GP practices must ensure nurses are trained to do spirometry

With the development of the national COPD strategy more spirometry is likely to be undertaken in primary care, but are nurses competent to carry it out, asks Monica Fletcher

Why do some GPs assume their staff can just pick up a spirometry machine, read the basic manual and then be proficient?

Performing and interpreting spirometry is a skill. It takes theoretical knowledge, practical application and a lot of practice.

Healthcare professionals are responsible and accountable for their own competence, including in spirometry. It is also the practice team’s responsibility, especially those who supervise others, to be clinically competent.

If you take your car to a garage for repair, you would expect the garage to ensure the mechanic was competent. If you had an accident because of their incompetence, you would be entitled to apply for compensation and could even proceed with a negligence claim.

It is in employers’ best interests to ensure their staff are trained and competent. So why should primary care be any different?

GPs and practice managers employ practice nurses and must ensure they are appropriately educated. In addition to their clinical skills, these nurses need to be aware of medicolegal issues and codes of conduct.

We have a draft national chronic obstructive pulmonary disease strategy that states improving the rate and accuracy of diagnosis is vital. Two of its main objectives are to: identify people earlier, as an estimated two million are undiagnosed; and improve diagnosis, ensuring people are not misdiagnosed.

This will, inevitably, mean more spirometry being undertaken in primary care, which poses the questions: who will do this and how competent are these practitioners?

As part of a national survey, Education for Health found only 12% of nurses undertaking spirometry had any form of accredited training to do so and fewer than half (49%) of those diagnosing and managing COPD had formal accredited training (Upton et al, 2007). How can this be allowed to continue, when government rhetoric – both previous and current – focuses on improving the quality of overstretched health services?

Transferring services into primary care should not be to the detriment of quality. The general public trust doctors and nurses and believe they are competent until proven otherwise. But how would they know if they had been misdiagnosed with asthma when they have COPD?

We have to clean up our act in primary care. GPs and their teams have risen to the challenges of the operating framework. Next, NHS primary medical services providing regulated activities will need to be registered with the Care Quality Commission from 1 April 2012. These include GP practices and out of hours services. Since patient safety and safeguarding the public is a high priority for the commission, GP practices will be open to scrutiny.

I am proud of the UK primary care system. My work gives me the opportunity to travel the globe and view other healthcare systems, and I have witnessed what happens in countries that do not have adequate services. We should not be waiting until we are forced to improve care for people with COPD. We should act now, while the strategy focuses attention on this condition.

Let us embrace the national strategy for COPD when it is finally published. It will be a vital framework for improving the care of thousands of people with this debilitating condition and appropriately trained and competent nurses will be able to play a crucial role in its implementation. However, nurses will have to ensure they receive this training, which employers must be prepared to pay for.

REFERENCE


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