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Sex Transm Inf 2002;78:98-100
doi:10.1136/sti.78.2.98

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ORIGINAL ARTICLE

A postal survey to identify and describe nurse led clinics in genitourinary medicine services across England

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Background: Nurses in genitourinary medicine (GUM) services are progressively extending their roles to conduct "comprehensive care" nurse led clinics. In such roles the nurse coordinates the first line, comprehensive care of patients presenting with sexual health conditions and issues.

Objectives: To identify and describe comprehensive care nurse led clinics in GUM services across England.

Methods: A postal questionnaire consisting of 17 closed response questions was sent to 209 GUM services across England. A second questionnaire was sent to non-responders to increase the response rate. Data were single entered and analysed using SPSS.

Results: Of the 190 GUM clinic respondents (91% response rate), 44 (23%) reported providing some form of comprehensive care nurse led clinic, 90% of which were initiated since 1995. Key results show staff development featured as the main reason for initiating such services and there was general consistency in the aspects of care undertaken by these nurses. There was evidence of guideline development specific to nurse led care and some patient group direction use for supplying medication. The level of support from medical staff while nurse led clinics were being conducted varied between services. Few services have conducted any audit or research to monitor/evaluate nurse led care. There was little consistency in the clinical experience and educational prerequisites to undertake comprehensive care nurse led clinics. Continuing professional development opportunities also varied between services.

Conclusions: The steady growth of comprehensive care nurse led clinics indicates that the skills of GUM nurses are being recognised. Nurses working in advanced practice roles now require courses and study days reflecting these changes in practice. Locally agreed practice guidelines can define nursing practice boundaries and ensure accountability, as will the development of patient group directions to supply medication. Monitoring and evaluation of nurse led clinics also require attention.

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Accepted for publication 15 February 2002

The role of the nurse in genitourinary medicine (GUM) has changed considerably from the traditional chaperone and technician, to practitioners skilled in delivering patient care, providing sexual health promotion, information, and support within the multidisciplinary GUM team.

Nurses have performed "extended" roles in GUM for some time¹ and nurse led clinics are now routinely seen in many GUM services.² The emergence of a new type of nurse led clinic, one in which the nurse coordinates the first line, comprehensive care of patients presenting with sexual health conditions and issues, can be termed "comprehensive care" nurse led clinics. In such clinics the nurse manages a caseload of patients with input from medical staff only when reaching nursing limitations of practice. The nurse takes on roles such as eliciting the sexual history, performing the examination, making a diagnosis, and supplying selected treatments, roles that in the past were mostly performed by doctors.

The number of GUM services conducting comprehensive care nurse led clinics is currently unknown. We therefore conducted a postal survey to elicit information regarding the growth of comprehensive care nurse led clinics, the impetus for initiating such services, nursing roles undertaken, protocol/guideline use, medical support, monitoring and evaluation, educational prerequisites, and continuing professional development (CPD) opportunities.

METHODS

The study sample consisted of all of the 209 genitourinary medicine clinics across England identified from a Communicable Disease Surveillance Centre database.

The questionnaire consisted of 17 closed response questions. The first question identified the different types of nurse led clinics being conducted in the respondent's service. Respondents were then asked to continue the questionnaire only if their

service conducted comprehensive care nurse led clinics. A definition and example was provided. Those not conducting these clinics were asked to return the questionnaire at this point.

The second part of the questionnaire focused on comprehensive care nurse led clinics only. A final section offered respondents the opportunity to make comments about any aspect of the questionnaire.

The questionnaire was piloted for content and layout with 13 members of the Forum for Advanced Nursing Practice in GUM, a London based network of nurses affiliated with the Genito-Urinary Nurses Association (GUNA). Following alterations, the questionnaire was sent to the charge nurse at each of the 209 GUM clinics with a cover letter explaining the purpose of the study. To maintain anonymity and offer respondents an opportunity to freely describe clinic practice patterns, we assured respondents that individual clinic details would not be linked to responses presented here.

Incomplete and ambiguous questionnaire responses were clarified following a telephone call with the respondent. The completed questionnaires were single entered and analysed using SPSS.

RESULTS

Of the 190 respondents (91% response rate), 150 (78.9%) conducted some form of nurse led clinic. One hundred and forty one (74.2%) provided nurse led wart treatment clinics, 99 (52.1%) test of cure clinics, 85 (44.7%) results clinics, 66 (34.7%) vaccination clinics, 65 (34.2%) cervical cytology clinics, and 21 (11.1%) provided some other type of nurse led service. These included nurse led clinics for HIV testing, contraception, and erectile dysfunction assessment.

Forty four (23.2%) of the responding GUM clinics reported providing comprehensive care nurse led clinics. These

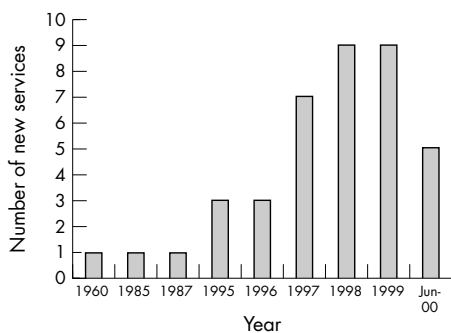


Figure 1 Establishment of comprehensive care nurse led clinics per year.

responses were divided into three categories. Thirty one (16.3%) comprehensive care nurse led clinics were part of the routine GUM services. Four (2.1%) services conducted comprehensive care nurse led clinics in specific settings: one in a termination of pregnancy service, two in off-site young person clinics, and one in the context of a recurrent candida study. Nine (4.7%) GUM clinics provided comprehensive care nurse led clinics on an informal, when required, basis. This meant that a senior nurse was able to provide comprehensive care nurse led care when, for example, there was no doctor present in the clinic, when the clinic was busy, or when there were not enough female doctors available. Of the nine respondents providing informal nurse led services, four did not complete the remaining questions of the questionnaire.

Figure 1 shows the growth of comprehensive care nurse led clinics with 36 (90%) in whom the development had been initiated since 1995. Respondents were asked the reason(s) why their GUM service initiated comprehensive care nurse led clinics. Most respondents provided more than one reason. Fifteen (37.5%) clinics were started as a response to government initiatives (for example, junior doctors' hours reduction), 26 (65%) as a response to professional nursing developments (for example, UKCC "Scope of Professional Practice"), six (15%) as a response to purchaser encouragement, 14 (35%) as a means of retaining staff or attracting new staff, 11 (27.5%) for perceived cost savings, 31 (77.5%) for staff development, four (10%) to keep up with trends, and 25 (62.5%) respondents provided other reasons, including not enough doctor appointments; to cope with workload; to provide holistic patient care; to cover absence of doctor or lack of female doctors; to formalise (nursing) practice that was already occurring; and inability to recruit clinical assistants.

There was little consistency in the titles of the practitioners providing comprehensive care nurse led clinics. Fifteen (37.5%) respondents used the title "nurse practitioner," seven (17.5%) used "clinical nurse specialist," four (10%) used "specialist nurse," and there were 14 (35%) who used generic nursing titles such as "staff nurse," "sister," and "senior staff nurse." Sixteen (40%) respondents had only one nurse providing comprehensive care nurse led clinics. Nine (22.5%) had two nurses, six (15%) had three nurses, and nine (22.5%) had four or more. Eight (20%) clinics employed nurses at F grade only, eight (20%) at G grade only, six (15%) at H grade only, and one (2.5%) at I grade. Seventeen (42.5%) services had nurses working at different grades. For example, E grade staff nurses and the G grade charge nurse were able to provide comprehensive care nurse led clinics. One clinic paid the nurses on an E grade when a doctor was present and an F grade when no doctor was present.

When asked what the minimum clinical experience required for nurses working in comprehensive care nurse led clinics was, 22 (55%) required 2 years or more GUM experience, six (15%) stated 1–2 years GUM experience, two (5%) stated less than 1 year, three (7.5%) didn't know, and seven (17.5%) stated other levels of experience were required.

Table 1 Aspects of care undertaken by nurses conducting comprehensive care nurse led clinics

Aspect of care	No of services (%)
Taking a sexual history	40 (100)
External genital examination	39 (97.5)
Vaginal examination (female only)	32 (91.4)
Pelvic examination (female only)	4 (11.4)
Proctoscopy (both sexes)	21 (52.5)
Specimen taking	39 (97.5)
Blood tests	39 (97.5)
Microscopy	34 (85)
Provide results	40 (100)
Health promotion discussion	40 (100)
Partner notification	31 (77.5)
Provision of oral contraceptives (female only)	20 (57.1)
Dispense medication	37 (92.5)

Thirty four (85%) services also requested minimum educational requirements. Twenty eight (70%) required an English National Board (ENB) for nursing, midwifery and health visiting GUM course, 19 (47.5%) an ENB family planning course, 19 (47.5%) an ENB HIV/AIDS course, and 13 (32.5%) requested that the applicant have, or be working towards, a degree or higher. Three (7.5%) stated other educational requirements including the ENB teaching course and DMS (military) GUM course and examination.

Five (12.5%) clinics provided comprehensive care nurse led clinics for men only, four (10%) for women only, and 31 (77.5%) for both men and women. The aspects of care provided by nurses conducting comprehensive care nurse led clinics are detailed in table 1.

In 11 (27.5%) of the clinics, nurses worked from specific nurse led protocols/guidelines, in 11 (27.5%) nurses used the same protocols/guidelines as the doctors, 17 (42.5%) used a combination of nurse and doctor protocols/guidelines, and one (2.5%) service reported to have none at all.

With regard to the supply of medication, three (7.5%) services required all patients to see a doctor for prescribing. In 16 (40%) services the nurse requested a doctor to prescribe before supplying the medication, nine (22.5%) used group protocols (now known as patient group directions), 10 (25%) used a combination of doctor prescribing and group protocols, and in two (5%) services the nurse supplied the medication and then asked the doctor to sign the prescription at a later date.

In 24 (60%) services there was always a doctor available on site when comprehensive care nurse led clinics were being conducted, in six (15%) services there were times when there were no medical staff on site (that is, no medical cover at all), and in 10 (25%) services there were times when there were no medical staff on site but a doctor was available to provide advice by telephone.

Only 11 (27.5%) services had conducted any form of audit/research to monitor or evaluate comprehensive care nurse led clinics. Such projects included audit of documentation, patient satisfaction questionnaires, comment cards, ongoing collation of nurse led activity, and one comprehensive process outcome evaluation incorporating a randomised controlled trial, patient satisfaction survey, and cost analysis.

When asked about CPD opportunities for nurses working in comprehensive care nurse led clinics, 30 (75%) respondents had access to regular in-house training, 26 (65%) had access to a range of ENB courses, 15 (37.5%) had access to a range of degree courses, and 10 (25%) had access to other opportunities including relevant study days and conferences. Four (10%) of the services stated there were no specific educational/professional development opportunities offered to nurses working in their comprehensive care nurse led clinics. When

the respondents were asked if they thought there was a need for an advanced GUM practice course focusing on nurses working in comprehensive care nurse led clinics, 33 (84.6%) said yes, four (10.3%) said no, two (5.1%) didn't know, and one respondent did not answer the question.

DISCUSSION

This survey attempted to distinguish between the various types of nurse led clinics and to focus on comprehensive care nurse led clinics. The high response rate of 91% would suggest the results are representative of GUM services across England. Such a response to a postal survey may also indicate the level of interest in this area of GUM nursing.

The inconsistency in job titles and grading of nurses conducting comprehensive care nurse led clinics reflects national nursing agendas. Nursing regulatory bodies have yet to define what constitutes advanced nursing practice and attach titles and pay awards that reflect the level of nursing practice. Once defined, we may see the job title of GUM nurses working in advanced roles become more consistent and recognisable. In the interim, GUNA has convened a working party to recommend job description standards for GUM nurses.³

Almost two thirds of our survey respondents requested that nurses providing comprehensive care nurse led clinics have 2 years or more of GUM experience and nearly 85% had some form of minimum educational requirement. However, this was not the case for all services. One case was described whereby nurses providing comprehensive nurse led care had less than 1 year of GUM experience with no specific educational preparation. Although senior nurses were always available to provide clinical advice for the lower grade nurses, it is still, none the less, a concern that nurses with limited GUM experience were able to perform advanced practice roles. In addition, the majority of courses listed by respondents do not truly prepare nurses for advanced GUM practice. The courses offered by the ENB and associated institutions have been slow to change their curricula to reflect recent changes in GUM nursing practice and nurse practitioner degree pathways tend to have a generalist rather than specific focus. Unless nurse practitioner programmes are able to offer the flexibility of teaching, mentoring, and assessment in the GUM setting, they risk failing to provide appropriate experience in applying the core skills and processes of patient care management and decision making to the complex issues encountered in the specialist GUM environment.

There was general consistency between clinics with regard to the core aspects of care provided. Tasks that varied from clinic to clinic were most likely to be a result of differing staff resource and access to allied health professionals, such as health advisers and laboratory technicians. The delegation of practices and tasks, such as pelvic examination and proctoscopy also varied between services. This was most likely to be dependent on individual nursing skill and expertise and consultant or hospital dictated policy, both reasons identified in a 1993 Department of Health study.⁴ From a professional nursing stance, there is no reason within current UKCC nursing regulation why nurses with appropriate training cannot perform tasks such as pelvic examination. The essence of the UKCC Scope of Professional Practice is that nursing practice should be limited only by the individual accountable practitioner's own knowledge and competence.^{5 6}

Seventy per cent of respondents worked to some form of specific nurse led protocol/guideline. While acknowledging the need to standardise clinical practice between doctor and nurse led clinics, guidance specific to nursing practice can clarify the limitations of practice in line with local, national, and legal frameworks for professional nursing practice. For example, guidelines agreed within the multidisciplinary team can list patients appropriate for routine assessment and management by nurses and those patients who must be seen by or involve a doctor.

Practice related to the supply of medication varied between clinics. For instance, there were two services in which supply of medication by nurses took place in the absence of any form of named prescription or direction. Issues of accountability may also be raised when doctors prescribe for patients whom they have not seen (40% of services). To overcome this, patient group directions⁷ (PGDs) drawn up by multidisciplinary teams, approved by local advisory bodies, and monitored accordingly can provide a safe and legal means for nurses to supply medication. With 40% of respondent services conducting comprehensive care nurse led clinics during times when no doctor was present, the need for practice guidelines and PGDs becomes implicit.

Finally, the poor level of monitoring and evaluation of comprehensive care nurse led clinics indicates the need to develop core audit/evaluation tools that can be used to assess and measure process and outcomes appropriate to local GUM service provision.

In conclusion, the growth of advanced practice roles for GUM nurses indicates that the skills of GUM nurses are being recognised. It is reasonable to assume that such role developments are likely to continue. The national strategy for sexual health and HIV proposes that nurses will have expanding roles as specialists and consultants.⁸ Nurses working in advanced practice roles now require role preparation and continuing professional development programmes reflecting these changes in practice. There is also scope for services and professional organisations to work in partnership to develop core generic standards of practice (for example, practice guidelines and PGDs) for GUM nurses nationally, while still allowing employers and practitioners to negotiate nursing role development at local level according to resource and specific need. Finally, effective mechanisms for the monitoring and evaluation of advanced practice roles need to be considered within local clinical governance frameworks.

ACKNOWLEDGEMENTS

We thank the HIV and STI Division of the CDSC for the use of their database, members of the Forum for Advanced Nursing Practice in GUM who piloted and commented on the draft questionnaire, and the survey respondents.

Conflicts of interest: None.

Source of funding: None.

CONTRIBUTORS

All authors contributed to the study design. KM distributed the surveys, managed, and analysed the data. All authors contributed to the writing of the paper.

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