# Customer Insights

## Industry intelligence in association with STAR

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**This month, Customer Insights profiles the role of the Practice Nurse. As more services move out of hospitals and into the community, the demands placed on Practice Nurses have increased. A Guildford-based Practice Nurse explains her role.**

### What is your title? What are any other variances in title for individuals who carry out the same type of work?

I am a Practice Nurse. If you are a qualified nurse working in a practice, you will be a Practice Nurse. There are also healthcare practitioners who are unqualified nurses that have been trained to take bloods, blood pressures, ECGs and give flu jabs – things like that – who may perform the role. The role, as you would expect, is dedicated to primary care. In general, practice nurses operate out of GP surgeries but you can also find them in occupational health, working inside businesses.

### What are the main objectives/ responsibilities within your role? How has it grown in importance in the past few years?

The role of Practice Nurse has changed considerably in recent years – or at least the demands placed on them have increased. With a greater emphasis on moving the delivery of healthcare out of hospitals and into the community, the volume of work we get through has escalated in the past five years. It used to be a case of taking blood, syringing ears and removing stitches. We still do these things, but now, in addition, we are involved in health education and meeting NICE guidelines. For example, patients with CHD have to be seen every 18 months, to have bloods taken and to be assessed – the Practice Nurse is generally the one that does most of the work in this regard.

We have several objectives. Primarily, patient education is a major part of the role. We are there to encourage health, with prevention a huge aspect of what we do. Within this, there are all sorts of facets. Another priority is the day-to-day running of chronic disease management. This covers things such as ischemic heart disease, asthma, chronic obstructive airways disease, diabetes, dementia, hypertension. Other aspects such as travel health are also a responsibility.

Personally, I also am a diabetic and cardiac trained nurse by training, but in my role as Practice Nurse, I am a generalist.

My main responsibility is to the patient. Aside from the obvious objectives to improve patient outcomes and manage chronic diseases, we also have wider national NHS targets to meet. For example, with the Childhood Immunisation Programme, we have to meet specific government guidelines. We are a very small practice, so these targets are very manageable. We are very proactive and the team is able to identify appropriate patients and bring them through. For instance, we have a higher than average uptake of the MMR vaccine compared to other surgeries. This is because we maintain a dialogue with parents from an early stage and prime them. It is very satisfying to know that we are able to influence this, and to see the results in the figures.

### What does a typical working week look like?

I work three days a week – and they are all very different. On Monday the focus is on chronic disease management. I review all patient notes before each clinic, so that I know what medication patients are on, what they've come off, and how they should be, before they come in. On other days, I simply take what walks through the door. This makes for an interesting and varied day, with support required across a range of areas such as anti-coagulation, childhood immunisation, dressing, counseling. It could be anything – and every patient is a different challenge.

### Who are the other influencers within your local healthcare economy with whom you liaise?

I am frequently in touch with district nurses – particularly when looking at chronic disease management. If someone doesn't turn up, or cannot get to the surgery, I will ask a district nurse to go out or, indeed, the community matron if appropriate. I also liaise with community psychiatric nurses, midwives and health visitors. Communication is very much two-way. We often have full team meetings within the practice, and also meet with other GP practices when there is a wider debate. Each month, the community pharmacist will visit, and is very accessible.

## What contact do you have with people from pharmaceutical companies?

I do, very occasionally, see medical representatives – if they are persistent enough! Most often, I see them at the various diabetic shared care meetings, or practice nurse meetings that are almost always sponsored by drug companies and include a lecture on a relevant topic. The education that representatives give, or arrange to give, is fantastic. There is an enormous value in what they can bring in the way of enhanced knowledge.

I have also been involved in clinical nurse audit programmes, which have been funded by pharmaceutical companies – though the sponsor, quite rightly, is not identifiable. We were involved in one such programme in diabetes – this came to us via the hospital and the diabetic team there. We had to audit the patient list every six months. I am not sure how much this particular exercise impacted patient outcomes or changed clinical practice, but this may well be because we are such a small surgery and can identify appropriate patients more easily than others.

## How can the industry achieve greater access to people who perform your role? What kinds of information, if any, might they be able to provide you with, to help you within your role?

It is easier to describe this using examples. Travel health is very well supported – there is probably more money in that – and so there are often sponsored meetings arranged that showcase developments in this area. On the other hand, there are very practical areas that remain central to what we do, that get less attention. Take wound care. There are very few lectures on wound care - it's not a very glamorous topic. Occasionally, someone is persistent enough to set up a meeting about wound care, and to arrange a lecture on the topic for all of the nurses in the practice. This is really useful.

Often representatives will leave samples of products and we are in a position to buy them. However, sometimes these products are not on the formulary and, try as we might to order them, we draw a blank. It's then that we go back to the representative and they, in turn, have to canvas the PCT very hard in order for us to be able to use it. We can influence that decision by feeding into the PCT ourselves. As I said, the community pharmacist, who works for the PCT, will come to visit us once a month, at which point we can discuss our requests and requirements.

## What qualities do you think medical representatives should have?

Flexibility in their approach is helpful. I'm sure everybody that wants to see medical reps wants to see them at lunchtime! Persistence is a key quality that they need to demonstrate.

## What is your over-riding opinion of the medical representatives that you see?

I think that representatives have a real value. They manage incredibly well. I am always amazed at their generosity and they impress me almost every time. When they sponsor different meetings, I always think it's incredibly kind of them – but that is only because we see a huge value in the information these meetings provide. There is always something to learn.