“A ‘Top Gear’ approach to flu clinics must be quashed”

It’s that time of year again, to try and catch, bin and kill any chance of a day off over the next few weeks. It’s time to start running the flu clinics and deal with all the challenges they bring.

The searches for “at-risk” patients are done. Invitations have been sent out. Extra sharps bins, needles, syringes, cotton wool and pneumococcal polysaccharide vaccine are available. No one is going to have a needle stick injury. The anaphylaxis kit is readied. Prescribing paperwork has been read, signed and dated. The next step is to contemplate the very real possibility that your patients will turn up before the vaccine ever does.

I believe a “Top Gear” approach to flu clinics must be quashed. We are nurses, not high-performance cars, and any suggestion that we can “do” nought to 60 jabs in less than 10 seconds is neither feasible nor safe. However, sometimes it becomes a game of one-upmanship to find out which practice allocates the least amount of time per jab. Seeing patients at one-minute intervals seems to be the most popular decision.

A lot depends on the weather. By the time wet umbrellas are shaken out, coats and sweaters adjusted, shirtsleeves frustratingly rolled up to well below the nearest available bit of deltoid, you are running out of time and unable to counter the common refrain of “I had the jab last year and it gave me flu”.

Despite the camaraderie of the clinics, a number of patients will be nervous and will need support. There will be this year’s bereaved putting a brave face on things. In addition, there are times when speed is undignified for our patients, for example, after a stroke, when dressing, speech and mobility may be impaired. Patients need to be offered an unhurried chance to dress themselves or be offered assistance to do so after their jabs.

A great team is essential, involving suitably trained healthcare assistants and receptionists. Accurate data input is vital. By the end of a clinic, when you are reeling with exhaustion, it is somewhat perplexing to realise you’re more likely to recall the batch number of the vaccine than the names of your own children.

The greatest bone of contention stems from the demands of the Quality and Outcomes Framework. Surely, practice managers think, we have a captive audience therefore we can act opportunistically, which is arguably a euphemism for meeting more targets. As someone who teaches health promotion within primary care I would be all for this, if it was not for the volume of work. But what happens if we suspect something potentially worrying, when there’s little or no privacy, the surgery car park’s full, and the corridor is packed? Nurses must be assertive. If we go down this target-driven route, we must be given time to do these extras, ensuring patients’ informed consent.

One final thing to remember regarding flu clinics is the importance of evaluation. So we need to reflect on how well we managed this season’s clinics, and, crucially, what we learn for next year.

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It is estimated that over two million people in the UK have undiagnosed COPD. As there is no cure, early interventions, such as smoking cessation, are vital to slow its progression. People with risk factors must be assessed to ensure an accurate diagnosis is made. Our update on NICE guidelines (page 22) stresses the importance of spirometry as part of this process. Anyone carrying out the procedure must be trained; Linda Pearce describes it on page 14. Next week part 2 of this article looks at the interpretation of results. Spirometry is also used to assess patients with suspected vocal cord dysfunction. Those with this condition are often misdiagnosed with asthma and receive inappropriate treatment for years. On page 18 Jemma Haines outlines the signs, symptoms, treatment options and the key role specialist services play in assessing and managing patients with this condition.

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