NHA: the evolving role of the nurse in hypertension

Hypertension is one of the major risk factors for vascular disease and its treatment to target requires not only careful monitoring with lifestyle advice and pharmacological intervention but also a good understanding of the condition by the patient. Nurses with a sound knowledge of hypertension can play an important part in this process and are increasingly deployed in both primary and secondary care to assess and monitor patients. The clinical nurse specialist in hypertension was developed in response to nurses being employed to collect data for research studies or to support doctors in specialised academic hypertension centres. A number of studies demonstrated that nurse-run clinics were at least as successful as the traditional medical format.[1-3]

'89% of NHA members think that nurses should increase their role in prescribing hypotensive medication'

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The Nurses Hypertension Association

The Nurses Hypertension Association (NHA) was formed in 1991 to act as a forum for nurses (www.nha.uk.net). Its objectives are:

- to keep members informed of new developments in hypertension
- to promote and provide ongoing research and education
- to encourage research and to facilitate the sharing of findings, skills and ideas
- to enhance the standards of nursing care and nursing research in hypertension.

Initially the membership comprised mainly nurses in secondary care, often working on research trials, but over the last few years the number of clinical nurse specialists and primary care nurses joining the organisation has grown.

The NHA holds an annual scientific meeting alongside the British Hypertension Society's (BHS) annual meeting. This gives nurses the opportunity to attend lectures and also provides continuing professional development by encouraging nurses to submit and present abstracts. A recent meeting highlighted a number of significant developments likely to impact upon nurses. These are supplementary prescribing, the General Medical Services (GMS) Contract, and the Department of Health's 'Agenda for change'.

Supplementary prescribing

Nurses may now prescribe or supply medicines by, i) independent prescribing (either the limited formulary or extended formulary depending on education completed), ii) supplementary prescribing (which first requires completion of the extended formulary independent prescribing course) and iii) patient group directions. At the recent NHA Scientific Meeting, members attending a forum on prescribing felt that supplementary prescribing would have the greatest impact upon the way nurses manage their patients with hypertension.

Supplementary prescribing would allow nurses and other health professionals – after initial assessment of a patient by a doctor – to prescribe for that patient in accordance with a clinical management plan. Many nurses find the variety of medicines used in hypertension complex. Despite this, a recent survey of NHA members found that 89% thought that nurses should increase their role in prescribing hypotensive medication. Specifically, the majority of responders (61%) to the survey agreed that nurses could:

- Initiate medication for untreated hypertension at the request of a medical practitioner.
- Discontinue medication for hypertension because of side effects.
- Add a new medication or increase the dose of a med-

ication for hypertension if blood pressure (BP) target is not reached.
- Follow a protocol on hypertension medication that includes choosing type and dose to be used.

The majority did not agree that nurses or pharmacists could initiate treatment after a nurse diagnosis. Interestingly, they also felt that doctors should not initiate treatment after a healthcare assistant assessment of BP. The BHS has recently tried to simplify prescribing in hypertension by promoting the Modified Cambridge AB/CD Rule.[4] Nevertheless, compared to type 2 diabetes or asthma, writing clinical management plans may be more complex. The NHA see a need for shared guidelines and algorithms to assist nurses who undertake the statutory education for supplementary prescribing to use in the management of hypertension. The NHA survey also highlighted the need for further education on the management of hypertension as well as the statutory education on prescribing. Most felt there was a need for both a specialist nurse qualification and a disease specific course on hypertension. This is certainly an area that the NHA are currently exploring.

Agenda for change

'Agenda for change' moves nursing pay away from clinical grading to new pay bands that will be determined by the jobs that nurses do. Profiles have been produced by the Joint Evaluation Working party that imply that specialist nurses could be awarded pay band 6 and – if the nurse is thought to be undertaking a highly specialised role – then pay band 7 may be more appropriate (www.doh.gov.uk). Practice nurses running specialist clinics such as in hypertension, should also qualify for pay band 6. This is clearly an incentive for nurses to develop specialist roles.

Changing role in primary care

Within primary care, nurses have been steadily developing their role in managing hypertension. A survey of Glasgow practice nurses in 2000 indicated that asthma and hypertension were the two areas of care that they spent most time on. The city's Local Medical Committee organised a hypertension project for a primary care health promotion payment, supported by a simple annual computerised data collection, which requires the entire primary care health team to be involved to achieve this payment.

The new General Medical Services (GMS) contract also provides an incentive for practices throughout the UK to structure their management of hypertension. There is significant financial reward if over 70% of patients with hypertension achieve a BP < 150/90 mmHg. This is part of the quality indicator payment scheme and provides one of the highest rewards for good practice, highlighting the value of controlling BP. Another quality indicator in hypertension is to record BPs every nine months. As a nurse who has run hypertension clinics with recall and annual reviews for nearly 20 years, I have some concern that this may lead to less quality rather than more. There is a danger that there will be a focus on BP recordings rather than a consultation to discuss all aspects of hypertension management including an assessment of other cardiovascular risks.

The new contract encourages skill mix including healthcare assistants (HCA). The HCA Course from the Primary Care Training Centre in Bradford includes learning how to take BP readings with manual and automatic devices, using a distance learning pack, and teaching from a mentor, usually the practice registered nurse. There is also a section advocating 24-hour BP monitoring. This and other initiatives, such as self BP monitoring by the patient who then phones in the result to their general practice, are innovations which suggest BP measurement is all important.

The role of the practice nurse is continually being extended; skill mix may be the only way to ensure that they will be able to maintain specialist areas of knowledge. Maybe in the future there will be cardiovascular nurse specialists in primary care. They will co-ordinate with doctors, other health professionals and HCAs, the care of patients for secondary prevention of heart disease and stroke, and primary prevention in hypertension, hyperlipidaemia and type 2 diabetes.

Changing role in secondary care

Within secondary care the role of a clinical nurse specialist in hypertension may bring benefits. The BP targets set in primary care will be difficult to achieve for many GPs and their practice nurses without the support of specialist physicians. Referrals are likely to rise and, with the reduction in junior doctor hours, consultants could be well supported by a nurse. There are still a significant number of referrals where a patient's BP has been incorrectly estimated because too small cuffs have been used. Standardised BP measurements are very valuable for consultants when making decisions about treatment. A clinical nurse specialist could also be a useful resource for other hospital departments, and primary care. For example, they can provide:
- advice on devices for BP measurement
- updates for staff on BP measurement technique
- management of a 24-hour ambulatory BP measurement service
- advice about referral to hypertension clinics.

If the role of the clinical nurse specialist is to grow, there needs to be better provision of further education in hypertension. Interestingly, 47% of the NHA membership felt this should be to degree level; a further 21% thought this could

be at Master's level. Research is needed into some aspects of the nursing role, such as how often is it necessary to repeat tests to monitor hypertension effectively, and how effective will supplementary prescribing be in hypertension?

Another whole area that has not been discussed in this editorial is the role of the patient and how this impacts on nursing. Nurses are in an ideal position to ensure that people diagnosed with hypertension receive adequate advice and knowledge about their chronic condition. Follow-up strategies should be discussed highlighting lifestyle and treatment goals that suit the individual. The results of hypertension management from the Health Survey for England in 1998 indicated that although there is some improvement in BP control there is much work still to be done.[5]

References

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