

Customer *Insights*

Industry intelligence in association with STAR February 09

Natasha Pradhan, Nursing Sister in A&E working for North West London Hospitals NHS Trust, spoke to Pf about the demands of her role and how the industry can improve relationships in emergency care.

What is your title?

I am a Nursing Sister in Accident and Emergency (A&E). Other titles such as Lead Nurse and Nursing Coordinator within the same specialty perform similar roles.

What are your main objectives?

The main objectives of my role are to ensure the effective clinical management of the A&E department. This includes allocation of staff resources to meet clinical need. I am also responsible for the prioritisation of clinical cases and this can often be a balancing act between making sure time targets are achieved and that patient outcomes are not adversely affected. The dynamic nature of emergency medicine means that another of my objectives is to constantly reassess the workload and bed capacity of the department to make sure that we are prepared for any major or untoward clinical incident that may occur. This also means ensuring that we have adequate supplies of drugs used to treat common presentations particularly in acute cardiac and respiratory emergencies.

How has the role changed?

Over recent years, there has been a significant increase in the number of patients attending A&E. In my department, we see about 86,000 patients a year and this figure looks set to rise further. In order to meet this level of

demand within the government target of four hours from initial presentation to admission or discharge, the importance of my role has grown significantly. The ability to co-ordinate a rapid turnover of patients without impacting on the quality of care is now a vital aspect of A&E.

I have also seen a greater importance placed on my role in relation to clinical leadership. As a coordinating clinician I can offer access to contemporary clinical advice for junior nurses and doctors or can put them in touch with specialists within the hospital who can assist them. This has become more important with time dependent diagnostics and therapies associated with acute coronary events and, more recently, strokes.

What does a typical week look like?

Almost all of my time is spent in the clinical environment and I work twelve hour shifts to cover the peak patient attendances. The main element of my work is co-ordination of the clinical staff and all sectors of the unit. However, my senior nursing colleagues and I will audit the number of daily attendances, the reason for their attendance and the impact this has had on clinical resources. I regularly assess pharmacy stocks and replenish levels according to what the audit data shows us is most likely to be needed. This changes as the demographics of our local population fluctuate.

I also attend regular clinical meetings to assess how A&E, other acute specialties and primary care can work together to meet patient needs. These meetings are also attended by A&E Consultants to allow medical and nursing contributions to be heard.

I liaise with a wide range of professionals. A&E sees patients from every specialty so I contact clinicians from surgical, medical, paediatric and primary care fields on a daily basis to discuss individual and generic patient care. I also have regular contact with a named pharmacist who deals with A&E orders and assists me with purchasing new medications and obtaining drugs not on our order list. A&E can be a hectic environment and it is not uncommon to see many health care professionals in the department at any given time providing a different aspect of patient care at a different point in the patient journey. This can include physiotherapists, occupational therapists, ambulance personnel and even coroners officers! I have regular hourly contact with senior level managers from within the hospital who are keen to know how the department is meeting its time targets. This also allows me to plan ahead with them to overcome any 'bottlenecks' in the system that may impact on patient care including delays with laboratory investigations or clinical cases.

What are the major influences on the decisions you reach?

Centralised government targets are a major influence on the decisions I reach in the clinical setting whether this is related to waiting times or standards in clinical care. I am also influenced by the health status of patients and by the assessment skills of the doctors and nurses who are working with me. If they are concerned about a patient's condition then I will ensure that the patient is reprioritised accordingly. I keep abreast of changes from within the hospital and ensure that this information is disseminated to the other clinical staff, particularly in relation to antibiotic guidelines and microbiology protocols. I find that prioritising within the A&E environment is a dynamic process and requires constant reassessment by talking to fellow professionals and thinking about my objectives for that hour.

The local PCT is gaining greater influence on emergency care and more aspects of primary care are becoming incorporated into A&E. We regularly have GPs working within our department and a PCT urgent care centre was recently opened adjacent to A&E to provide greater patient choice.

What contact do you have with people from pharmaceutical companies?

I am having less contact with pharmaceutical representatives than ever before for a number of reasons. Primarily, the shorter

length of patient stay in A&E has significantly reduced the range of drug therapies clinicians need to prescribe in an emergency situation. I think this has been recognised by pharmaceutical companies who know that A&E is not the right clinical area for their product to be used. Another significant factor is the growing sense of unease among the nursing and medical professions about the ethics associated with free gifts from pharmaceutical companies. Much of the advice I receive now is that unless the department is looking for a new product, visits from pharmaceutical companies should be declined.

However, senior nurses in all specialties are playing a much more influential role in prescribing and selecting drug therapies so I would certainly recommend that the industry does not shy away from contacting Nursing Sisters. Accessing those working in A&E is better achieved by an

old fashioned letter with a brief description of the product and the representative's contact details. Address this letter to the A&E Lead Nurse and it will soon find its way into the hands of a senior nurse with an interest in the product who can then arrange a mutually convenient meeting. Cold calling by telephone or in person is not advisable since A&E is far too busy to allow a productive ad hoc interaction to take place.

The best form of information that the industry can provide for A&E departments are eye catching posters that provide details about the product including indications for use, administration and dosage. Given the large geographical area of most A&E departments and the high numbers of staff employed within them, posters can be easily placed and sighted in patient care areas aiding the use of a new product. This also eases the pressure on lead nurses to

disseminate information to other staff and frees up my time allowing me to concentrate on other aspects of emergency care. (See 'Pf says' for comment.)

How can sales professionals improve communication with this group?

Pharmaceutical sales professionals must be knowledgeable about the clinical area they are entering. I am not interested in evidence that shows a drug improves hypertension after six months of use. I have four hours to treat and stabilise a patient and I want to feel confident that pharmaceutical sales professionals have done their homework about my specialty, particularly in relation to time and clinical targets. Unfortunately, coming armed with product data that has no bearing on its use in A&E is not going to result in a fruitful sales call.

Pf Says...

A lot of A&E nurses think about equipment as much as product and may not be aware that the rules are different from a rep's perspective. The challenge for industry is to take the customer's needs and work out how best to achieve them within the context of the Code.

So, for example, introductory letters are certainly possible – however, they have to be formally approved by the company signatories and they need PI, etc.

The promotional poster in a patient-access area is an absolute no. However, the industry can provide disease awareness posters for such areas and there is no reason why promotional posters can not be displayed in appropriate staff-only areas (although I suspect that HCP reactions will be mixed). Posters that provide instructions about how to use products safely would be acceptable in certain circumstances. Again – these would have to be carefully considered by the company signatories.

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