded that disease management programmes improve process of care, reduce admissions to hospital and enhance quality of life or functional status in patients with coronary heart disease.

Read More


Nurse led clinics in primary care have been shown to be cost effective when compared with most interventions in health care with the main gains in life years saved.

Read More


Health Prevention: Preventative health strategies have the potential to improve long-term outcomes for the patient. Implementation of these strategies in general practice offers added service to the patient while bringing down long-term health costs. The primary immunisation scheme and the influenza vaccination scheme may be run completely by the nurse, from recall, through administration and follow up according to practice protocol. This time commitment by the nurse will greatly assist achieving national immunisation targets.

Benefits for Practice

Clinical/Professional Support for GP: The availability of another health care professionals in the practice can provide a different perspective in case management and additional clinical/professional support to the GP, especially the single handed GP. There is also the opportunity for the practice to be involved in interdisciplinary learning, audit and research.

Potential for New Services: The practice can become proactive; planning what services it might offer the practice population. New services can be planned based on assessment of need, cost of implementation and expected benefits and return for the practice. A systematic framework of planning identifies the advantages and disadvantages of providing this service for patients, practice and staff.

Manage Acute Minor Illness: With appropriate education and training practice nurses can successfully manage patients with a range of conditions. General practitioner workload can be reduced while maintaining high patient satisfaction levels.

Read More


Increase Practice Revenue: General practice provides healthcare services to both public and private patients. General practice services to ‘public’ patients are provided
under a variety of contracts with the state including the General Medical Services (GMS) contract. Approximately 70% of the population access general practice services as private patients and pay the practice directly for these services.

Increased revenue opportunities include:

- Payment of consultation fee for private patient consultations.
- Special Type Consultation (STCs) payments for services for example cryotherapy, ECG tests, nebulisation, influenza, pneumococcal and hepatitis B vaccinations.

**Read More**

- Access the schedule of fees for STCs.
- Access a sample STC claim form.
- Access a STC claims online article from Forum.
- Access information on completing an STC form.

- Primary Immunisation.
- Influenza and Pneumococcal vaccination (Private patients).

**Read More**


**Childhood Immunisation - How to Achieve a 95% Target**, Dr Peter Harrington, Updated 2002.

- Travel Vaccine Clinic.
- Health Screening e.g. Cervical Smears, Cardiac Risk Clinic.
- Chronic Disease Management.
- Patient Education.

**Research and Audit**: There is an opportunity for the practice to plan practice research and audit practice management and clinical care.

**Proactive Health Service**: A nursing service allows the practice to operate as a more proactive health service through the provision of a greater range of services, including disease prevention and health promotion. Education and monitoring of the patient with a long-term illness by the nurse can lessen the number of GP consultations required by that patient, reducing stress for the patient and clinician.

**New Developments in General Practice**: New initiatives in general practice may be dependant on the employment of a practice nurse e.g. Heartwatch and the development of primary care teams.

**Benefits for Nurse**

**Team Work**: Working in a GP setting provides an opportunity for the nurse to work as part of a small team, delivering a quality, evidence-based, holistic service to the client population.
Continuity of Care and Professional Satisfaction: The nurse has the opportunity of developing a range of clinics where she offers advice, support and treatment to patients/clients. This allows for continuity of care and the development of therapeutic relationships with patients, which will improve their health outcomes through education and compliance. The client population in general practice for the most part is constant, this offers increased professional satisfaction and a sense of achievement, which is unique to general practice.

Expand Practice: General practice provides an ideal environment for the practice nurse to develop her clinical career pathway in line with the needs of the practice. The practice nurse can expand her practice using the ‘scope of practice’ framework, to offer a comprehensive nursing service in general practice.

Access section 4.2: Professional Accountability/Scope of Practice

Formal post-registration education, extensive clinical experience and expansion of practice facilitates the development of clinical nurse specialist and advanced nurse practitioner roles in primary care in response to patient needs and healthcare service requirements.

Access section 4: Career and Role Development of the Practice Nurse.

There are currently two advanced nurse practitioners and 189 clinical nurse specialists in general practice.

1.2 Practice Nurse - Job Description

As with other positions within the practice the job description for the practice nurse should include the main duties and responsibilities, reporting relationships (both clinical and professional), the nurse’s role within the multidisciplinary team and levels of autonomy/responsibility. Flexibility should be a key feature of the job description to encourage role development and progression.

An assessment of the needs of the practice should be undertaken before recruiting a practice nurse.

- What are the practice needs?
- Who would best meet these needs?
- Another GP.
- Practice nurse.
- Practice manager.
- Administration staff.

The immediate and longer term implications (including costs/benefits) for the practice should be fully considered. The following issues should be addressed:

- What role will the nurse take as clinician and as part of the practice team?
- What are the needs of the practice population and what needs are not currently being met by existing services?
- What areas in the practice are underdeveloped?
- What are the areas of special interest? Is it viable to allocate more time to these? Will other services be neglected?
- What specific areas of current practice/GP workload could a nurse undertake within her scope of practice?
- What facilities, space and equipment are needed?

The job description should be flexible to allow for role and service development within the practice. In the beginning, the GP should decide on the areas of care, which can be best provided by a suitably qualified nurse that would benefit the patients attending the practice. As time progresses and as the nurse becomes familiar with this position, services can be developed and expanded depending on the expertise, education, training and competencies of the nurse.

The role of the nurse is one of clinician, educator, communicator, manager and researcher.

**Clinician:** the nurse should carry out the clinical aspect of her role based on current evidence and up to date research. Safe and effective nursing care must be provided for the practice population. The nurse’s practice is regulated by An Bord Altranais (The Irish Nursing Board).

**Read More**

- The Regulation of Nursing and Midwifery Practice (An Bord Altranais).
- The Code of Professional Conduct for each Nurse and Midwife (An Bord Altranais, 2000).
- Scope of Practice Framework (An Bord Altranais, 2000).

**Educator:** the nurse must have the ability to educate patients in health promotion and prevention and assess the success of these interventions.

She should also be able to educate practice staff in relation to issues such as health and safety, infection control and management of emergencies when they present at reception.

**Communicator:** the nurse is an integral member of the multidisciplinary team in general practice and should be actively involved in team/practice meetings. She is also a link between primary and secondary care to ensure the needs of the patient are being addressed. The nurse should have the ability to communicate well with the patient, patient’s family and with all members of the practice team.

**Manager:** the nurse should develop and utilise practice management skills. She may have particular responsibility for areas such as health and safety, infection control or for example become the IT link person. Managing clinical activity i.e. appointment times, special clinics and practice systems is an essential part of the nurse’s role.

**Audit and researcher:** the nurse should have the ability to audit the nursing services she provides to assess its effectiveness and plan service improvements. She may
also be involved in clinical research or act as a data gatherer as part of her role. As her role develops within the practice she may carry out research and quality initiatives.

Read More

Dooque R (2005) Dealing More Efficiently with Lab Samples. Forum 22(8), 17

**Potential Practice Nurse Clinical Activities**

The following list illustrates the range of clinical activities a practice nurse may undertake. It is not exhaustive and the actual activities the nurse undertakes in a particular practice will be dependant on the needs of the practice population and the competencies, education, qualifications and experience of the nurse.

**Direct Clinical Care**

- Phlebotomy.
- Ear lavage.
- Skin and wound care/minor surgery:
  - Treatment of venous leg ulcers and other skin injuries.
  - Post-operative suture removal.
  - Cryotherapy/treatment of warts and verrucae with appropriate training.
  - Nursing management of skin conditions—eczema, psoriasis.
- Immunisations:
  - Infant vaccinations.
  - Childhood vaccinations.
  - Travel vaccinations.
  - Hepatitis B, tetanus booster, rubella booster.
  - Flu and pneumococcal vaccinations.
- Chronic disease management:
  - Nursing management of chronic disease including the development of practice protocols and guidelines.
  - Hypertension.
  - Asthma.
  - COPD.
  - Diabetes.
  - Secondary prevention of coronary heart disease.
- Cardiology:
  - Cholesterol testing and dietary advice.
  - ECGs.
  - 24 hour blood pressure monitoring.
  - Monitoring patients on anti-coagulant therapy.
  - Smoking cessation.
  - Stress management.
- Drug treatment programmes e.g. shared care with the GP in methadone maintenance.
Screening and preventative healthcare.

Women’s health:
  - Cervical screening.
  - Advice on various methods of contraception.
  - Pre-conceptual advice.
  - Advice on HRT.

Management of emergencies, treatment room triage, phone triage.

Infectious disease management and prevention.

Administering prescribed long-term medication/injections.

Explanation and interpretation of test results, X rays etc.

Health promotion – smoking cessation, weight loss, exercise/physical activity, safe sex, alcohol use.

Nurse led clinics.

Indirect Clinical Care

  - Patient chaperone.
  - Infection control e.g. sterilisation.
  - Organisation and management of clinical equipment.
  - Maintain emergency equipment.
  - Clinical stock control.
  - Develop practice policies and guidelines.

Reporting Relationships

It is important that the reporting relationships both professional and clinical are clearly outlined and documented in the job description. The ‘employment reporting relationship’ should be clearly stated in the employment contract. From a clinical and professional perspective the nurse is accountable to the patient, the general practitioner and to An Bord Altranais.

Professional Development

The nurse must take measures to develop and maintain the competence necessary for professional practice (An Bord Altranais, 2000).

Read More

An Bord Altranais (2000), The code of professional conduct for each nurse and midwife: http://www.nursing.board.ie (follow relevant link).

It is the responsibility of the nurse to ensure ongoing professional development relevant to her area of practice. The professional development coordinator for practice nurses is available to assist the practice nurse in accessing relevant courses,
educational material and study days and supports the professional development of the practice nurse.

Access information on Professional Development Coordinator for Practice Nurses in section 3.1 Orientation Period.

1.3 Practice Nurse – Person Specification

Developing a job description based on the needs of general practice is an important consideration before recruiting a practice nurse. The person specification helps outline the essential and desirable qualifications, knowledge, experience, skills and attitudes that candidates should possess. The person specification is used to shortlist a panel of candidates for selection who best meet the job description.

The balance of relevant knowledge, skills, attitude and motivation that the person brings to the role is important. Personality and disposition may not be an easy attribute to measure but are important attributes given the close working nature of health professionals in primary care. The practice nurse will interact with patients each day, work closely with the GP(s) and other members of the practice team and the professional reputation of the practice is entrusted to the practice nurse when patients are referred.

Consideration needs to be given to whether the person selected shares a similar value system to the norm in the practice.

The person selected needs among other things to have the following qualities:

- An understanding that general practice is a service based organisation with all this implies both in relation to quality and delivery.

- An appreciation of the differences between primary care and secondary care and the practical implications of these differences in terms of service provision.

- Compatibility with existing practice administrative, nursing staff and GP partners.

- Ability to work well as part of a team.

- Comprehension of the ‘business’ and public/private context in which the practice operates and how it is organised.

- Ability to work under pressure and to deadlines

The person specification should detail the following areas:

**Registration (Essential)**

- Registered General Nurse (RGN). The nurse must be registered with An Bord Altranais (The Irish Nursing Board) in the general division. [http://www.nursingboard.ie](http://www.nursingboard.ie)

**Experience (Essential)**

- Minimum two years post-registration clinical experience.
Post-Registration Qualifications and Education (Essential or Desirable)

Essential and desirable requirements will depend on the present and future needs of the practice.

Is the nurse willing to undertake further education as required?

- Certificate, Diploma or Higher Diploma in Practice Nursing.
- BSc Nursing/ MSc Nursing.
- Nurses providing antenatal or postnatal care must be registered midwives.
- Family Planning Certificate.
- Certificate/Diploma in Asthma Care/COPD.
- Certificate in Cervical Screening.
- Certificate in Research Methodology.
- Certificate /Diploma in Coronary Heart Disease.

Clinical Skills (Essential or Desirable)

Essential and desirable skills will depend on the needs of the practice.

Willingness to learn new skills through education and supervised practice is essential. Examples of specific nursing skills applicable to general practice are outlined.

- Patient education.
- Phlebotomy.
- Administering injections.
- Cervical smear taking.
- Ear syringing.
- Electrocardiograph (ECG).
- Spirometry.
- Cryotherapy.
- Assisting with minor surgery.
- Wound care.
- Triage.
- Cardiopulmonary resuscitation/basic life support skills.
■ Emergency care.

Other Skills (Essential)

■ Interpersonal and communication skills.
■ Analytical skills.
■ Ability to work under pressure and to specific deadlines.
■ Organisational and managerial skills.
■ Computer skills.

Attitude/Personality (Essential)

■ Self-motivated.
■ Empathetic.
■ Adaptable, assertive, enthusiastic and flexible

One individual is unlikely to possess all skills and competencies desired. However, candidates should be short listed to those who possess the core essential competencies required by the practice. Evidence of previous continuing professional development may imply a willingness by the nurse to acquire skills and competencies in the future that are not already possessed.

Desirable and essential competencies should be based on present needs of the practice and possible future requirements.
SECTION 2

Recruitment, Selection and Employment of a Practice Nurse

2.1 Recruitment and Selection Process

Best Practice - Staff Recruitment and Selection

The recruitment and selection of staff should follow best practice procedures. As with other aspects of employment, the GP employer is legally obliged to act in a fair and reasonable manner and in compliance with the relevant statutory provisions. This section (2.1) outlines an approach to the recruitment and selection of a nurse for employment in the practice.

Staff recruitment and selection is a predictive exercise and best practice procedures will increase the probability of selecting the right person for the position.

The Public Appointments Service Recruitment and Selection Toolkit provide a comprehensive aid to best practice selection and recruitment. While this is primarily aimed at recruitment in the public service the principles apply to any employment context including general practice. Of particular interest is assessment and selection based on definable competencies.

While general practitioners are ‘private’ employers, the recruitment and selection of staff is subject to Equality Legislation both in the public and private sectors. The following link provides guidance on the equal opportunities aspects of recruitment and selection.

Read more

Guidelines for Health Service Employers on Equal Opportunities Aspects of Recruitment and Selection and Promotion.

Steps to Recruitment and Selection of the ‘Right’ Candidate

The following approach to recruitment and selection will generate a field of potential candidates:

- Advertise in relevant nursing, medical and or public media.
- Short list suitable candidates based on the predefined job description and person specification.
- Avoid limiting choice by short-listing too few candidates.
- Prepare for interviewing – including adequate protected time to prepare and conduct interview and use best practice interviewing procedures.
The interview board may be made up of the employing GP, a colleague with experience of selection and one other person e.g. an established practice nurse with experience of selection will all improve the selection process/outcomes.

The objective of the process is to select the person whose profile best matches person specification as previously defined and who is most suitable to the practice work environment.

Advertising

The position may be advertised in the nursing, local and/or national publications /and or websites. The following are the main locations:

Irish Practice Nurse: [http://www.irishpracticenurse.ie](http://www.irishpracticenurse.ie)

World of Irish Nursing: [http://www.ino.ie](http://www.ino.ie)

Local or National Press: One may also consider advertising in the medical media; however advertising exclusively in medical media may not be effective, as many nurses do not have direct access to these publications. The following are the relevant links:

- Irish Medical News: [http://www.irishmedicalnews.ie](http://www.irishmedicalnews.ie)
- Irish Medical Times: [http://www.imt.ie](http://www.imt.ie)
- Medicine Weekly: [http://www.medicineweekly.ie](http://www.medicineweekly.ie)

Practice Nurse Courses

Advertising the vacancy on notice boards in colleges/institutions providing postgraduate practice nurse courses may prove productive.

Short-listing

Establish a short list from the CVs received, based on the job description and person specification. It is recommended to call 4-6 applicants for interview. Applicants who are deemed unsuitable for the position should be notified that they will not be called.

The Interview Board

A board of experienced interviewers, with first hand knowledge of the role of the practice nurse, will ensure a more effective selection. In addition to the prospective employer, an interview board may consist of, for example: a GP colleague, who already employs a practice nurse, a practice manager or an established practice nurse. A professional interviewer may also make a significant contribution to the final outcome.

Effective Interviewing

A structured approach to the interview is recommended. Interviewers will need to have thoroughly reviewed the job description and person specification and agree the marking schedule. A list of questions is required that will assess the strengths and attributes of interviewees. It is important that consistency is maintained, covering the same areas with the same questions for each interviewee. At this point the process is about comparing each candidate to the requirements of the job and not to one
another. An average candidate can be perceived as better than they really are if interviewed after a mediocre candidate.

The objective of the selection process is to predict the competency and suitability of the candidate for the role of practice nurse. One of the best predictors of future job performance is past performance in previous employments.

A competency assessment format is recommended with questions focusing on each of the most important areas relevant to the position. Typical interview questions may include:

- Tell me about your experience working at X.
- Have you ever had to deal with Y and if so, how did you do this?
- What do you know/ have experience about Z?
- Why do you want to work in general practice?
- What do you feel are the key aspects of this job?
- How does your current role prepare you for working in general practice?
- What do you think might be the challenges to providing nursing services in general practice?
- Can you give an example of a situation from your previous work that you found difficult and can you describe how you managed the situation?
- What did you find difficult or challenging in your previous work.
- What is your appraisal of the provision of health care in Ireland?
- How can general practice be improved/developed?
- Describe your professional ambitions/aspirations.
- What are the key issues regarding the treatment of X?
- Posing questions in the format of prepared typical GP/practice nurse scenarios are effective and legitimate.

The key to interviewing is to create a situation where the candidate is given the opportunity to fully respond to relevant questions from the interview board. Questions need to be clear and concise and open. Questions which encourage yes or no answers should be avoided.

**Marking the Interviewees:**

Each member of the interview board should rate the candidates on the agreed ‘weighted’ scale according to the essential and desirable competencies listed in the job/person specification.

**Access Appendix 8: Formatting the Interview Marking Schedule for Practice Nurse.**

Each candidate should be compared to the requirements of the job as detailed in the job description. Comparing candidates to one another should be avoided. Each
candidate should be marked immediately after the interview and a record kept of 
interviewer observations on each candidate, during the interview. Each member of the 
interview board should score and rate interviewee independently.

**Final Selection**

After the last interview the interviewers should rank order their preference. At this point 
comparisons can be reviewed and discussed of the ranking of candidates by each 
interviewer. The interview board can then agree a consensus on the final rank order 
the candidates. Notes made during the process by each interviewer should be factual 
and unbiased.

Note: All documentation from interviews should be retained for one year following 
interview

**The Job Offer**

The position may then be offered to the top ranked candidate. The offer should be 
accompanied by details of the terms and conditions of employment and the job 
description. The offer should be made in writing and offered **conditional to 
confirmation** of the following:

**Qualifications:** Documentary confirmation of the candidates’ nursing qualifications.

**Registration:** It is recommended that current original certificates of full registration 
with An Bord Altranais together with certifications of other relevant qualifications 
should be obtained and authenticated by the employer.

**Certificate of Fitness to Work:** An independent medical examination should be 
completed before commencement of employment.

**Confirmation of Professional Indemnity/Insurance:** The practice nurse may have 
professional indemnity insurance or it may be acquired as a practice expense.

**Satisfactory References:** It is recommended that the employer/practice manager 
make direct contact with the referees provided. At least one of the referees should be 
the previous employer/immediate clinical nurse manager. References should be 
followed up with the permission of the candidate and the previous employers/referees 
should be contacted directly. The objective is to seek corroboration of the information 
provided by the candidate and the suitability of the person for the position. The best 
predictor of future performance in the job is the performance achieved in similar or 
equivalent previous positions of employment.

**Garda Clearance:** At present it is not mandatory for employers in the private sector to 
s seek Garda clearance for employees. However, it has been suggested as best 
practice in the ‘Children First’ guidelines. Currently in the Health Services Executive it 
is a requirement that those who may have unsupervised access to vulnerable clients 
during the course of their employment would have Garda clearance.

Garda vetting however, only covers Irish, English, Welsh, Scottish and Northern 
Ireland addresses and only relates to actual convictions. The Garda clearance 
procedure confirms that the person vetted has not had a criminal conviction on record. 
Because of these limitations it is essential that references be checked thoroughly.

Further Information is available from the Garda Central Vetting Unit. Postal Address: 
Technical Bureau, Garda Headquarters, Phoenix Park, Dublin 8, Tel: 01 6662562.
**Satisfactory Probation:** The written offer of employment should explicitly indicate that the offer of employment is made subject to the candidate completing a period of probation and that their performance in the post is acceptable to the practice/employer.

**Written Acceptance of Job Offer**

Written acceptance of the job offer should be obtained from the candidate including agreement of commencement date. Once this acceptance has been obtained the unsuccessful candidates may be notified.

### 2.2 The Contract of Employment – Issues to Consider

Once an offer of employment has been made and the candidate has accepted the post of practice nurse, a legally binding relationship exists between the parties i.e. a contract of employment. The employment contract contains both explicit and *implied terms*. Implied terms are the rights and obligations of both employer and employee under both Common Law and Statute Law. It is important to detail clearly terms and conditions of employment in the contract.

The written contract of employment will be the key reference point, assisting both parties prior to commencement of employment and in any subsequent negotiations on the terms and conditions.

The practice nurse and GP employer should draft the employment contract on practice headed paper for joint signature.

All employees are entitled by law to be provided with the terms and conditions of the job in writing within two months of commencement of employment.

A copy of the employment contract will also be submitted to the Primary Care HSE office where the practice is eligible/applies for GMS practice support subsidies for the employment of the practice nurse.

It is recommended that the contract cover all the terms and conditions of employment applicable to the position as comprehensively as possible.

The following issues need particular consideration when drafting the contract of employment. The contract terms should also be referenced to relevant HR documentation such as employee handbooks and policies and procedures relating to HR compliance.

**Probation**

The contract of employment should be offered subject to the completion of a satisfactory probationary period. The contract should explicitly state the probationary period (e.g. six months). During the probationary period the nurse’s performance and progress in the job should be jointly reviewed and recorded. It should be noted that for the probationary clause to be valid it must be stated in writing. The probationary period may be extended but cannot exceed 12 months. The probationary period allows for a regular review of the work performance and working relationship. After 12 months of continuous employment the provisions of the Unfair Dismissals’ legislation apply.
Professional Indemnity/Employers Liability Insurance

The nurse should provide the original certificate of professional indemnity and a copy made for the practice personnel records. The practice should also notify the GP’s medical indemnity company that a practice nurse is now employed to provide nursing services in the practice. The practice public/employers’ liability insurance policy should be updated to incorporate the new employee.

Note: In the event of the practice nurse using her own car for practice related activity (e.g. collection of specimens) the practice must ensure that appropriate insurance cover is provided.

Note: Practice nurse indemnity insurance is provided by a number of companies for further information. Access section 7: Practice Nurse Indemnity

Duration of Contract

The contract of employment may be permanent, fixed term or specific purpose. The contract should state clearly which category is intended. With regard to notice of termination statutory minimum notice periods apply unless specified otherwise. It may be advisable for a longer period of notice to be requested and specified in the contract depending on type of contract and category of employee.

Hours of Work

The normal working hours should be explicitly stated. The contract should specify whether the lunch break is paid or unpaid. The practice is entitled to reserve the right to change working hours. Contract should include a small clause.

Annual Leave Entitlements

Leave entitlements, which are offered, should be specified. Consideration needs to be given to the amount of annual leave and whether this is related to length of service or other conditions. All employees are entitled by law to minimum statutory leave entitlements.

Read More

http://www.oasis.gov.ie/employment/holidays_and_leave

The Irish Nurses Organisation recommends an annual leave schedule based on length of nursing service.

Professional Development/Training/Study Leave

It is important to anticipate the requirement for on going professional development of the practice nurse. Training and development will be ongoing in the job and also will occur externally. There should be clear policies with regard to training including external courses and other educational activities, which will address among other issues:

- Notification of requests for study leave.
- Amount of study leave.
- Funding in full or part of professional development activity.
Balancing practice requirements with professional development and absence from the practice.

The relative value to the practice of specific educational activities.

Provisions (in the contract) for the refund of course fees to the practice if the employee resigns within a specified period, following completion of the training/course.

The employer is entitled to require employees to engage in training relevant to their role and work in the practice.

**Place of Work**

It is important to explicitly state all locations if the employee is expected to work in more than one site. House calls/visits are not within the scope of practice of the practice nurse.

**Remuneration**

The manner in which the salary is to be paid, and how overtime is calculated should be explicitly stated including whether payments will be weekly or monthly. The position in relation to continuity of salary in respect of absence from work, other than annual leave, needs to be clear and written into the employment contract e.g. sick leave payments, payment during maternity leave. An incremental scale should be considered relating to the experience or role of the practice nurse.

**Overtime**

Provisions regarding overtime should be stated on the contract. The contract may stipulate that an employee be prepared to work overtime at the discretion of the employer.

**Additional Benefits**

Where it is intended to offer additional benefits these should be referred to in the contract:

- Pension plan.
- Professional membership subscriptions.
- Uniform allowance.
- Indemnity costs reimbursement.
- Permanent health insurance.

**Reporting Relationships**

The reporting structure in which the practice nurse will work should be clear both in the clinical and practice management/employment areas e.g. on clinical matters the nurse may report directly to the GP but on matters relating to employment she may be required to report to the practice manager.
Performance Review and Appraisal

Regular joint review by the GP and practice nurse of her work and the nursing role is recommended. The GP and practice nurse both need to review capabilities and competencies of the practice nurse. A system for developing competencies through education and professional development is helpful.

Grievance and Disciplinary Procedure

All dismissals are deemed by law to be unfair and the employer must show that the grounds for dismissal are fair and that proper disciplinary procedures are followed.

Grounds for ‘fair’ dismissal are - incompetence, misconduct, and incapacity, failure to carry out instructions, redundancy or some other substantial reason. The contract/employment polices should state clearly practice grievance and disciplinary procedures. This will include informal and formal warnings, suspension without pay, transfer to other duties and dismissal following final written warning.

Professional/Ethical Considerations

The GP employer should also understand that the practice nurse is a professional in her own right and as such is subject to ethical and other professional regulations of An Bord Altranais.

Health and Safety

All employers are obliged to provide all employees with a copy of the practice Health and Safety statement and related protocols.

Access the ICGP publication Managing Health and Safety in General Practice.

Change and Flexibility

The job description sets out the main duties of the position but this may change over time and there is an obligation on employees to be flexible and cooperative in relation to future changes in the job role and reasonable requests made by the employer.

Confidentiality

It is strongly recommended that a specific clause be included in the contract to address the employee’s legal obligations to maintain confidentiality in all practice/workplace related matters.

Signature and Date of Contract

The contract should be signed by both parties indicating the acceptance of the terms and conditions of the contract and dated. A copy of the signed contract should be provided to the practice nurse.

Employee File

As for all employees, it is recommended that the practice maintain, a file/record all ‘employment’ related information in relation to the practice nurse.
Orientation of the New Employee

The provision of written human resource policies in the practice will speed up the orientation process. The practice nurse, as with all newly appointed employees, should be provided with written information on the practice policies in relation to the following:

1) Leave/absence from work:
   - Annual leave.
   - Sick leave - certification of absence.
   - Maternity leave.
   - Parental leave.
   - Study leave.
   - Compassionate leave.
   - Force Majeure leave.
   - Late attendance.

2) Appraisals and performance review.

3) Health and safety.

4) Bullying and harassment policy.

5) Security of personal belongings.

6) Practice policies with regard to use of IT resources in the practice.

7) Practice policies with regard to use other resources in the practice e.g. car parking facilities.

It is recommended that the above be incorporated into an Employee Handbook for all practice staff.

PAYE/PRSI Taxation Requirements

On commencement of employment the practice will need to notify tax office of employment of nurse on commencement of employment.

2.4 Costs and Financing Employment of Practice Nurse

Investment in staff is a key financial decision for any business and general practice is not an exception. It is important to project costs accurately in relation to the employment of a practice nurse. Costs may include: recruitment, salary, PRSI, training, equipment, premises costs, locum if employed, expenses, pension, sick pay,
PPF increases, bonus. Equally important is the accurate projection of income potential from nursing services.

**Financing the Employment of a Practice Nurse**

**Practice Support Subsidy**

A practice support subsidy is available from the General Medical Services (Payments) Board. The amount of the subsidy is based on a number of factors:

- The panel size, maximum subsidy paid on panels of 1200 or over and pro rata for less than 1200 (100-1100). Where the practice is in receipt of the rural practice allowance, the practice is eligible for the maximum subsidy.
- The number of years general practice experience of practice nurse.
- A weighting of 1:3 applies to the panel for over 70s GMS card patients.

The maximum practice support subsidy for a GMS panel of 1200 is €38,636.45 (December 2005)

[Read More](http://www.gpit.ie/egms)

**Private Patient Consultation Fees**

Private patients are those whose family income is above the eligibility guidelines for a medical card under the General Medical Services Contract. These patients pay the practice directly for services provided by the GP or practice nurse. The practice nurse should be aware of the respective fees charged for services and the procedures for collection and recording of fees.

From a practice management perspective, reconciliation must be made between all services provided to private patients and fees received in the practice. Fees are charged at the point of service or patients are invoiced at a defined later date. All services provided for must be recorded and the fees policy applied.

The schedule of fees for services provided should be documented in the practice policy. Consider the rationale for fees. Is there a standard fee for a consultation with the practice nurse or a schedule of practice fees dependant on clinical activities?

**Special Type Consultation Payments**

Practice nurses will be involved in providing special type consultations (STCs) to GMS patients e.g. ECG, nebulisation, pneumococcal and influenza vaccine and must follow the practice procedures for the completion of STCs.

**Primary Childhood Immunisation Programme**

Practice nurses involved in the administration of childhood immunisations must complete the appropriate forms correctly. This includes parental consent for vaccination, name and manufacturer of vaccine, batch number and site of injection. In some practices computer generated forms can be printed from the patient's health care record. Correctly completed forms returned to the primary immunisation section of the appropriate health service executive will not only ensure correct payment to
practice for vaccines administered, accurate vaccination records for each child but also accurate local and national statistics on immunisation targets.

**Mother and Infant Services Contract**

Further clarification is required to determine the extent to which it is appropriate for a GP to delegate antenatal care to the practice nurse/midwife when providing services under the Mother and Infant Contract. This document will provide an update on the issue when clarification is available. In providing antenatal care to patients it is important to note that the practice nurse must have midwifery qualifications.

**Remuneration of the Practice Nurse**

The remuneration package provided by the practice is determined in the same way as for all businesses in the private sector, through negotiation between the parties, in the context of the conditions of the market. The remuneration offered and the final remuneration package agreed will be the result of some or many of the following factors:

- Requirements of the job.
- Experience and qualifications of the nurse.
- Responsibilities of the role.
- Current and future competencies.
- The financial status of the practice.
- Benefit to the practice
- The size of the practice.
- Level of GMS subsidies.
- Additional benefits offered.
- Work flexibility.
- Workplace precedents.
- Salary scale review; determined relative to experience, qualifications and competencies
- Remuneration Rates in related sectors - the public sector and recommendations of employee representative bodies

Remuneration rates in related sectors, including the public sector will influence the negotiations and remuneration agreed between the GP employer and the Practice Nurse. Nurses working in the public sector are remunerated on the salary scales negotiated nationally between the nursing trade unions and the State. The Irish Nurses Organisation (INO) has recommended to its members, that practice nurses salary levels be linked to the following public service salary scales and leave entitlements.
Remuneration of Nurses in the Public Service and INO Recommendations on the Employment Terms of Practice Nurses

Salary

The INO takes the view, that in order to reflect the level of responsibility and the autonomous nature of the practice nurse role, that the minimum salary appropriate for a practice nurse should be the maximum point of the staff nurse scale.

Salary Scales recommended by INO for practice nurses:

A) Maximum point of Staff Nurse Scale.

B) Maximum point of Dual Qualified Nurse Scale (A nurse registered in any two of the five Disciplines)¹.

C) Senior Staff Nurse (Senior S.N.) (20 years post registration experience).

D) Senior Dual Qualified Nurse: A nurse registered in any two of the five disciplines.

E) Clinical Nurse Specialist (CNS).

Access section 4: Career and Role Development of the Practice Nurse.

F) Advanced Nurse Practitioner (ANP).

Access section 4: Career and Role Development of the Practice Nurse.

At the individual practice level the salary negotiated will reflect relevant experience, qualifications and competencies on commencement of employment and thereafter in subsequent reviews.

Annual Leave

The minimum statutory annual leave entitlement for all employees is 4 working weeks.

Note: Maternity leave, parental leave, sick leave and force majeure leave do not affect annual leave entitlements.

http://www.entemp.ie

http://www.oasis.gov.ie

Access ICGP Management in Practice section on GP as Employer.

¹ General midwifery, children's psychiatry, intellectual disability.
The INO has recommended to its members that the following public service annual leave schedule apply to practice nurses.

<table>
<thead>
<tr>
<th>Service</th>
<th>Full-time (39 hrs/week)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td>25 days</td>
</tr>
<tr>
<td>5 -10 years</td>
<td>26 days</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>28 days</td>
</tr>
<tr>
<td>Pro-rata for part-time nurses</td>
<td>25 days – 9.6% of hours worked</td>
</tr>
<tr>
<td></td>
<td>28 days – 10.7% of hours worked</td>
</tr>
</tbody>
</table>

E.g. a practice nurse with 12 years nursing service working 3 x 8 hour shifts/week based on the above grid, is entitled to 16.7 days annual leave. 24 hrs x 52 weeks = 1248 hrs. 10.7% of 1248 = 133.5 hrs, ÷ 8 = 16.7 days.

**Sick Leave Entitlements (Comparison with Public Service)**

While employees have no statutory right to sick leave payments, the practice policy on continuity of salary should be clearly defined and agreed with the Practice Nurse. The INO has indicated that, in line with public service conditions, 13 weeks paid sick leave in each leave year should be considered as the sick pay entitlement for practice nurses.

Note: Where payment is continued and the nurse is in receipt of her salary from her employer, any disability benefit payments she receives from the Department of Social, Community and Family Affairs are submitted to her employer.

**Compassionate Leave**

Similarly, other than the statutory minimum entitlements there is no obligation to grant compassionate leave. In the public service, special leave with pay is granted to nurses as follows:

- Spouse/child: five days.
- Mother, father, sister, brother, mother-in-law, father-in-law: three days.
- Other leave: one day (or time off to attend funeral).

In exceptional circumstances, where the employee may find her/himself being required to organise all of the necessary arrangements, the leave itemised under the latter two points above may be extended to five days.

**Overtime Rates**

For nurses employed in the public service overtime is calculated on the following basis: Monday-Friday: Time and ½ for all hours worked in excess of rostered shift up to midnight.
**Maternity Leave**

As with sick leave, the practice policy should be clearly defined and agreed with the practice nurse. While employees do not have a statutory right to payment during maternity leave this is a matter of negotiation between the parties.

In the public service context – salary continuity is provided for the full period of maternity leave. Statutory maternity leave consists of 22 consecutive weeks paid maternity leave – a minimum of 4 weeks before the birth, and a minimum of 4 weeks after the birth. Up to 12 weeks additional maternity leave without pay may be taken.

Note: From March 2007 Statutory Maternity ‘paid’ leave is increased to 26 weeks and unpaid leave to 16 weeks. In this context ‘paid’ leave refers to maternity benefits paid by the Department of Social and Family Affairs.
Section 3

Orientation to the Role of the Practice Nurse

3.1 Orientation Period

A formal orientation period for the new practice nurse is recommended to ensure a smooth transition for the entire practice team. Every general practice operates differently with different practice systems. A formal introduction of all practice staff and their roles and responsibilities develops good interpersonal relationships and teamwork. During the orientation period the new practice nurse should spend time working alongside various team members in order to provide insight into each person’s role within the practice. It is important to allow the nurse to integrate slowly on commencing employment, allowing her time to become familiar with practice systems and routine, and not to become inundated with direct patient consultations at the outset.

The Professional Development Coordinator for practice nurses is a valuable resource for the new practice nurse during the orientation period. The GP or the practice nurse may contact them for assistance during the orientation process.

Orientation to the practice should include:

- An outline of practice policies, written policies and protocols.
- Practice nurse job description and written contract.
- A list of basic duties and responsibilities for all employees including those shared by the nurse.
- Health and safety statement and procedures.
- Practice systems:
  - Appointments.
  - Credit control.
  - Record keeping.
  - Telephone system.
  - Test and lab results.
  - Repeat prescriptions.
  - Referrals.
  - Special Type Consultation (STC) claims.
  - Call and recall systems.
  - Copy of practice directory.
- Practice IT Systems (instructions and training in use of clinical database).
- Introduction to local services e.g. Public Health Nurse(s), community pharmacists, dieticians, physiotherapists, home care teams and other community services.

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Build Team Relationships

Receptionist/Secretary: The practice nurse should be introduced to receptionist or secretary and spend time with them learning their role responsibilities. The GP must clarify for the secretary the role and responsibilities of the nurse and the support she will provide for the nurse.

Practice Manager: An introduction to the role of the practice manager is necessary and clarification of reporting relationships.

Doctors as Clinicians: Where there is more than one general practitioner in the practice it is important that there is clarity on the following:

- Who is senior clinician?
- Who are assistants?
- What areas of special interests do they have?
- What is the policy for house calls?
- What protocols are in place for referral of patients from the GP to the practice nurse and from practice nurse to the GP?
- What is the policy for reviewing a patient if the nurse needs a medical opinion?
- Do all the doctors share a common understanding of the nurse’s role as part of the general practice team?
- How is clinical work reviewed in the practice generally and how is the clinical work of the practice nurse in particular, reviewed and with whom?

Doctor as Employer: To whom is the nurse accountable as an employee of the practice – designated partner, practice manager etc. It is important that the nurse have a reporting relationship with one designated person rather than reporting to several people on an ongoing basis. A system of individual performance review needs to be elaborated and applied.

The review of clinical work should be addressed at formal meetings. Discussion of individual performance, clinical or employment related issues should be undertaken directly with the nurse. It is not appropriate to address an individual's work performance at practice meetings.

The practice nurse must be provided with the opportunity for addressing any difficulties she may have with the job/role and also to offer feedback and her perspective on any issue directly to her line manager. This is will benefit both parties and the practice team.

It is recommended that for the first six months that the nurse and doctor should meet weekly (or twice weekly) to review orientation to the role, discuss experiences and implement change where needed.

Practice Population/Patients – Orientating Patients

Practice leaflets and notices advertising the arrival of the nurse could be placed in waiting areas with a short description of consultations that the nurse will be performing and how to access nursing services. Reception/secretarial staff needs to implement agreed method for scheduling appointments for nursing services.

Having the nurse sit in with the doctor during consultations for the first week or two is a very effective strategy for introducing the nurse to the patients.
Referral of patients by the GP to the nurse establishes trust in the nurse and encourages patients to self refer directly to the nurse.

The availability of nursing services and the addition of a new member to the practice team need to be actively promoted to patients. All practice personnel must be involved in promoting/marketing the new service.

### 3.2 Consultation/Treatment Room

**Practice Nurse’s Consultation Room**

The nurses consultation room and treatment area should be designed to best meet the needs of the practice nurse and nursing services. Room size, design, lighting, ventilation privacy, equipment and layout need to be addressed to allow for optimal nurse consultation and treatment. All workspaces should conform to health and safety standards. The physical environment will influence the patient’s perception of nursing services.

Where space allows, the nurse’s consultation room and the treatment room may be two different rooms reflecting the different type of work activity, which is carried out in each work area.

**Layout & Design of Treatment Room**

The treatment room needs to be equipped and laid out to best facilitate the clinical activity taking place in this area. Some form of roster/timetable for room usage and access may be useful to avoid unnecessary interruption, compromising privacy and confidentiality.

**Size:** Ideally minimum of 12m squared (13 x 10ft approx).

**Floor/Walls:** Appropriate surface for good hygiene maintenance: spills or bio hazardous material can be easily and safely removed. Non-slip.

**Sink:** Sink and drainage area for hand washing and cleaning of equipment.

**Room Design:** Allows maximum privacy for the patient. Curtains or screens available as appropriate.

**Clinical Waste Disposal:** Facility for separation of waste into clinical, household, recycling and sharps. Pedal bin. Sharps box.

**Furniture:** Couch, hydraulic if possible, paper couch rolls, blanket and a pillow. Screen/walled partition or curtain. Desk or writing surface plus swivel chair on wheels.

**Storage Space:** Cupboards/drawers. Lockable fridge with Max/Min thermometer.
3.3 Practice Equipment

The equipment required by the practice nurse will depend on the role of the nurse and the services she will provide. When employing a practice nurse for the first time in the practice, the nurse should be involved in planning equipment requirements based on her job description. Expansion of services may require new or upgrading of equipment (e.g. spirometer for assessing patients with COPD or asthma, ECG, 24 Hour Blood Pressure Monitor).

**Standard Equipment Required**

- Sphygmomanometer – desk/wall mounted, aneroid, digital. (Various cuff sizes a cuff that is too small or big will give a false reading).
- Stethoscope.
- Auroscope.
- Ophthalmoscope.
- Adult weighing scales.
- Baby weighing scales.
- Height measure.
- Baby measuring mat.
- Height and weight conversion charts.
- Thermometer – tympanic most convenient.
- Steriliser e.g. autoclave.

**Emergency Equipment**

Access information on recommended contents of a doctor’s bag.

**Local Health Service Executive (HSE) Lab Supplies**

It is recommended that the practice nurse check the laboratory supply list from local HSE, ordering criteria, delivery or collection details.

All equipment should be based on service needs. There are many medical equipment companies in Ireland who provide services for primary care. Catalogues of equipment with current prices are available. Some companies provide an information service to answer questions regarding the equipment. Medical equipment is expensive so research before purchase is essential.
SECTION 4

Career and Role Development of the Practice Nurse

4.1 Education and Training

As with the medical profession continuous professional development in nursing is a responsibility of the individual nurse and also mandated by the professional bodies. Unlike other nurses, the practice nurse will generally not have a ‘nurse line manager’. Given this and the current changes in nursing it is important that continuing professional development is considered by both the GP and the practice nurse.

Once the practice nurse has orientated herself to the immediate needs of the practice both the GP and the practice nurse can begin to look at the development of the role. This can be progressed with both on the job training and development and accessing external educational opportunities. Professional nursing autonomy should be recognised in choosing appropriate continuing nursing education.

Postgraduate Education

There is no mandatory course in Ireland leading to registration as a practice nurse. However there are many education and training opportunities available that will assist the nurse develop the education and skills necessary to provide a quality nursing service in general practice.

Post Graduate Courses Available

National University of Ireland Galway
http://www.nuig.ie/general_practice

- Higher Diploma in Nursing Studies (Practice Nursing).

- A national agreement for funding for this course is being considered by the Health Services Executive (HSE) and it is expected that application for funding for the course will be to the area HSE. The GP will be required to sign the application form indicating their support for the practice nurse attending the course. Further information is available from Professional Development Coordinators for practice nurses.

- Higher Diploma in Health Science Primary Care (This course can be used as the first year of a two year course leading to a Masters in Health Science Primary Care).
Royal College of Surgeons in Ireland
http://www.rcsi.ie/faculty_nursing

- Higher Diploma in Practice Nursing (This course can be used as the first year of a two year course leading to MSc Practice Nursing).
- MSc Practice Nursing.

Irish College of General Practitioners
http://www.icgp.ie

The ICGP provides a range of courses through distance learning many of which are relevant to the work of the practice nurse, including:

- Diploma in Women’s Health.
- Certificate in Diabetes.
- Theory Course for Cervical Smear Takers.

Other relevant postgraduate nursing courses are available by contacting the department of nursing studies or general practice in the various universities.

Dublin City University: http://www.dcu.ie

Institute of Technology Athlone: http://www.ait.ie

Institute of Technology Dundalk: http://www.dkit.ie

Institute of Technology Galway Mayo: http://www.gmit.ie

Institute of Technology Letterkenny: http://www.lyit.ie

Institute of Technology Sligo: http://www.itsligo.ie

Institute of Technology Tralee: http://www.ittralee.ie

Institute of Technology Waterford: http://www.wit.ie

National University of Ireland Galway: http://www.nuig.ie

Royal College of Surgeons in Ireland: http://www.rcsi.ie/faculty_nursing

St Angela’s College Sligo: http://www.stangelas.com

Trinity College Dublin: http://www.tcd.ie

University College Cork: http://www.ucc.ie

University College Dublin: http://www.ucd.ie

University of Limerick: http://www.ul.ie

University of Ulster: http://prospectus.ulster.ac.uk
Many stand-alone modules related to particular areas of clinical practice are available. Distance learning modules are also available to Irish students through universities in the United Kingdom.

There are many courses available which are relevant to practice nursing. Please contact the professional development centre for information.

**Other Sources of Education**


Irish Nurses Organisation: [http://www.ino.ie](http://www.ino.ie) - Courses are available to the INO Professional Development Centre.

**Nursing and Midwifery Planning Development Units**

Professional Development Coordinators for practice nurses are appointed in each HSE area. One of their roles is to source and provide education and professional development opportunities for practice nurses. Day release and evening courses are available on many areas pertinent to general practice.

Access section 4.4: Professional Development Coordinators for Practice Nurses.

**Irish Practice Nurses Association (IPNA)**

[http://www.ncnm.ie/ipna](http://www.ncnm.ie/ipna)

The IPNA is a voluntary organisation set up by practice nurses to provide support and encourage professional development of nurses working in general practice. There are approximately 700 members of the IPNA with 19 regional branches throughout the country. Benefits of membership include: peer professional support, regional meetings on topics relevant to practice nursing, free delivery of the Irish Practice Nurse journal.

Contact: Lisa Nolan, Administrator IPNA
Phone: 042 969 2403
Text: 087 130 4115
Email: [ipnaadmin@gmail.com](mailto:ipnaadmin@gmail.com)
Address: Lisa Nolan, Cormoy, Culloville Road, Carrickmacross, Co Monaghan.

**Aims and Objectives of IPNA**

- To establish and maintain an organisation which provides professional support and guidance to nurses working in general practice, through its' Regional Branches and National Executive Committee.

- To encourage and foster the highest possible standards within general practice nursing through post registration education.

- To work positively with other groups and organisations that it deems to be suitably equipped to provide the necessary educational programmes or skills required for the enhancement of nursing in general practice.

- To disseminate information to its' members on all matters relevant to nursing in general practice by means of journals, periodicals, meetings, conferences, etc.
- To encourage members to undertake and publish research and original work that is relevant to the role of nurses in general practice. To assist others who may be undertaking research relevant to nursing in general practice.

- To act as a resource base for members or those with an interest in general practice nursing.

**Education and Training Costs**

The full cost of training should be considered, these may include course fees, travel costs, examination fees and locum costs if a locum nurse is employed. The full impact on the practice of the nurse's absence needs to be considered. However, while there are financial and non-financial costs to staff training this expenditure may be considered a practice investment from which patients and the practice will accrue benefits.

All training costs incurred are a practice expense and as such should be allocated accordingly and are fully allowable for tax. It is important to retain all relevant records – invoices, syllabus etc relating to these costs.

Fees may also be recouped from the indicative drug budget savings under ‘education’ heading, which has been nationally agreed upon for all Health Service Executives.

Further details may be obtained by contacting the local HSE Primary Care Unit.

A provision may be included in the employment contract for the refund of course fees to the practice if the nurse resigns within a specified period following the training/course.

**‘In-House Training’**

In-house training may be appropriate for some clinical functions; however training ‘on the job’ needs to be properly structured and undertaken during protected time.

Competencies need to be jointly agreed before the doctor allows the nurse to carry out this function independently and the nurse accepts responsibility for the role. Training should include the background theory behind the task, as well as signs and symptoms of adverse advents. A review of current literature on the subject will ensure standards and guidelines developed are current best practice.

### 4.2 Professional Accountability/Scope of Practice

An Bord Altranais is the statutory body responsible for the regulation of nursing and midwifery in Ireland. The general concern of An Bord Altranais is the promotion of high standards of education, training and professional conduct among nurses and midwives.

An Bord Altranais introduced the scope of nursing practice framework in 2000 in response to the changing socio-economic environment within which nursing and midwifery in Ireland are practiced. The ever-changing demographic and epidemiological profile of the Irish population has implications for both the management and the delivery of healthcare services. Given that nurses and midwives currently account for 40% of the health services workforce, their role and the scope of their practice within these services continues to be of paramount importance to the
success of healthcare provision in Ireland. Nursing and midwifery practice needs to be responsive and dynamic, in order to effectively contribute to health and social gain among the population.

The framework provides principles, which should be used to review, outline and expand the parameters of practice while ensuring the protection of the public and the timely delivery of quality healthcare in Ireland.

The scope of nursing practice is the range of roles, functions, responsibilities and activities which a registered nurse is educated, competent and has the authority to perform (An Bord Altranais, 2000).

Considerations in determining the scope of nursing and midwifery practice include:

- Competence.
- Accountability and autonomy.
- Continuing professional development.
- Support for professional nursing and midwifery practice.
- Delegation.
- Emergency situations.

The scope of practice framework has been seen as a restrictive framework by some, preventing nurses from carrying out certain roles and functions due to deficiencies in experience, competence or education. On the other hand many others view it as an enabling and dynamic framework. It encourages nurses to reflect on their practice, examining whether they are educated and competent to carry out a particular role or function. Professional development, education, support (including local and national guidelines) and competence will allow the nurse accept accountability for new and expanded roles and functions.

“The individual nurse is accountable for her practice. This means that she is accountable for decisions she makes in determining her scope of practice. This includes decisions to expand or not to expand her scope of practice” (An Bord Altranais, 2000).
Read More

4.3 Expanding the Role of the Practice Nurse

Clinical Career Pathway for Practice Nursing

The Clinical Career Pathway for nursing has been outlined by the National Council for the Professional Development of Nursing and Midwifery. This pathway assists the nurse to acquire education and expand knowledge and skills. The pathway extends from: practice nurse to clinical nurse specialist in primary care and advanced nurse practitioner in primary care. There are currently two advanced nurse practitioners and 189 clinical nurse specialists accredited by the National Council.

Read More

The Practice Nurse

It is appropriate that the practice nurse have relevant training in many clinical areas for e.g. asthma, diabetes, family planning and cervical screening. The ability of the nurse to perform clinically will be determined by her scope of practice. Further training will be necessary to achieve clinical nurse specialist status. The expansion of the practice nurse role should be encouraged through research, publication and education.

The Clinical Nurse Specialist in Primary Care

The CNS in primary care has undertaken formal recognised post-registration education relevant to practice nursing. Such formal education is underpinned by extensive experience and clinical expertise in practice nursing (National Council for Nursing and Midwifery, 2003).

The CNS can provide assessment, planning, delivery and evaluation of care given to clients and their families within the practice. The CNS may make alterations in prescribed clinical options along agreed protocol driven guidelines with the GP. The CNS is expected to participate in nursing research and audit and act as a consultant in education and clinical practice to nursing/midwifery colleagues and the wider multidisciplinary team.

The Advanced Nurse Practitioner in Primary Care

The role of the advanced nurse practitioner in primary care is designed to equip practice nurses to meet the future challenges in general practice. ANP/AMP (Advanced Nurse/Midwife Practitioner) roles are developed in response to patient/client need and healthcare service requirements at local, national and international level.

Advanced nursing and midwifery practice is carried out by autonomous, experienced practitioners who are competent, accountable and responsible for their own practice. They are highly experienced in clinical practice and are educated to master's degree level (or higher). Professional Development Coordinators (PDCs) for practice nurses have a role in facilitating practice nurse career development along these pathways.

The future is bright for the evolution of practice nursing, as the nurse develops from novice to expert, perhaps becoming a (nurse) practitioner in her own right. Having a
practice nurse as a practice business partner has occurred in general practice in other countries and may not be such a novel idea in the future in Irish general practice.

Figure 1: Nursing Roles in Primary Care

<table>
<thead>
<tr>
<th>Practice Nurse Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>GN-working novice to competent.</td>
</tr>
<tr>
<td>Accepts delegated tasks.</td>
</tr>
<tr>
<td>Assesses, plans, implements and evaluates patient care.</td>
</tr>
<tr>
<td>Refers patients to GP and other health professionals who require complex assessment, diagnosis and treatment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CNS Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>RGN with post grad qualification in practice nursing.</td>
</tr>
<tr>
<td>Has experience working in primary care.</td>
</tr>
<tr>
<td>Practice is guided by evidence-based protocols.</td>
</tr>
<tr>
<td>Involved in patient teaching, colleague and advisory role to other health professionals.</td>
</tr>
<tr>
<td>Strong patient advocate.</td>
</tr>
<tr>
<td>Carries out clinical audit as part of her role.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANP Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>RGN with MSc qualification.</td>
</tr>
<tr>
<td>Has own caseload of patients.</td>
</tr>
<tr>
<td>Initiates and conducts nursing research.</td>
</tr>
<tr>
<td>Autonomous reflective practitioner and an integral part of primary care team.</td>
</tr>
<tr>
<td>Carries out clinical assessment, diagnosis, prescribes clinical and nursing care.</td>
</tr>
<tr>
<td>Clinical leader- actively involved in the development of policies at practice, regional and national level.</td>
</tr>
<tr>
<td>Negotiates new nursing practice boundaries and expands these within her scope of practice.</td>
</tr>
<tr>
<td>Refers patients to other health professionals within primary care and secondary care.</td>
</tr>
</tbody>
</table>

Reference:
4.4 Professional Development Coordinators for Practice Nurses

**Background**

In 1998, the Department of Health & Children published the findings of the Commission on Nursing. The Commission had taken cognisance of the submissions from practice nurses requesting professional support. The Commission recommended that the Nursing and Midwifery Planning and Development Units in planning continuing professional development needs of nurses should also assist practice nurses in their professional development. It also advised “a practice nurse be attached to the General Practice Unit within the health board to assist in identifying and supporting the development needs of practice nurses” (Commission on Nursing- a blueprint for the future, 1998).

The Commission did however give recognition to the Irish College of General Practitioners for their assistance to practice nurses in their professional development and hoped that it would continue.

As a direct result of the recommendations of the Commission, the first Professional Development Co-ordinator (PDC) for practice nurses post was established in 2002 and subsequently other PDCs were appointed to positions throughout the country, to work within the NMPDU, with the exception of three posts that would function within the Primary Care Units of the old Eastern Regional Health Authority (ERHA). Currently there are nine PDCs for practice nurses.

Role Summary: To support the professional development of practice nurses and the practice nurse role within the primary care arena.

**Main Responsibilities**

1. **Liaison:** Developing and maintaining a good working relationship with the community nursing team and with all members of the primary care team, with other professionals within the Health Service and other relevant governmental bodies. Liaising on nursing issues with the Nursing and Midwifery Planning Development Unit (NMPDU). Initiating and developing alliances with institutes of higher education.

2. **Support and Development of the Practice Nurse Role:** Helping practice nurses assess their personal training and educational needs with recognition of the Scope of Practice for Nursing and Midwifery framework. Help facilitate those educational needs by providing information on relevant courses and securing funding to run courses pertinent to practice nurses. Encouraging investment in practice nurse education, which encourages evidence, based practice and improves the quality of service. Supporting the development of the practice nurse role to its full potential. Primary care and in particular general practice is central to the delivery of health care and is constantly changing to meet the needs of the general population. We support the practice nurse in adapting to the changing needs of general practice. Access section 4.2: Professional Accountability/Scope of Practice.

3. **Quality Assurance:** Support quality initiatives. Provide practice nurses with information on new clinical developments and best practice guidelines. Assist in the development of practice protocols and guidelines that will encourage up to date evidence based practice. Encourage a focus on excellence in nursing practice.

4. **Health Promotion:** Ensure that practice nurses are aware of current health policies for health promotion. Assist in the facilitation of regional initiatives (e.g. cardiovascular strategy), by providing practical advice and assistance to practice nurses in establishing health-promoting activities with the aim of reducing preventable diseases.
5. **Research:** To encourage and support practice nurses in initiating and undertaking research relevant to primary care.

Practice nursing is an exciting and challenging career. The career pathway of Clinical Nurse Specialist and Advanced Nurse Practitioner is particularly suited to general practice nursing with practice nurses constantly expanding their practice. The number of practice nurses in Ireland is continually increasing with approximately 1239 practice nurses currently in employment on a full-time or part-time basis.

The PDCs have formed a national group in order to develop national strategies that will encourage uniformity in the ongoing development of practice nursing throughout the country. These national meetings facilitate a forum for planning educational and skills updating sessions for new and experienced practice nurses.

The PDC is available for consultation with any practice nurse or with any general practitioner who may be considering employing a practice nurse in relation to professional and educational issues.

The PDC is not a nursing supervisor, HSE inspector or a recruitment agent; however PDCs encourage collaboration with the other community nursing services and health professionals in keeping with the ethos of the team approach to care. The function of the PDC is to support the professional development of the practice nurse.

The supportive role of the Professional Development Co-ordinator has been welcomed by the Irish College of General Practitioners, the Irish Practice Nurses Association and the Irish Nurses Organisation.

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2 In 2005, approximately 35% of practices in Ireland employed a part time nurse and 45% of practices employed a nurse full time. (O’Dowd T, O’Kelly F, 2006, Structure of General Practice in Ireland 1982-2005, Irish College of General Practitioners).
<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone Number</th>
<th>Fax Number</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netta Williams</td>
<td>The Civic Centre, Main Street, Bray, Co Wicklow</td>
<td>01 2744334, or 087 6831433</td>
<td>01 2744288</td>
<td><a href="mailto:netta.williams@maild.hse.ie">netta.williams@maild.hse.ie</a></td>
</tr>
<tr>
<td>Rhonda Forsythe</td>
<td>Primary Care Unit, Swords Business Campus, Balheary Road, Swords, Co Dublin</td>
<td>01 8131885 or 01 8098740</td>
<td>01 8908707</td>
<td><a href="mailto:rhonda.forsythe@mailc.hse.ie">rhonda.forsythe@mailc.hse.ie</a></td>
</tr>
<tr>
<td>Rita Lawlor</td>
<td>Primary Care Unit, Block E, Westland Park, Nangor Road, Clondalkin, Dublin 22</td>
<td>01 4609667 or 4609686 or 086 3837432</td>
<td></td>
<td><a href="mailto:rita.lawlor@mailm.hse.ie">rita.lawlor@mailm.hse.ie</a></td>
</tr>
<tr>
<td>Marian Wyer</td>
<td>NMPDU, Unit 4, Central Business Park, Clonminch, Portlaoise Road, Tullamore, Co Offaly</td>
<td>0506</td>
<td>57858/57866 or 086 3802606</td>
<td><a href="mailto:marian.wyer@mailq.hse.ie">marian.wyer@mailq.hse.ie</a></td>
</tr>
<tr>
<td>Ina Crowley</td>
<td>NMPDU, Primary Care, 5th Floor, Bank House, 106 O’Connell Street, Limerick</td>
<td>061 464007</td>
<td>061 317407</td>
<td><a href="mailto:ina.crowley@mailh.hse.ie">ina.crowley@mailh.hse.ie</a></td>
</tr>
<tr>
<td>Ruth Taylor</td>
<td>NMPDU, St Brigid’s Hospital, Ardee, Co Louth</td>
<td>041 6853206 or 087 0506070</td>
<td>041 6853460</td>
<td><a href="mailto:ruth.taylor@maile.hse.ie">ruth.taylor@maile.hse.ie</a></td>
</tr>
<tr>
<td>Patricia McQuillan</td>
<td>NMPDU, (SE), Office Complex, Kilkenny Hospital Grounds, Kilkenny, Co Kilkenny</td>
<td>056 85613 or 087 2281548</td>
<td>056 7785549</td>
<td><a href="mailto:patricia.mcquillan@maila.hse.ie">patricia.mcquillan@maila.hse.ie</a></td>
</tr>
<tr>
<td>Marie Courtney</td>
<td>NMPDU(s), 8a South Ring Business Park, Kinsale Road, Cork, Co Cork</td>
<td>021 4361543</td>
<td></td>
<td><a href="mailto:courtneym@mailp.hse.ie">courtneym@mailp.hse.ie</a></td>
</tr>
<tr>
<td>Kathy McSharry</td>
<td>CNE, St Mary’s Campus, Castlebar, Co Mayo</td>
<td>094 9042162 or 087 1206184</td>
<td></td>
<td><a href="mailto:kathy.mcsharry@mailn.hse.ie">kathy.mcsharry@mailn.hse.ie</a></td>
</tr>
</tbody>
</table>
5.1 Policies, Protocols and Guidelines

The literature suggests that where review and expansion of nursing and midwifery practice has been most successful, certain supports have been present and are considered essential. These include guidelines, policies or protocols that have been developed collaboratively with practicing nurses and midwives with reference to legislation and research based literature where this is available.

The development of policies, guidelines and protocols is about introducing, maintaining, reviewing and changing practice based on high quality information. A key part of the process for development of policies, guidelines and protocols is the consideration of how these may be implemented and resourced. (An Bord Altranais, 2000).

Read More


Policy

A policy is a course or principle of action adopted or proposed by a group or individual (Concise Oxford Dictionary 1995). A policy document outlines a principle that governs activity and which individuals are expected to follow.

Protocol

A protocol is defined as: "a written plan that specifies procedures to be followed in defined situations, a protocol represents a standard of care that describes an intervention or set of interventions" (Ohio Nurses Association, 1992). Protocols are more specific and explicit in their detail than guidelines; they specify who does what, when and how.

Guideline

A guideline is a principle or criterion that guides or directs action (Concise Oxford Dictionary 1995). Clinical guidelines have been defined as: "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (Field and Lohr 1990). Clinical guidelines may be developed locally, nationally or internationally.

Policies, guidelines and protocols aid in improving the quality of health care provision by articulating consistent approaches for best practice. They serve to:

- Improve and standardise patient/client care.
Act as a basis for audit and evaluation of care.

Provide guidance for practitioners on appropriate parameters of care.

Facilitate effective staff induction.

Act as educational tools.

In the formulation of policies, guidelines and protocols consideration must be given to the extent to which they are realistically achievable given the resources available. This consideration must be ongoing even when the policy, guideline or protocol has been adopted.

The nature of the language used in policies, guidelines and protocols will indicate to nurses and midwives the extent to which compliance is required. Therefore, consideration must be given to the use of words such as should, must, consider, always as they indicate different levels of imperative (for example the use of should indicates a directive whereas may allows the exercise of judgment).

Policies, guidelines and protocols cannot possibly account for every particular circumstance that the practice nurse may encounter. They should provide a background to individualised patient/client care. Nurses and midwives must be cognisant that their own professional judgment should not be compromised or ignored if deviation from policies, guidelines or protocols is appropriate. However, this decision should not be taken lightly and appropriate consultation with colleagues is advisable. Reasons for the deviation should be well documented.

References


5.2 Template for Developing Protocols and Guidelines

A practice meeting provides a forum to initiate the development of protocols/guidelines for good practice.

The meeting may be structured as follows:

- Identify the areas of practice, which could benefit from a unified approach.
- Nominate one individual to research the subject and to prepare a discussion document with recommendations.
- Circulate to all for comments.
- Set meeting date and time to reach consensus opinion.
- Set a programme to implement the new protocol/guideline for good practice.
Set a date for audit of the protocol/guideline for good practice – usually 6-12 months.

Template for development of protocols/guidelines for good practice:

- Implementation date.
- Name of practice.
- Names of stakeholders involved in the development of the guideline.
- Purpose of the guideline.
- Documentation of an evidence based guideline including responsibilities of the nurse, patient information.
- References.
- Methods of audit.
- Review date.
- Signing off from the PN/CNS/ANP and GP.

The following worksheets demonstrate a structure/template for developing a written protocol:

- Work Sheet Ear Care.
- Work Sheet Cryotherapy.
- Work Sheet Childhood Immunisation.
- Work Sheet Hypertension.
- Work Sheet Asthma

Useful websites to assist the development of guidelines in the practice include:

- [http://www.prodigy.nhs.uk](http://www.prodigy.nhs.uk)
- [http://www.nice.org.uk](http://www.nice.org.uk)
- [http://www.wellclosesquare.co.uk](http://www.wellclosesquare.co.uk)
- [http://www.icgp.ie](http://www.icgp.ie)
- [http://www.sign.ac.uk](http://www.sign.ac.uk)
- [http://www.nzgg.org.nz](http://www.nzgg.org.nz)
SECTION 6

Developing Nursing Protocols/Guidelines in the Practice

The following five ‘templates’ are provided as examples to assist the general practitioner and practice nurse to jointly develop and agree nursing protocols/guidelines for the practice.

6.1 Ear Care

**Aim**

To provide the GP and the practice nurse with a structure/template for the development of a practice guideline or protocol for ear care and ear syringing.

**Objectives**

- Identify the role of all personnel involved including role limitations.
- Set clear guidelines on practice policy in relation to treatment.
- Establish agreed standards of care (evidence based).
- Discuss quality care issues.
- Form basis for audit.
- Establish qualifications, training, and experience in ear syringing of the practice nurse.
- Define indications and contraindications.
- Establish practice nurse’s role and GP’s role in treatment.
- Define referral pathways.
- Patient information and consent: what, when and by whom will include written and verbal information.
- Describe assessment procedures: pre-syringe, post-syringe.

**Emergency/Adverse Events/Hazards/Complications**

Establish procedure in writing and allocate responsibilities.

**Record Keeping: Documentation Must Cover**

- Initial assessment.
- What is seen.
- Consent form.
- Examination following syringing.
- Advice given.

**Medical Indemnity Issues**

Is the nurse covered under her own indemnity policy, under the GP's policy and/or both for this procedure?

**Fees and Claims Issues**

Protocol review:

How, when and by who will it be reviewed?

Note: The protocol should indicate the nurse's willingness and competence in carrying out the standards of care set by the protocol and the GP's acknowledgement of her competence. The agreed protocol should be signed and dated by the GP and the practice nurse.
6.2 Cryotherapy

**Aim**

To provide the GP and practice nurse with a structure/template for the development of a written nursing protocol/guideline for a cryotherapy service in the practice.

**Objectives**

- Identify all personnel involved in providing cryotherapy service.
- Set clear guidelines on practice policy in relation to cryotherapy.
- Establish agreed standards of care (evidence based).
- Improve quality of care.
- Form basis for audit.
- Identify conditions are suitable for treatment? Assessment procedures.
- Agree referral pathways.
- Determine what criteria are to be applied before commencement of cryotherapy, e.g. signed consent?

**Qualifications/Competencies**

Consider what qualifications/competency/experience is required by practice nurses providing cryotherapy?

- Stocks and supplies/equipment and maintenance, health and safety issues. Who does what and when?
- Record keeping: what records are needed and how will data be recorded?
- Follow-up care? By whom and when? If not resolving refer to GP?
- Emergency procedures, e.g. define procedure for emergency/accidents. Is everyone familiar with emergency procedure and equipment? How will adverse incidents/complications/hazards be managed?
- Fees and claiming procedures.
- Protocol review: how will it be reviewed and with what frequency?

Note: The protocol should indicate the nurse's willingness and competence in carrying out the standards of care set by the protocol and the GP's acknowledgement of her competence. The agreed protocol should be signed and dated by the GP and the practice nurse.
6.3 Childhood Immunisation

Aim

To provide the GP and the practice nurse with a structure/template for the development of a written nursing protocol/guideline for childhood immunisation.

Objectives

- Identify the role of all personnel involved in providing an immunisation service.
- Set clear guidelines on practice policy in relation to immunisation.
- Establish competence, qualifications, and experience necessary.
- Provide for ongoing review and training.
- Establish emergency procedure.
- Establish agreed standards of care.
- Improve quality of service.
- Form basis for audit.
- Define professional accountability and medico-legal requirements.

Role Definition in Immunisation Programme

<table>
<thead>
<tr>
<th>Nurse</th>
<th>General Practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information and informed consent</td>
<td>Information and informed consent</td>
</tr>
<tr>
<td>Call and recall system</td>
<td>Emergency procedures</td>
</tr>
<tr>
<td>Clinical competence</td>
<td>Referral procedures</td>
</tr>
<tr>
<td>Review best practice guidelines</td>
<td>GP on site for vaccination appointments</td>
</tr>
<tr>
<td>Establish and maintain emergency</td>
<td></td>
</tr>
<tr>
<td>Procedures and equipment</td>
<td></td>
</tr>
<tr>
<td>Stock control</td>
<td></td>
</tr>
<tr>
<td>HSE returns and payment</td>
<td></td>
</tr>
<tr>
<td>Audit</td>
<td></td>
</tr>
<tr>
<td>Administration Staff</td>
<td>Practice Manager</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Vaccine appointments</td>
<td>HSE returns and vaccine payments</td>
</tr>
<tr>
<td>GP on site for vaccination appointments</td>
<td></td>
</tr>
</tbody>
</table>

Note: The protocol should indicate the nurse's willingness and competence in carrying out the standards of care set by the protocol and the GP's acknowledgement of her competence. The agreed protocol should be signed and dated by the GP and the practice nurse.
6.4. Hypertension

Aim

To provide the GP and the practice nurse with a structure/template for the drawing up of a written protocol/guideline for nursing care in the treatment of hypertension.

Objectives

- Identify the role of all personnel involved in management of hypertension.
- Set clear guidelines on practice policy in relation to treatment.
- Establish agreed standards of care (evidence based).
- Form basis for audit.

Educational Objectives

- What qualifications/competency/experience is required?
- Nursing management of hypertension.

Role: identification, monitoring, investigation.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Investigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define assessment</td>
<td>Tools of investigation</td>
</tr>
<tr>
<td>Define tools of assessment</td>
<td>Accurate measurement of BP</td>
</tr>
<tr>
<td></td>
<td>Frequency of measuring</td>
</tr>
</tbody>
</table>

Diagnosis and Management

Nursing Role

- Non pharmacological management
- Monitoring and compliance
- Patient information
- Define targets
- Define limits, referral pathways

GP Role

- Referral pathways
- Pharmacology
6.5. Asthma

**Aim**

To provide the GP and the practice nurse with a structure/template for the drawing up of a written nursing protocol/guideline for asthma care.

**Objectives**

- Structure and develop a practice protocol for asthma management involving both GP and practice nurse.
- Define what is an asthma assessment.
- Decide how the patient accesses the practice nurse, i.e. GP referral, self-referral, outside referral.
- Establish agreed standards of care.
- Improve quality of care.
- Form the basis for audit.
- Establish competence, qualifications, experience required for the nurse providing care.

**Nurse’s Role**

- Discuss practice nurse training, education capabilities.
- Define legal cover, responsibilities, accountability and record keeping?

**GP Role**

- Discuss delegation.
- Monitor the outcome of management, treatment, etc.
- Liaise with practice nurse re: procedures and ongoing education.
- Oversee the practice nurse role.

**Practice Nurse Role**

- Minimum involvement, i.e. teaches inhaler technique only?
- Medium involvement, i.e. assessment, allergy testing, home monitoring?
- Maximum involvement, i.e. total management including recommended prescribing?

**Audit (Practice Nurse/GP)**

- Examine outcome of treatment?
- Examine impact on numbers seen?
- Examine nebuliser use and referrals to hospital?
- Examine patient well-being, numbers of days lost to school/work?

Further assistance on guideline and protocol development is available from PDCs for practice nurses.

Reference: Guideline/policy/protocol template and user manual. Nursing and Midwifery Planning Development Unit (South East) HSE, available from margaret.mhickey@maila.hse.ie.
Section 7

Practice Nurse Indemnity

The following organisations provide indemnity cover for practice nurses and / or advice and information regarding professional insurance for nursing in general practice.

MDU Services Ltd
MDU Services Ltd, 230 Blackfriars Road, London, SE1 8PJ
Tel: 0044 20 7202 1500
Email: mdu@the-mdu.com
Web: http://www.the-mdu.com

MDU: Irish Representative
Quinn Associates Ltd., 7 Cope Street, Dublin 2
Tel: 01 6794644
The Medical Defence Union has a nurse advisory section, with specific knowledge into general practice and practice nursing.

Medical Protection Society
Medical Protection Society, Granary Wharf House, Leeds LS11 5PY, United Kingdom
Tel: 1800 509 411
Email: international@mps.org.uk
Web: http://www.medicalprotection.org

Medisec
Medisec, 10 Fitzwilliam Place, Dublin 2
Tel: 1800 460 400
Email: info@medisec.ie
Web: http://www.medisec.ie

Irish Nurses Organisation
Irish Nurses Organisation, The Whitworth Building, North Brunswick Street, Dublin 7
Tel: 01 6640600
Email: ino@ino.ie
Web: http://www.ino.ie

INO 24 Hour Legal Advice: 24 hour legal advice telephone help line is now available to all INO members to provide around the clock legal advice on all legal issues other than employment related issues. Telephone: 1850 670 707 (Calls charged at local rate).

24 Hour Counselling: 24-hour access to a professionally qualified counsellor to all INO members and their immediate family. This service is completely confidential and at no stage is the organisation ever aware of calls that are made to this service. Telephone: 1850 670 407 (Calls charged at local rate).

SIPTU
SIPTU, Liberty Hall, Dublin 1
Tel: 01 8586300
Email: nursing.unit@siptu.ie
Website: http://www.siptu.ie/nursing
Formatting the Interview Marking Schedule – Practice Nurse

Date: day/month/ year/ time  Candidate Name:

Weighting

1. Qualifications:  
   - 1  
   - 2  
   - 3  
   - 4  
   - 5  
   x 15 =  

Combination of qualifications and level of qualifications which best match job requirements.

Note: Marks should only be allocated for qualifications above the minimum necessary to be called for interview.

Consider: Relevant Certificates, Diplomas, Degrees, Masters and other Higher Qualifications.

2. Relevant Experience:  
   - 1  
   - 2  
   - 3  
   - 4  
   - 5  
   x 30 =  

- Work experience as practice nurse applicable to the post.
- Other relevant nursing experience: consider - midwifery, paediatrics, other nursing related areas.
- Organisation/practice management experience.
- Direct experience in conducting research.

3. Demonstrated Knowledge/Understanding of Key Issues for GP/Practice Nursing:

   - 1  
   - 2  
   - 3  
   - 4  
   - 5  
   x 15 =  

4. Relevant Skills:  1  2  3  4  5  \( \times 30 = \)  

Consider: List most relevant nursing clinical skills required for the job, other skills may include: research, audit, people management, interpersonal communications, application and use of IT, marketing etc.

5. Personal Suitability:  1  2  3  4  5  \( \times 30 = \)  

Consider: Acceptability of candidate as work colleague to GP(s), to other practice nurses, to administrative staff and to patients. Motivation, work style, team worker, leadership potential. Approach to work consistent with ethos of the practice, compatibility with management structures in the practice

GENERAL COMMENTS

Interviewer considers candidate - Appointable  

Not appointable  

TOTAL SCORE:  
(Out of 600)

Interviewer: _________________________

Date: _________________________
Scoring System: Excellent 5, Very Good 4, Good 3, Fair 2, Poor 1

Classifying candidates with a view to awarding marks that reflect the relative differences between candidates:

76% - 100%

The candidate possesses highly developed and relevant skills and abilities and his/her performance clearly exceed requirements.

51% – 75%

The candidate possesses well-developed and relevant skills and abilities and has demonstrated competency at the required level.

26% – 50%

The candidate possesses some relevant skills and abilities. She/he would need some further training and development to enhance his/her existing capacity, in order to perform the duties satisfactorily. She/he does not, at present, fully meet the standard required.

1% – 25%

The candidate is unable to demonstrate that she/he possesses the relevant skills and abilities to a satisfactory standard.
SPECIAL TYPE CONSULTATION FORMS

E: Emergency only, rarely if ever used, eg person collapses on the street, but you are not their doctor.

T: Temporary resident

C: European community

H: Out of hours, ie All hour on call work (Rota)

D: Temporary resident, EEC Resident between 9am – 5pm.

N: All patients seen from 5pm – 9am. Monday to Friday and Saturday to Monday 9am (where these hours are not already contracted as the Health Board) and all Bank Holidays.

Where it states; ‘Reason for Visit’ etc …. Write ‘Acute Medical Condition, Out of Hours’.

Special Items of Service

CODE

A  Excisions - cryotherapy - diathermy of skin lesions - warts, verruca, solar keratosis, cysts papillomata, ingrown toenails, abscesses.

B  Suturing of cuts and lacerations.

C  Draining of hydroceles.

D  Treatment and plugging of dental and nasal haemorrhages.

E  Recognised vein treatment.

F  ECG tests and their interpretation.

G  Instruction in the fitting of a diaphragm.

H  Removal of adherent foreign bodies from the conjunctival surface of the eye.

J  Removal of lodged or impacted foreign bodies from the ear, nose and throat.

K  Nebuliser treatment (in the case of Acute Asthmatic Attack).

L  Bladder catheterisation.

M  Attendance at case conferences (in cases here such case conferences are convened by a DCC/MODCC/MOH).

N  Advice and fitting of a diaphragm.

P  Counselling & fitting of an IUCD.

R  Pneumococcal vaccination.

S  Influenza vaccination.

T  Pneumococcal/influenza vaccinations.

U  Hepatitis B vaccine.

Fees for the Above Services as at 1 December, 2005

<table>
<thead>
<tr>
<th>Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-J</td>
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</tr>
<tr>
<td>M</td>
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</tr>
<tr>
<td>P</td>
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</tr>
<tr>
<td>T</td>
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<td>K &amp; L</td>
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</tr>
<tr>
<td>N</td>
<td>€47.12</td>
</tr>
<tr>
<td>R &amp; S</td>
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</tr>
<tr>
<td>U</td>
<td>€136.23</td>
</tr>
<tr>
<td>L</td>
<td>€45.45</td>
</tr>
</tbody>
</table>

Hep C

Surgery: €34.46

Domiciliary: €45.45
GENERAL MEDICAL SERVICES
CLAIM FOR SPECIAL TYPE CONSULTATION/SPECIAL SERVICE OR OUT OF HOURS PAYMENT

To be completed by patient.
Please circle number relevant to this claim

1. I verify that the time of the Out of Hours Consultation was: __________ Hrs.

2. I verify that I have received the following Special Service from my Doctor: __________

3. I consent to have myself/child vaccinated with the influenza/pneumococcal/Hep. B Vaccine* 
   *Please delete vaccines not relevant!

Patient Signature (If not patient, please indicate relationship):

<table>
<thead>
<tr>
<th>STC Code</th>
<th>Form No.</th>
<th>Claim Date</th>
<th>Location</th>
<th>Agency for EU Patient</th>
<th>Visit Class</th>
<th>Distance Code</th>
<th>Time</th>
<th>Special Service Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>STC</td>
<td>4778</td>
<td>D D M M Y Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SIGNATURE AND STAMP OF CLAIMING DOCTOR:
The Consultation/Service detailed hereon has been given by me and I claim the appropriate fee.

Notes:
(i) This claim form and others for services provided in the same month should be sent to the GMS/PJB within 7 days of month end.
(ii) Failure to complete this form correctly may result in delay in payment.

FOR S.S. CODES R.S.T.U.
Name of Vaccine & Manufacturer
Injection Site
Batch Number
Expiry Date
Shot (Hep. B Only)

S.S. Codes R.S.T.
Please tick appropriate box
S.S. Code U.
Please tick appropriate box
Electronic primary care link
a welcome advance for GPs

A new electronic link to the Primary Care Reimbursement Service allows GPs to claim for STCs on-line. Bernadette McKenna reports

THE ELECTRONIC LINK to the Primary Care Reimbursement Service (formerly the GMS Payments Board) is a very welcome advance in general practice. It provides practices with access to accurate and up to date information in relation to patient’s GMS status and provides the facility to claim for special type consultations (STC) on-line.

It is now possible to examine capitation details, submit STC claims on line and validate patient numbers from the practice.

To avail of these services, a GP must request an application form from the Reimbursement Service. Requests can be made via letter or email following which you will be issued with a unique user and password code. The only requirement is that your practice has internet access.

The internet address used to submit STC claims online is https://apps.gmspb.ie/pls/doctors/login. At the prompt, the user is requested to enter the GP ‘user name’ and ‘password’.

Special type consultation claims

Submitting STC claims on-line is a very simple and efficient method for claiming these payments. The site is simple to navigate, with the main screen almost a mirror image of an STC form, making data entry a relatively straightforward process.

The bane of every practice is the rejected/invalid STC claim report; however, the Reimbursement Service site validates all claims and instantly notifies any problem by prompting an error message, giving the user time to re-examine the claim and amend any error, thus eliminating the rejected claim list.

Claims can be submitted to the Reimbursement Service website as regular as is practical for each practice; daily, weekly, etc. The claims uploaded on the last day of each month will be automatically processed. As with the paper system, online STC claims are paid two months in arrears, ie. December claims will be paid in February.

For audit purposes, STC forms must be kept for a period of five years. This means that STC forms must be completed in the usual way, ie. patient details, claim codes, signatures, etc. The advantage for practices is that claims can be submitted online at any time during the claim month, they are automatically validated and once they have been uploaded payment is guaranteed.

Validating patients’ GMS numbers

Another useful link is: http://client.gmspb.ie. This facility is helpful to validate patient GMS numbers. Now it is possible to enter a GMS number, LTI (long term illness) number or Drug Payment Scheme number and the site will confirm if the number is a valid card. This is particularly useful for validating GMS numbers for temporary residences; as we have all discovered, an in-date GMS card does not guarantee a valid GMS card holder. The facility to validate a GMS number will ensure that in the case of temporary residents an STC Claim will be paid. If the GMS number is invalid the STC claim will be rejected. It also has an implication for the IDBS (Indicative Drug Budgeting Scheme). Not many GPs may be aware that if they sign a GMS script for a patient whose GMS number is invalid, the cost of the medications is deducted from the prescribing GP’s drug budget. Another good reason to validate GMS numbers.

Capitation details for your practice

The internet address for the GP capitation website is https://gpweb.gmspb.ie. This site allows the user to perform a capitation download or patient download along with obtaining capitation details. As with the STC claims, the user is issued with a unique login name and password.

It is possible to examine in detail patients on a GMS list, categorised by distance code, age/sex breakdown. Further patient details can be viewed by clicking on the patient numbers for each category. This site is very safe and the user can only view details relating to their panel which is determined by the user name and password.

GMS lists can be examined in greater detail for management purposes, eg. monitoring over 70s patients in nursing homes – who qualify for additional capitation payments, or over 70s patients receiving a weighting of three for the purpose of calculating practice support subsidies.
The site offers the user the facility to download the panel details, i.e., the total number of patients categorised by distance code and age/sex. The details are downloaded in an Excel spreadsheet format, so it is necessary to have Excel to view the download.

The "patient download" facility will provide a full patient listing, name, address, distance code, age group, medical card number, sex, date of birth and PPSN. With basic Excel knowledge the downloaded file can be sorted alphabetically, by date of birth, distance code, etc., and printed to produce an accurate GMS patient listing. This will provide an accurate first-line information channel to patient GMS status which can be printed on a monthly basis.

In relation to which link is the most beneficial to general practice; STC claims, capitation or client identifier, certainly online STC claims provides the best rewards. By submitting STC claims online they are checked, validated and payment is assured, unlike the manual system, where by it will take two months for an invalid claim to be returned for checking on an rejection list. Submitting STC claims online ensures prompt accurate payment.

Let’s hope that the practice management software providers are looking at these developments and will plan to integrate these services with their software for future releases. Hopefully this is start of great things to come.

“This is part of two pilot projects, STC claims on-line and secondly allowing practices to review their capitation list via the website: https://gpweb.gmspb.ie/”, says Dr Donal Buckley, GPIT director.

“This online facility, currently a pilot project, has the advantage of providing transparency for payments in real time and immediately indicates any errors in the completing/submitting claims. In an ideal situation there should be no double entry of information into practice management systems for every item of service and this should allow the generation of data/claims directly to the Primary Care Reimbursement Service from the practice management system.

“There are issues in relation to the present audit regime, in particular the requirement that the patient signs every STC form. Alternative audit processes to check the validity of claims needs to be explored in order to avoid the millions of STC duplicate forms produced in practices around the country each year”, he says.

Bernadette McKenna is a practice manager in the Virginia Medical Practice in Co Cavan.

**COMPOSITION**

Talks are due to start shortly on a new contract for GPs. The aim is to overhaul the current contract, the bones of which date back to 1972.

Everyone has their own ideas about what changes they would like to see. Forum is inviting you to share your thoughts with us.

- **Have you got a big (or even a small) idea about how general practice could be improved?**
- **An idea that might be practical enough to implement?**

We would like to hear from you. We are offering two prizes (gift vouchers – €150 each), one for people in active general practice and one for GP trainees for the best ideas put forward.

The two winning entries will be published in Forum. In addition, we will also publish other good suggestions to add to the general debate.

To enter, you must write a short 500 word item concisely setting out your idea. The piece should be succinct and focus on a particular area you would like to see tackled in the review. Please include why you think your idea would benefit general practice and patient care.

Entries should be sent to the Editor of Forum, Niall Hunter at Email: niall@medmedia.ie
<table>
<thead>
<tr>
<th>CLAIMING CATEGORIES</th>
<th>DOCTOR NUMBER</th>
<th>STC CODES</th>
<th>CLAIM DATE</th>
<th>LOCATION</th>
<th>PATIENT NUMBER</th>
<th>VISIT CLASS</th>
<th>DISTANCE CODE</th>
<th>TIME</th>
<th>SPECIAL SERVICE CODE</th>
<th>SIG REQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEMPORARY RESIDENT</td>
<td>Reg No of claiming Dr Cannot be own pat Partner pat, or rota- Partner pat.</td>
<td>Must = 'T'</td>
<td>Card must be eligible on date of claim</td>
<td>S = Surgery D= Domicillary</td>
<td>Must=Eligible M/C No.</td>
<td>D = Day L = Late N = Night A = Additiona l</td>
<td>For Dom Visits A=0-3 miles B=3-5miles C=5-7miles D=7-10miles E= &gt; 10miles</td>
<td>24hr Clock D=0800-20.00 L=20.00-24.00 N=24.00-0800</td>
<td>Optional A - U</td>
<td>Yes if Special Service / OOH</td>
</tr>
<tr>
<td>EMERGENCY</td>
<td>Reg No of claiming Dr Cannot be own pat, Partner pat, can be rota Pat where urgent consult outside specified rota arrangement</td>
<td>Must = 'E'</td>
<td>Card must be eligible on date of claim</td>
<td>S = Surgery D= Domicillary</td>
<td>Must=Eligible M/C No.</td>
<td>D = Day L = Late N = Night A = Additiona l</td>
<td>For Dom Visits A=0-3 miles B=3-5miles C=5-7miles D=7-10miles E= &gt; 10miles</td>
<td>24hr Clock D=0800-20.00 L=20.00-24.00 N=24.00-0800</td>
<td>Optional A - U</td>
<td>Yes if Special Service / OOH</td>
</tr>
<tr>
<td>EEA RESIDENT</td>
<td>Reg No of claiming Dr</td>
<td>Must = 'C'</td>
<td>Date of claim in a valid date format DD/MM/YY</td>
<td>S = Surgery D= Domicillary</td>
<td>Pat Name and Number on top left side of claim/country code must be in agency box</td>
<td>D = Day L = Late N = Night A = Additiona l</td>
<td>For Dom Visits A=0-3 miles B=3-5miles C=5-7miles D=7-10miles E= &gt; 10miles</td>
<td>24hr Clock D=0800-20.00 L=20.00-24.00 N=24.00-0800</td>
<td>Optional A - U</td>
<td>Yes if Special Service / OOH</td>
</tr>
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<td>OUT OF HOURS</td>
<td>Reg No of claiming Dr Must be own patient, Partner patient or rota Partner patient</td>
<td>Must = 'H'</td>
<td>Card must be eligible on date of claim</td>
<td>S = Surgery D= Domicillary</td>
<td>Must=Eligible M/C No.</td>
<td>Must = 'N'</td>
<td>For Dom Visits A=0-3 miles B=3-5miles C=5-7miles D=7-10miles E= &gt; 10miles</td>
<td>24hr Clock Excluding 09.00-17.00 Mon to Fri &amp; Registered Surgery Hours</td>
<td>Optional A - U</td>
<td>Yes</td>
</tr>
<tr>
<td>SPECIAL SERVICE</td>
<td>Reg No of claiming Dr</td>
<td>Can Be E/T/C/H</td>
<td>Card must be eligible on date of claim</td>
<td>S = Surgery D= Domicillary</td>
<td>Must=Eligible M/C No.</td>
<td>D = Day L = Late N = Night A = Additiona l</td>
<td>For Dom.Visits A=0-3 miles B=3-5miles C=5-7miles D=7-10miles E= &gt; 10miles</td>
<td>24hr Clock D=0800-20.00 L=20.00-24.00 N=24.00-0800</td>
<td>SS Code must match masterfile</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Childhood Immunisation: How to achieve a 95% target

Dr Peter Harrington

UPDATED 2002
CONTENTS

Preface

Introduction

1. The Gold Standards of Immunisation Practice
   - Know when to immunise and when not to
   - Create and scrutinise a register of eligible babies
   - Remind defaulters within four weeks
   - Immunise defaulters within eight weeks
   - Send returns to the health board
   - Create a reminder to review vaccine status during each consultation
   - Use every visit as an opportunity to immunise
   - Offer vaccines during all surgeries
   - Give overdue DTaP/IPV/Hib and MenC vaccines with MMR

2. Evidence for the Gold Standards
   - A review of the relevant literature, international and Irish

3. ICGP Immunisation Audit Template

References
Preface

A number of excellent publications are already available to GPs on the subject of immunisation. There is ample evidence that GPs are providing a high quality service to patients who attend for immunisation. Nevertheless, it appears that some practices in some parts of the country are failing to reach acceptable target levels amongst their eligible population. In some cases even where targets are achieved they are not being notified to health boards.

Immunisation is the first of what is likely to be a series of population-based health initiatives. The College strongly believes that general practice is the best setting in which to achieve high quality in the delivery of such initiatives. To support that claim practices in general must achieve their population targets. Their ability to do so will be the yardstick by which we will all be judged.

This booklet has been compiled by Dr Peter Harrington to address the specific problem of targets. It includes many useful suggestions to make the task easier and more effective. It is essential reading for any GP struggling to organise an immunisation system that works. Above all it is short and to the point but well referenced for those wishing to delve further for the evidence to support practice. Read and use it.

Dr Michael Boland,
Director ICGP Postgraduate Resource Centre,
March 1998.
Few medical procedures or treatments can compare with the enormous benefit to humanity from immunisation, one of the safest and most cost effective of interventions. Yet an examination of the most recent childhood immunisation uptake figures released by the National Disease Surveillance Centre (See Table below) confirms the ongoing failure by GPs to achieve the 95% target level with MMR uptake falling below the psychological 70% level. The measles epidemic of 2,000, which left 3 children dead, is a sad testimony to this failure.

<table>
<thead>
<tr>
<th>Uptake Rates In Children 24 Months Of Age in Q4 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthboard</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>No.in Cohort</td>
</tr>
<tr>
<td>D1</td>
</tr>
<tr>
<td>P2</td>
</tr>
<tr>
<td>T3</td>
</tr>
<tr>
<td>HIB3</td>
</tr>
<tr>
<td>Polio3</td>
</tr>
<tr>
<td>MMR</td>
</tr>
</tbody>
</table>

**P3 could not be accurately calculated as DTAT/DT uptake was reported as a combined value.

The 14-16% difference in uptake performance between the Eastern Regional Health Authority and the North-Eastern Health Board confirms the impression from general practice that there is much infra structural homework yet to be completed at health board level to fulfil their side of the national primary immunisation contract. While acknowledging that organisational inadequacies at health board level are a considerable barrier to the achievement of adequate uptake levels, I want to focus in this document specifically on the potential barriers to uptake within our own surgeries. My message is that every GP in the country, with the possible exception of those in very disadvantaged areas, is capable of reaching the 95% immunisation target within his/her own practice. The degree to which the practice population overlaps with the health board registered population for each GP is variable over time and also from health board to health board. All each of us can do is to identify and tend to our own practice cohort.

The great failure of Irish General Practice is our inability to organise. It is possible for a GP to achieve 95% uptake without ever having to lift a syringe, if the practice secretary and practice nurse are utilised to the full. Time spent defining the roles of the various
practice members in achieving targets will reap dividends. In this regard it is worth emphasising that the percentage of the total remuneration for achieving the 95% immunisation target has risen from 19% in 1995 to 37% at present.

The recently published Royal College of Physicians of Ireland Immunisation guidelines for Ireland outline a number of changes to the childhood immunisation schedule, which are outlined below. Further detail is contained in the RCPI's document.

1. Oral polio vaccine (OPV) has been replaced by Inactivated polio vaccine (IPV) given by intramuscular injection.
2. IPV in turn has been incorporated into DTaP to give a 4 in 1 vaccine and further combined with Hib to create a 5 in 1 vaccine.
3. Meningitis C is now on offer to anyone who has not had their twenty third birthday. Many patients who had left school before introduction of the vaccine remain unimmunised and should be offered this vaccine opportunistically if presenting for other reasons.
4. Egg allergy and egg anaphylaxis are no longer considered contraindications to MMR vaccine. All children should receive 2 lifetime doses of MMR vaccine. The first should now be given at 12 months, reduced from 15. Second doses, through health board personnel, are offered at age 4-5 and again age 11-12.
5. Patients should receive 5 lifetime doses of both Diphtheria and Tetanus, with low dose Diphtheria vaccine used after the age of 10 years. Fourth and fifth doses, through health board personnel, are offered at age 4-5 and again age 14-15. Adsorbed Tetanus vaccine (ATT) has disappeared from our vaccine fridge and patients over 10 years should receive Td (incorporating Tetanus and low dose Diphtheria vaccines) in lieu..
6. Pertussis has been incorporated into the school entry booster. Thus DT + OPV has become DTaP/IPV.
7. Minor illness incorporating a temperature <38C is no longer considered a contraindication to immunisation.
8. The only absolute contraindication to a first series of vaccines is a previous anaphylactic reaction to neomycin or streptomycin (contrainindicating IPV), obviously a highly improbable event. The opinion of a Paediatrician is, however, recommended in the event of a previous convulsion or an evolving neurological syndrome.
9. The only additional absolute contraindication to a subsequent series of vaccines is an anaphylactic reaction to a previous series or, encephalopathy within 7 days of a first series.
10. Severe local adverse reactions are no longer listed as contraindicating subsequent immunisations.
11. Unexplained temperature >40.5°C within 48 hours, seizure within 72 hours, prolonged crying episode within 48 hours or hypotonic-hyporesponsive episodes within 48 hours are now considered relative, rather than absolute, contraindications to further doses of DTaP.
Introduction

This package will assist GPs to achieve the immunisation target of 95% uptake of the childhood vaccines Diphtheria/Tetanus/Pertussis (DTaP), Haemophilus influenzae type b (Hib), Meningitis C (MenC), Inactivated Polio (IPV) and Measles/Mumps/Rubella (MMR).

It is a pragmatic guide prompting GPs to examine present practice critically and make appropriate amendments.

The target is achievable but not without two crucial ingredients:

- An in-practice system, which is rigorous and operated by all members.
- A small amount of dedicated time, *but not necessarily GP time*, to scrutinise performance and recall defaulters.

The package outlines a ‘best practice’ of practice organisation. Where possible it is evidence-based. It consists of three parts with increasing complexity:

1. The gold standards of immunisation practice
   - a brief summary of suggested best practice;

2. Evidence for the gold standards
   - a review of the relevant literature, Irish and international;

3. An audit package and template
   - incorporating the gold standards, for the enthusiast. Completion of the audit package is approved by the College for study leave allowance of one day

ACKNOWLEDGEMENTS

Many thanks to Drs Michael Boland, Niall Maguire, Ray O’Connor, Mary Sheehan, Fiona Bradley, Mark Rowe, Kevin Kelly, Deirdre Murphy and also to Profs Andrew Murphy and Bill Shannon for their advice and support. Thanks also to all who practise at the Palms, Gorey for their tolerance.

**Dr. Peter Harrington,**
March 1998.
1. THE GOLD STANDARDS OF IMMUNISATION PRACTICE

<table>
<thead>
<tr>
<th>Gold Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Know when to immunise and when not to.</td>
</tr>
<tr>
<td>2. Create and scrutinise a register of eligible babies.</td>
</tr>
<tr>
<td>3. Remind defaulters within four weeks.</td>
</tr>
<tr>
<td>4. Immunise defaulters within eight weeks.</td>
</tr>
<tr>
<td>5. Send returns to the health board.</td>
</tr>
<tr>
<td>6. Create a reminder to review vaccine status during each consultation.</td>
</tr>
<tr>
<td>7. Use every visit as an opportunity to immunise.</td>
</tr>
<tr>
<td>8. Offer vaccines during all surgeries.</td>
</tr>
<tr>
<td>9. Give overdue DTaP/IPV/Hib &amp; MenC vaccines with MMR.</td>
</tr>
</tbody>
</table>

Standard 1. Know when to immunise and when not to

The general practitioner has up to date knowledge regarding childhood immunisations, particularly vaccine contraindications, both valid and invalid.

Clearly each GP must know when vaccines are – and are not – contraindicated. Remember there are very few contraindications to a first dose of DTaP.

If in doubt refer to:
- The ICGP protocol Guidelines on immunisation and vaccination in general practice together with the 1996 and 2000 updates;1 a, 1b
- The National Immunisation Committee’s excellent Immunisation Guidelines for Ireland which has now a 2002 edition.2

PRACTICE TIP
The commonest false contraindications leading to postponement of immunisation are:
- afebrile URTIs
- recurrent cough.

All babies should receive a first dose of DTaP unless the baby:
- suffered neonatal cerebral damage
- suffered a prior convulsion
- has a progressive neurological disorder in which cases the advice of a local paediatrician should be sought.
‘A history of febrile convulsions and a family history of convulsive fits do not constitute contraindications’. (Data Sheet, Infanrix, SmithKline Beecham)

All babies should receive subsequent doses of DTaP unless suffering a contraindicating general adverse vaccine reaction.

<table>
<thead>
<tr>
<th>VACCINE REACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEVERE LOCAL REACTION</td>
</tr>
<tr>
<td>An extensive area of redness and swelling which becomes indurated and involves most of the anterolateral surface of the thigh or a major part of the circumference of the upper arm.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SEVERE GENERAL REACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaphylaxis, bronchospasm, laryngeal oedema, generalised collapse. Fever &gt;40.5°C within 48 hours.</td>
</tr>
<tr>
<td>Any of the following within 72 hours:</td>
</tr>
<tr>
<td>– prolonged unresponsiveness</td>
</tr>
<tr>
<td>– prolonged inconsolable crying</td>
</tr>
<tr>
<td>– high pitched screaming for more than four hours</td>
</tr>
<tr>
<td>– convulsions or encephalopathy.</td>
</tr>
</tbody>
</table>

**Standard 2. Create and scrutinise a register of eligible babies**

The practice creates and scrutinises a register of all new births to act as a target population. Your practice is unlikely to achieve a 95% target without creating an accurate list of all births for surveillance purposes.

Use:
- a ledger
- a computer
- a card index box.

Use as many data sources as you can:
- Mother and Child Scheme
- six week checks for mother or baby
- maternity hospital discharge letters
- health board/public health nurse notifications
- word of mouth.
Don’t wait until the child first attends. **Delegate this task to your receptionist or practice nurse who may be the first to hear anyway.**

The following details should be recorded:

**PRACTICE REGISTER DETAILS**
- Mother’s and baby’s names, address, date of birth.
- Grandmother’s name and address, if likely to be mobile.
- Contact telephone number for recall.
- Dates of administered and due vaccines.

Sample registers are outlined in greater detail in the ICGP’s *A guide to the National Immunisation Programme*. The paperwork employed for notification by some health boards may be sufficient to replace the practice register as a working template once the health board has acknowledged the baby’s registration.

**PRACTICE TIP**
- Patients who move address are less likely to receive immunisations
- Always review the immunisation status of new children joining your practice.

**Standard 3. Remind Defaulters within Four Weeks**

Parents of babies defaulting on immunisation receive systematic reminders within four weeks.

**Standard 4. Immunise defaulters within eight weeks**

Vaccine defaulters are immunised within eight weeks.

With the best of intentions many mothers who wish to immunise are slow to complete the schedule, putting their babies at risk of pertussis in particular. Such mothers are less likely to complete the primary vaccines or to obtain MMR. Targets will not be met unless these mothers are identified, contacted and engaged when they next attend the surgery.
Systematic identification involves:

- A review of immunisation non-attendance at a set time every month using the practice register. The practice computer is a huge asset in this regard.
- Sending a reminder by phone, letter or postcard all of which are effective.
- Sending a second reminder one month later to mothers who fail to attend.
- Flagging the chart of baby and mother.

*This is the rate limiting step to convert uptake from 85% to 95%. With experience it should take less than two hours per GP per month.* Delegate this task to your receptionist or practice nurse.

**Standard 5. Send returns to the health board**

---

The practice sends regular returns to the health board.

The integrity of the entire scheme is put in jeopardy by a small minority of GPs who fail to send returns or are extremely late in doing so.

Send returns monthly. It may become the point of entry for that baby on to the health board database.

Every three to four months the vaccine returns sent by the practice must be tallied against the vaccines acknowledged by the health board as having been completed and remunerated.

Delegate these tasks to your receptionist or practice nurse.

**Standard 6. Create a reminder to review vaccine status during each consultation**

---

The child’s correct vaccine status is clearly visible, on chart or on computer screen, during each consultation.

The great advantage of general practice over health centres as a site for immunisation is that we will encounter defaulting babies and their mothers during illness attendances.
Review immunisation uptake at every encounter until completion of the MMR. A visual prompt is crucial. Aventis Pasteur MSD produce such an aid in the form of an adhesive sticker for use on paper records. Computer software packages contain immunisation templates, which should be defaulted to appear automatically during each infant’s attendance until completion of the MMR.

Keep these prompts up to date by entering the date of the next due vaccine at every immunisation. Defaulters, identified during the monthly review, should be highlighted on the paper record or computer.

**Standard 7. Use every visit as an opportunity to immunise**

No ‘missed opportunities’ to immunise.

Many of the occasions on which defaulting babies attend will prove suitable for opportunistic immunisation, assuming the child is afebrile and well. Each such attendance is an opportunity to immunise or to arrange to do so if the child is unwell. Maximising uptake during such visits reduces the workload involved in subsequent recall efforts.

**PRACTICE TIP**
- The advent of single dose ampoules has made opportunistic immunisation much easier than formerly.
- It may also help to move the vaccine fridge closer to the consulting room!

**Standard 8. Offer vaccines during all surgeries**

Vaccines are available by appointment, without appointment and at all surgery sessions.

Sickness, toddlers, school collections, bad weather, transport and long delays in the surgery all militate against young mothers wishing to immunise, particularly for disadvantaged groups. Single dose ampoules allow us to immunise whenever we want.
If it is present practice to have a vaccine clinic in the practice, perhaps because of the availability of other health personnel, mothers should be free to attend also during any other surgery session.

**Standard 9. Give overdue DTaP/IPV/Hib & MenC vaccines with MMR**

All due vaccines are administered at each immunisation visit.

All due vaccines should be administered at each immunisation visit. Review the uptake of previously due vaccines when babies present for MMR. Any overdue vaccines may be given concurrently with MMR at different sites.
2. EVIDENCE FOR THE GOLD STANDARDS

A review of relevant literature, international and Irish.

Standard 1
The general practitioner has up to date knowledge regarding childhood immunisations, particularly vaccine contraindications, both valid and invalid.

Summary
Immunising health professionals still defer or refuse immunisations contrary to guidelines disseminated by professional bodies. This may represent a knowledge deficit or overcautious behaviour in fear of litigation arising from vaccine mishap.

International evidence
Numerous descriptive surveys, usually using clinical vignettes, demonstrate the continuing reluctance among immunising health professionals to immunise ‘problem babies’. 4-7

Two studies from the UK attempted to relate knowledge about vaccine contraindications to immunisation performance. 8,9 Both found that GPs with higher knowledge scores (or lower caution scores) regarding vaccine contraindications had statistically higher vaccine uptake. One of these, the Peckham Report, 9 is the largest macro epidemiologic study relating uptake to parental and health professional knowledge and attitudes. It concluded that doctors were contributing to low vaccine uptake, particularly Pertussis vaccine, by perpetuating the myths proffered by parents for non-compliance. “The main obstacle to a child being immunised was general practitioners’ misconceptions concerning contraindications to immunisation”.

Irish evidence
Hurley assessed GP adherence to the then recently published 1983 Royal College of Physicians of Ireland Statement on DTP vaccination, interviewing 55 GPs in south Dublin. 10 Despite RCPI reassurances, 27% would not immunise asthmatics with DTP. Sixty-four per cent would not administer DTP to a child with a family history of epilepsy.

Kumar et al interviewed 200 parents attending paediatric OPD and accident and emergency services in Dublin. 11 Seven had obtained no vaccines for their baby allegedly on the advice of health personnel. Reasons for this advice included assisted ventilation as a newborn (2), birth asphyxia (1), infections (2), seborrhoeic dermatitis (1) and HIV positive mother (1).
Recent work surveying 48 GPs in south-west Dublin suggests a significant improvement since Hurley’s study (Harrington et al, in progress). All would give MMR vaccine to a child reported by its mother to have already suffered measles compared to 80%,12 72%13 and 71%14 in comparable UK studies. Ninety-six per cent would give Pertussis vaccine to a moderately severe asthmatic or to a child with an atrial septal defect. However, 30% would postpone immunisation of a baby with an afebrile upper respiratory infection.

In addition, anxiety regarding the neuro-toxicity of DTP vaccine seems to persist, with 42% declining to administer DTP to the child of an epileptic, 34% following a febrile convulsion and 46% to a child who “cried more than usual for 24 hours after a previous dose of DTP”. Similar degrees of caution have been observed in other countries4,7,9,15,16 despite revised recommendations from a variety of bodies.17,18

**Standard 2**
The practice creates and scrutinises a register of all new births to act as a target population.

**Summary**
Practice performance can only be measured if the eligible population for that practice is established. It is very difficult to create a register, which exactly matches the health board’s register of children for immunisation purposes. Failure to establish, update and prune such a register will result in unimmunised children and reduced practice income.

**Irish evidence**
There is high population mobility among young mothers, particularly in cities. One study found a mobility of 47% by age four years in Dublin’s south inner city.19 Murphy et al,20 in the same location, found a 36% underestimate of the practice’s population of under-fives after liaison with the Eastern Health Board.

White,21 in County Meath, created his register through close liaison with the local public health nurse and obtained a 100% uptake of the primary antigens.

But beware! Mothers may attend one GP for antenatal care and another for child care.22
Standard 3
Parents of babies defaulting on immunisation receive systematic reminders within four weeks.

and

Standard 4
Vaccine defaulters are immunised within eight weeks.

Summary
Most mothers want to fully immunise their children. A significant minority fail to do so. Mothers who delay are less likely to complete their babies’ immunisation schedule. This group can usually be prompted to immunise if reminded face to face during a surgery visit, or through a reminder letter or phone call.

Defaulting mothers fall into three broad groups:
- A small minority harbour a strong fear of vaccine harm or have a strong abhorrence of injections and need time and a lot of coaxing to consent to immunisation.
- The great majority intend to immunise, but mostly due to practical constraints never get around to completing their babies schedules. At particular risk are mothers living in poor social circumstances with limited support structures, without independent transport and with other children to care for.
- Mothers whose children are ‘always sick’, especially the catarrhal possibly asthmatic child who is never seen as cough-free long enough to safely immunise.

These groups lend themselves particularly well to opportunistic immunisation during surgery visits for other reasons.

International evidence
Failure to complete the DTP/OPV schedule is a risk factor for non-compliance with MMR immunisation.12,23,24 A retrospective record audit in Los Angeles found an age appropriate immunisation rate of 67% at three months, falling to 25% at 19 months.23 Mothers who delayed starting to immunise beyond three months were less likely to have obtained MMR vaccine by two years (p < 0.05). A survey of 1,500 employees of a multinational company found delay in commencing the DTP schedule as a risk factor for non-completion (p < 0.001).25
A cohort study examining uptake in 10 English health districts found the odds of being immunised against MMR for children who had not had Pertussis vaccine was 43% the odds for children receiving the vaccine.\textsuperscript{24}

The five most important negative predictors of MMR uptake were incomplete previous vaccines, no pertussis vaccine, single parent family, later birth rank and clinic (versus GP) immunised. The importance of birth rank is also emphasised by a cohort study showing a fall in completion of Pertussis vaccine from 86% for families with one child to 58% for families with five or more.\textsuperscript{26}

Two studies from the US examining immunisation behaviour of parents found that 75\%\textsuperscript{27} and 66\%\textsuperscript{28} deferred a due immunisation. By far the commonest reason was ‘minor illness’ followed by ‘not convenient’.

Studies from the US suggest that reminder communications appear effective in prompting mothers to immunise. Postcard reminders one month and two months from the default date among babies receiving their second or third DTP, produced significantly higher uptake (49\%) compared to controls (23\%) receiving no reminder (p < 0.01).\textsuperscript{29} Telephone messages either the day before a due vaccine or after an missed appointment produced higher uptake when compared to controls, especially for the third DTP and MMR.\textsuperscript{30} UK practices which involve practice nurses in the giving or organisation of vaccines have higher vaccine uptake.\textsuperscript{9}

Irish evidence
An audit in Co Wexford noted that 25 out of 39 mothers receiving health board generated reminder letters when visits were due completed DTP/OPV/Hib by eight months.\textsuperscript{31} Murphy \textit{et al}, in Dublin’s inner city, increased DTP uptake from 30\% to 57\%(p < 0.0005) and MMR uptake from 53\% to 75\% (p < 0.0005) after a single postal reminder to defaulters.\textsuperscript{20} The study had considered telephone reminders, but estimated telephone ownership among the practice population to be < 10\%.

Kumar \textit{et al}, in their paediatric OPD/A&E survey found ‘colds and chestiness’ as the commonest reason for immunisation deferral.\textsuperscript{11} Clarke confirmed the importance of birth rank in her survey in Dublin’s south inner city with uptake by age two years falling from 73\% for first time mothers to 47\% for those with more than one child (p < 0.001).\textsuperscript{19}

Two practice-based Irish studies achieving > 95\% uptake of primary vaccines worked in close liaison with public health nurses, both to create a practice register and to follow-up defaulters.\textsuperscript{21,32}
Standard 5
The practice sends regular returns to the healthboard.

Summary
Liaison between immunisation activity in general practices and relevant health boards before introduction of the new immunisation contract has been poor. GPs have acted autonomously. Health board records have not accurately reflected vaccine uptake. Successful models of immunisation involve rigorous liaison and feedback on performance.

International evidence
Studies examining accuracy of data stored in practice and in health board equivalent records have demonstrated significant discrepancies with underestimation by the health boards. A UK audit recorded completed uptake of 40% on health authority data, 51% on practice records and 56% in practice notes. Combining the results, uptake rose to 71%. The only errors found were false negatives. Vaccines were available both in health authority clinics and through GPs.

Irish evidence
A number of studies demonstrate large discrepancies between health board data when compared to maternal recall and practice records.

Standard 6
The child’s correct vaccine status is clearly visible, on chart or on computer screen, during each consultation.

and

Standard 7
No ‘missed opportunities’ to immunise. That is, defaulters attending the surgery for other purposes receive immunisations at that visit unless suffering from a contraindicating condition.

Summary
Immunisation status of every child should be reviewed at every surgery contact at least until completion of MMR immunisation and the reason for any delay explored.
This is best accomplished by a visible *aide memoire*, on each baby's chart or appearing by default on the screen for practices using computers during each consultation. This should be updated after each completed immunisation.

Every visit of a child to the surgery is an opportunity not only to review immunisation status but also to immunise. Any occasion where a child attended the surgery with a non-contraindicating illness and failed to receive a vaccine which was overdue, may be deemed a 'missed opportunity.'

Children with minor illness, including upper respiratory infections, may safely and effectively be immunised if they are well.

**International evidence**
A record audit in the US23 examined the charts of 254 children aged 15-48 months. A total of 137 missed opportunities to give MMR vaccine were identified in 77 (33%) children.

In another study, five of 10 children contracting measles had attended the surgery with non-contraindicating illnesses after 15 months of age.12

Among child health clinic attenders in Los Angeles, one in three children attending for the first time after reaching 15 months was not given MMR vaccine.39

**Standard 8**
Vaccines are available by appointment, without appointment and at all surgery sessions.

**Summary**
Responses to the problem of suboptimal uptake particularly among disadvantaged groups in the US have highlighted the problem of restricted hours of availability in many immunisation centres.18,40

There are calls for vaccines to be made available both by appointment and without, and also during evening and weekend surgeries.

**Evidence**
In a survey of 54 programme managers from the 57 largest immunisation projects in the US, 93% felt that too strict an appointment system was a major barrier to immunisation of disadvantaged groups while 56% pointed to inadequate hours.41 Also in the US, a
parental survey examining barriers ranked ‘office wait too long’, ‘lack of time’ and ‘inconvenient hours’ fourth, fifth and sixth out of 15 items. 

**Standard 9**
All due vaccines are administered at each immunisation visit.

**Summary**
All due antigens should be administered at each visit.
Identification of defaulters is especially likely:
- when administering MMR vaccine, when uncompleted DTaP/IPV/Hib and MenC may be given
- at school entry when uncompleted DTaP/IPV, MenC and MMR, but not Hib vaccine, may be given.

Any number of antigens may be given simultaneously, in different sites, at one visit.

**International evidence**
Ten (38%) of 26 confirmed measles cases in a Florida outbreak had received DTP/OPV after 16 months of age, but not Measles vaccine. Measles vaccine defaulters were statistically more likely than controls to also default on DTP/OPV. 

**Standard 10**
The practice (or the health board) sends a systematic postal reminder when a vaccine is due.

At present this is a contractual obligation of each health board.

**Standard 11**
The practice carries out a systematic audit of immunisation performance related to practice.

**Summary**
Practice performance can only be measured and improved by ongoing audit activity. Critics of the failure of immunisation policy in the US to achieve targets particularly in disadvantaged pre-school children point to the private-public mix in vaccine provision, the absence of a defined target population and the almost complete absence of audit activity. 

There is a need to develop audit activity at both practice and health board levels.
Standard 12
Explicit and informed consent to immunise is obtained in advance

Summary
Raising the issue of immunisation during visits for other reasons tells the mother that you value the procedure and prompts her to reflect and make her decision regarding immunisation. Mothers who are better informed regarding immunisation are less likely to default.

International evidence
There is little written in the literature on communication aspects of immunisation decision-making. As outlined in Standard 1, there is some evidence that doctors are complicitous in propagating mythical vaccine contraindications by not challenging them.8,9 There is some evidence that GPs are effective persuaders in favour of immunisation if they choose to address the risk-benefit equation with their patients.44 Mothers who are unaware when the next antigen is due are more likely to default.28,45,46

In a controlled trial the issuing of vaccine information pamphlets did not reduce the proportion of parents who would have liked more time discussing immunisation with their physicians, nor the proportion of parents who were anxious about how DTP vaccine would affect their child.47

Irish evidence
Two Irish papers outlining successful practice immunisation strategy with achievement of > 97% uptake of DT(P)/OPV, point to importance of explicitly discussing immunisation with initial discussion antenatally48 or at a two week and six week check.21

An MRBI survey commissioned by the Health Promotion Unit after the launch of MMR vaccine listed the GP as the most frequently quoted positive influence on uptake, mentioned by 29% of mothers.49
3. ICGP Immunisation Audit Template

The purpose of audit is to scrutinise performance and effect relevant changes. All practice members should be aware that the audit is taking place. The person most responsible for immunisation in the practice should direct the audit, but doesn’t necessarily have to carry it out. If the audit is to be repeated on a number of future occasions, as all good audits should be, it makes sense to delegate the bulk of the task to a practice nurse or secretary. The person responsible for recall is the most obvious.

Once completed, the findings should be discussed by all practice members and a strategy for implementing any changes established.

- Download the master copy as needed, 10 babies per sheet.
- Select a cohort whose youngest child is perhaps eight months if examining DTaP/IPV/Hib and MenC uptake, 17 months if examining MMR uptake.
- Starting at the beginning of the cohort, pull charts in manageable amounts.
- An obstetric calculator is useful for calculating dates and intervals. Use the templates provided to establish performance. Fresh coffee and no interruptions are advisable extras!
- For each criterion, calculate your present performance by establishing the percentage of ‘No’ answers to each criterion. (The aim is for no ‘No’ answers).
- Obtain the most recent health board generated data on the cohort for comparison.

Remember this audit has no value unless it prompts relevant changes to improve performance.

Notes
1. No audit template is provided for Standard 8 (immunisations without appointment.) A review of present practice policy should be sufficient to establish if this Standard is being met.
2. An abbreviated audit might focus only on vaccine defaulters and those not immunised against whooping cough.
3. Criteria 2, 3 and 5 obviously depend to a significant degree on adequate support from health board public health resources. Deficiencies highlighted in these criteria should be raised with appropriate health board or GP Unit personnel.
4. Contraindicating reactions to a dose of DTaP vaccine are outlined in part 1.
5. Study leave allowance of one day will be approved for general practitioners who submit copies of completed audit templates for 20 or more babies.

Application/templates should be submitted for approval to:
The Irish College of General Practitioners,
4-5 Lincoln Place, Dublin 2.
<table>
<thead>
<tr>
<th>ICGP Immunisation Audit Template</th>
<th>Place Baby's Initials, date of birth and ID number here.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S1.</strong> The baby received all antigens, with the exception of valid vaccine contraindications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby received 1st dose of DTaP unless neonatal cerebral damage, progressive neurological disorder or previous convulsion Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby received subsequent doses of DTaP unless:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>severe local reaction (see part one) N/A / Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>severe general reaction (see part one) N/A / Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>S2.</strong> Practice creates a register of all new births to act as a target population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered with the health board Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered with the practice Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>S3.</strong> Parents of babies defaulting on immunisation receive systematic reminders within four weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defaulting baby sent reminder within four weeks N/A / Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>S4.</strong> Records show that vaccine defaulters are immunised within eight weeks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defaulting baby immunised within eight weeks N/A / Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scrutiny of defaulters chart for possible reasons:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disadvantaged, Traveller, Chesty child, Vaccine reaction, Large family, Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>S5.</strong> Practice sends regular returns to the health board</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notification of administered vaccines to the health board Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health board data confirms notification Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>S6.</strong> Records show that the child’s correct vaccine status is clearly visible, on chart or computer screen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccine prompt is visible on screen or computer Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccine prompt is accurate, including date of next due</td>
<td></td>
<td></td>
</tr>
<tr>
<td>vaccine Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Defaulters are highlighted N/A / Yes / No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**S7.** Records show no ‘missed opportunities’ to immunise

Number of visits when vaccine was overdue

Number of visits when vaccine overdue and non-contraindicating illness

**S10.** Records show that all due vaccines are administered at each immunisation visit

Overdue DTaP/IPV/Hib and MenC given with MMR

N/A / Yes / No
REFERENCES


Dealing more efficiently with lab samples

The ICGP Quality in Practice Committee recently ran a successful quality improvement initiative competition. This, the winning 2005 entry, was submitted by Roisin Doogue

OUR PRACTICE IS A SINGLE handed general practice working from two medical centres in south Co Kildare, with a mostly rural-based practice community.

The practice employs one part-time practice nurse and two job-sharing secretaries. A practice manager works one-and-a-half days per week. Our practice has 850 GMS patients and also sees private patients.

Computerisation of the practice has been evolving since 1999 and currently all health records, consultations by doctor and nurse, appointments and prescriptions are on computer.

Laboratory analysis of blood, urine and swabs are a common part of many consultations. As part of a plan to improve the overall effectiveness and quality of service offered by our practice, a system for tracking all blood and lab samples taken in the practice was developed two years ago. A method of auditing the process and outcomes was incorporated into the system.

Prior to the development of this initiative, blood and other samples required for medical tests were taken and sent by patient, courier or post to various labs. Samples were sent to either of two hospitals equidistant from the surgeries.

Results returned to the practice were followed up as appropriate. Patients were asked to phone for their results two weeks after the samples were taken.

However, despite best efforts, sometimes results were missing from the patients’ files at their next consultation or were not available when the patient phoned back for results. These results had then to be tracked down and dealt with. Obviously, this lack of efficiency wasted valuable practice time.

In addition, we had no method of ensuring that we did not miss any results. We were relying on memory and on patients to phone for their results. As the GP or nurse is ultimately responsible for all samples taken by them, obviously we needed a more effective and efficient system.

New system

A system for tracking and auditing all samples obtained for medical tests was developed in our practice following consultation with staff. All blood and lab samples taken from patients are now recorded in a special logbook.

The practitioner taking the sample is responsible for ensuring that the information is recorded. The details recorded include name of patient, date of birth, tests, hospital name, mode of transport, etc. Tick-boxes ensure writing is kept to a minimum.

The patient is advised to phone for results two weeks after the sample has been taken, but the doctor or nurse will contact them if they need to discuss the results with them.

When results return to the practice they are date-stamped and marked with a practice stamp. The doctor checks all the results, which are then entered in the computer or scanned in as appropriate.

Abnormal results are scanned to the patient’s computerised healthcare record and results are checked off in the logbook, with the doctor or nurse dealing with abnormal results.

Patients are offered treatment or advice and health education as appropriate and this information is recorded in the patient’s healthcare record. If a result is abnormal, a brief note is made in the logbook and the action to be taken; this information is used to audit the process.

Monthly audit

A monthly audit is in place to check that all results have been returned to the practice and that abnormal results are dealt with by informing the patient and offering treatment or advice, and this information is documented in the patient’s notes.

The practice nurse has been identified as the person responsible for overseeing the maintenance of the logbook and carrying out the monthly audit.

The keys to the successful management of this new system are teamwork and time dedicated to planning practice developments.

Time is allocated for a monthly team meeting of all practice staff, and it is only with the full cooperation of everyone in the practice that system breakdown is avoided.

A system flowchart is available in our practice handbook for new staff or locums, outlining how the system works.

Our log and audit system for samples has definitely improved the efficiency of our service, as a failsafe system is now in place to ensure that all medical tests are dealt with thoroughly and appropriately.

A result or sample cannot be overlooked or mislaid and follow-up consultations provide more effective care for the patient, as all results are available to the doctor or nurse during the consultation.

Improving patient care was the cornerstone for the development of this system, with the added benefit of improving the efficiency and effectiveness of our clinical practice.

Roisin Doogue is a practice nurse in Monasterevin, Co Kildare