Nursing focus group transcription

Introductions

1 – Community Sister

2 – Staff nurse

3 – Care Assistant HCA

4 – Community nurse / HCA

5 – Community Matron

6 – Staff nurse

LS: Can you tell us a bit about what your experiences are with pressure ulcers in the community?

1: Sometimes we get, erm, people discharged from hospital with a pressure sore, we’re not always informed of the grading of the pressure sore or it’s not accurate and, rarely, we get people that develop a pressure sore on our caseload with our, during our care, erm, it’s usually due to, usually being the operative word, usually due to non-compliance of the patient or lack of equipment, declining equipment, things like that. We’re, we do, we are quite hot on, err, relaying preventative measures to our patients, erm, so we don't get too many, but we do see a lot, whether it, mainly be discharge from hospital with them, and we pick up the pieces and quickly heal them up.

LS: and what kind of prevention when you get them?

1: Erm, it’s mainly if, I mean if one of the nurses was to do the initial assessment we need to go in and erm obviously highlighting any equipment that could be useful, erm, obviously preventative advice, offloading, turning, regular turning, erm, but mainly I mean and if we’re coming up against barriers with equipment we usually can get OTs involved who can do a proper equipment assessment because we’ve only got access to certain things from stores.

We give out pressure, the information leaflet…

1: Oh yeah

…as well as verbal

6: Communication, communication isn’t it all the time, it’s at the forefront of our mind all the time, it’s there all the time you go to someone, not only are we required to ask about it anyway, but it’s there, we’re always worried about it, communicating to people all the time about what they can do prevent it and how they can help. I saw a women this morning, a young able women in her accident, erm, and so she’s immobile for a while and I just sort of ran through it with her, thinking actually there wouldn't be much of a problem, she said well actually my heels are quite sore now you come to say that and she’s laying in bed, she’s on the appropriate mattress and actually her heels were quite sore, not physically sore, but she was beginning to feel that they were getting a little bit sore, so you can give that advice of offloading and a cushion, and when we were finished she said I’m glad you explained that to me because I didn't realise what that was all about, I’m an intelligent person and I never really even thought about it. Communication I think, always keep communicating

And also setting, the capacity of the patient, whether they retain the information or understand that information

So then in that respect, we would educate carers or family members who are with the patient who can’t make decisions erm due to their lack of capacity so we’d educate carers and they've also got access to this leaflet that the trust has come up with so yeah it’s been quite useful

6: We also have the second pair of eyes policy, if one of our team spots a pressure area, then erm the next day someone, another member of the team will go in and look at it with a second pair of eyes

1: Sort of for confirming once seen from one instance and actually confirming the grade to it so you've just got, sometimes you’re unsure it is a moisture lesion, is it a pressure sore so it’s just that extra bit of support really from the team.

5: And it’s about trying to identify vulnerable patients, we use the xxxx tool so if you find a grade one or grade two pressure sore then use the xxxxx tool that we review weekly to keep an eye and prevent that deteriorating and we use red stickers that you put on the notes to identify that that patient is vulnerable of pressure damage and to refer to a care plan, we would do a care plan obviously to prevent pressure ulcers or to heal, heal them. So everyone has to refer to that so that we all give the same treatment.

1: A universal one

5: Universal, yeah

1: They’re universal but they are patient specific, some, some piece of equipment may suit a particular patient so you don't try something else, but there are, it’s a sort of general care plan, but they’re individualised for that patient

6: Then you have the two week rule don't you if you put a dressing on for two weeks and you’re not seeing any change, then we’ll change it and after we’ve exhausted everything we’ll call in tissue viability nurse specialist

1: Yeah we’ll trial them…

6: Often we’ll get prescriptions for creams, barrier creams and again we’ll try, and if that’s not working we’ll try another one, so…

1: We’ve got a sort of hierarchy

6: Yeah

1: Yeah I mean if somebody’s skin’s red but blanching, we usually go in with cream first of all and actually that has really good results

2: We don't find that dressings on buttocks, on sacral areas is necessarily very useful cause they can ruck up and actually cause more problems so we do have to consider that rather than going straight in and putting a dressing on, we’d advise them to maybe offload that area as much as they can. In some cases where there’s a pressure sore and it’s quite bad we’d advise bed rest cause patients will tend to sit out in chairs for long periods of time and you’ll advise them to mobilise, sometimes that’s not possible for some people, but sometimes people just don't want to so we’ll suggest bed rest and we’ve had good results from people actually going onto the bed rest and obviously we’d look at their mattress, whether it’s appropriate for them to have an overlay mattress or a full foam mattress or air mattress and if it’s something that we all have to consider and as 1 said if we feel that maybe we need more support we can get an occupational therapist to go in to assess as well. We work quite closely with them and we have done joint visits with them as well so…

3: Well, I think we have really good, like procedure from individual of us check patients, talk with them on each visit, pretty much weekly so it’s an easy discussion so you get involved in their diet information and also we focus on their pressure areas and at the same time we check their mental capacity and if they’re able to get us the right information we needed and if we need more we can contact the carers to check and monitor their skin integrity just more regularly and so the patient will get the right information and how important it is for their health wellbeing, so yeah, I think that's the input from us, all the information that we’re not aware.

5: And sometimes we’ll not necessarily have to visit regularly if that patient’s skin is actually intact so we will work with the care agency and they will monitor the skin integrity and highlight any concerns to us and that would be documented in the care plan that the carers have taken that responsibility and as has been said on every visit, whatever we’re going to see a patient for we will be examining pressure areas, obviously if they decline that’s fine, if they've got capacity we just document that, but that is something that we’re all doing at every visit for every patient and some people just say they’re fine, they don't want us to look and obviously we just document that and obviously just document that they have declined and have capacity to do that but as district nurses we’re very hot on pressure area care and giving out advice and we are monitored on how many we get and we have to report anything from a grade 2 and above on our reporting system and we do have to occasionally go through pre-panel to have things looked into to see if it was avoidable or unavoidable so we need to do the best we can to obviously avoid going to pre-panel cause it’s not nice [laughter].

1: And we handover obviously in our handovers

5: Yeah

1:…if we’re concerned, if there’s any problems

3: And we’d change our plans for visiting support for certain patients in different stage of their skin care

4: And also, if you go to a patient and they haven’t got mental capacity and we know that they've got carers we’ll always read their carers notes to make sure there’s no concerns because they have to document everything, well, they’re meant to anyway

[laughter]

LS: And they don't?

4: Sometimes they don't but on the rare occasion, they’re pretty good around this area actually, the carers

5: Or family, obviously if there’s family that lives in the house we can speak to them…usually they’re quite helpful

14.22

4: But that tends to need documenting on every visit doesn't it

5: Sometimes we get people saying they've got pressure sores but actually it’s not a pressure sore and we’ll go out, we’ll get a message saying someone’s got a grade 4 pressure sore or a grade 3 pressure sore, it’s, sometimes it’s a shearing wound or some sort of trauma wound erm so we have to erm do our second pair of eyes, check, you have to be quite careful with our grading of sores and obviously confirming whether it’s pressure, pressure damage or not, so…

1: We do make it a priority though don't we and I think people know that

5: Yeah

1: …so we would maybe visit a bit sooner that we would have done…

5: Yeah

1:…nobody likes to hear that word so we do go and visit asap really

5: Mmm [agreeing], yeah we would

1: And also from us, the group of patients we were saying, they are house bound patients and most of them, they are old people, you know from their skin condition compared to a younger generation they need a bit more support and monitoring, information and advice from nutrition wise err and even the basic equipment on the bed or with some patients there preference is to sleep in the chair rather than a proper bed. Those are the information that we’re having to talk to them over and over again to get them to realise the importance of the right equipment or the right place to sleep which will help them.

6: And it’s painful and costly, at the end of the day it's a very painful thing to have and prevention is better than cure because it can go on for so long

1: I think also I mean if we’re doing erm initial visits we’d go for the prevention, if people are a bit more sedentary we’d suggest a cushion or an overlay mattress just to try and prevent anything happening, sometimes it works, sometimes they are, they do just happen…

5: And we see some very poorly people

1: Yeah

5: …with a chronic condition, comorbidities and in those instances you know sometimes you do everything you can but they still are going to develop a sore, if they've got poor nutrition or they’re not mobilising, perhaps they’re having chemo, these, we look after some very vulnerable people and particularly like end of life care, it’s very difficult isn’t it.

1: And then a lot of people have just got carers going in periodically through the day so it’s not like being in somewhere that they’re regularly looked at and assessed so

5: With somebody who’s end of life, they can develop a grade 4 pressure sore very quickly and that would happen

1: within hours

5: …hours, erm, which we then have to go to a pre-panel for. You know and we talked about this before and it’s a bit unjust us having to take patients who are end of life and we’ve cared for, you know, to a panel , because you know that is because of the dying process, their bodies are shutting down and they are going to develop those sort of marks on their body, but as of yet we still have to go to stick up for ourselves in the panel unfortunately.

1: And in those circumstances sometimes it’s the relatives that **(don't)??** want their relative to be turned so we have to be careful with documentation in that instance

5: And also at the end of someone’s life, you know, we’re there to look after that patient and care for them, it’s not about us trying to cover our own backs by moving patients when actually they’re pain free, they’re comfortable, they’ve got their family with them. Why would you want to cause stress to the patient, to their family at a very difficult time purely so that we don't get into trouble from having a grade four pressure sore, it’s very difficult, it’s a bit of a moral dilemma

3: I think from us as health care professionals we are trying to update all the information knowledge regarding pressure ulcer, how to stage them as a grade, how to grade them and when we’re uncertain we always share all the information within the team regarding the wound care plans, the dressings or any other advice or equipment we can supply to the patient and I think that sharing that information, we do have a link nurse to attend at tissue viability meetings regularly and every time she comes back she will feed back to us the latest information she heard from the meeting and she always asks. Every time there is always something new from that meeting.

1: And also our handovers that we have as 2 mentioned erm, if somebody’s not sure about something we’ll ask you know. It’s like oh not sure quite what to do with this because they don't want this and that then, you know, people’s knowledge and someone will say well have you tried that and you’re like no, I’ll give that a go. We also ring up the joint equipment services if we’re not quite sure what equipment to order or if somebody’s completely refusing to use something, is there an alternative that we could put into place.

5: We also we all have a camera so obviously with consent we can photograph a wound, a pressure sore, so obviously that’s a good record for us to keep and we can upload that to our system so that is something that we can refer to and we will do that regularly obviously to see if there’s improvement or deterioration and we also have for our wound care plan, that’s updated weekly or if we change a care plan then it’s updated earlier than that and we take measurements of wounds as well so we can all monitor, we can all see if there’s improvement or deterioration, the documentation is obviously very important part of our job, very time consuming but important.

3: You’re talking about our care as a continuity

6: Team work is really important isn’t is, really important, that’s when you feel it, when you come back and you think I just don't know what to do with this. This isn’t getting better or this isn’t working and you've got someone who says I’ve seen something before or can get something out and say let’s try this.

1: Also if you’re worried at the patients house, you know, call someone. If you think argh, I can’t do anything, you've got to ring, that's what we’re here for

5: I will do joint visits as well, go out and do visits together, cause we’re all kind of at different stages, you've got someone who’s newly qualified [laughter] so it’s about supporting each other basically, so we do the best we can to, but we are a team and as I said we have our daily handovers and we use that as an opportunity to talk about anything that we’re concerned about and share our knowledge.

6: They are always there, they’re always supportive, everybody, whoever I call they’re always there aren’t they.

All: [laughter]

6: I could chat quite a lot I think [laughter]. I had to call xx this morning to ask where there was a house, I couldn't find it, I couldn't find it. I knew xx had been there before. They’re always there on the end of the phone.

22:08

LS: So your team is nurses?

All: Yes

LS: So, do physios in the teams come into pressure ulcer prevention and treatment?

1: They do, yeah, we don't work directly with them, but we can certainly refer via our single point of access, erm, but yeah we do work, you know err, or we do seek advice, somebody may say maybe we’ll try physios or OTs and we’re like oh yeah. They would then go and assess and see whether they can help

5: You can just ring them as well, we know them quite well, we do work…

1: More OTs

5: Yeah more OTs, so we can ring them and just ask their advice and do joint visits

3: And the physio team leader, she comes pretty much most of Monday afternoons and is just popping into our office and asking us if there are any patients we are concerned about so she could have a look to be active and approachable to us

5: We don't work in the same building but we do work closely so even though they’re not here it’s easy for us to get access to that service, obviously we would discuss it with the patient first, you know, sometimes you have to make that decision in the patient’s best interests, but we would discuss a referral to OTs or physios, so…

LS: So, who’s responsibilities are pressure ulcers?

1/5: They’re everyones

1: I think and also it’s not just health care professionals I think it’s the patients as well, you know, in some circumstances sometimes it’s unav – it is unavoidable as we were discussing end of life, erm and with regard to sort of offering equipment people are just so no, no, no, no it’s difficult so I think some of it is down to the patient as well, and carers, and family members, everyone’s really including us, because there’s only so much we can offer and give advice and people don't want to listen or don't take it there’s not really a lot we can do.

5: It’s about education. If we give them that advice and that knowledge we’re sharing that with them and also giving them a leaflet so there’s something actually tangible they can look at, erm…

1: It’s what they choose to do with it

5: It’s what they choose to do with it, basically, and I think everybody, when you’re talking to a patient and you actually discuss, I mean, pressure sore, they might not even really know what that is, so they don't really know what that is…

6: Yeah, so today the young lady who’d had a car accident it’s never crossed her mind before with things like that, and when I left her the leaflet she said you know what I’m actually going to read this, I am going to read this and actually I’m going to get my husband because again we talked about cream, erm and I said I can get you some cream and she said okay I’ll get my husband to do that and he, they both sort of look at each other, quite surprised that she might even have a potential pressure sore, you know she said it’s for old people isn’t it, well no you’ve been lying around for a little while so yeah he’s going to be creaming her feet in future and she’s going to be reading her leaflet to him [laughter] so she’s very aware now

5: If you explain to a patient that actually they can be very nasty, painful and take a long time to heal, in some cases, you know we had a gentleman who was quite non-compliant, erm, had developed quite a nasty sore on his bottom and it wasn't really until we showed him a picture of it that I think he realised actually how bad it was and then he did start to comply a bit more with what we were asking him to do and it has, I think it’s almost healed now, but I think in some cases they don't want to know, but obviously you have to treat each patient as an individual, you know how you can be with certain patients, but yeah it’s about education and trying to work, building that rapport up with the patient so that they have trust in you, obviously then you can build that relationship and hopefully we can support them and reduce their risk of getting these things, but it isn’t always the case, but we try.

3: For that particular patient really is that we had all the inputs from community nursing team, physio, occupational health, even doctor had been to the patient to discuss with him and explain to him how serious the condition was then, He declined for everything and until I think we took the picture and showed him he understands, err, how bad that was. I think that was sort part of his medication procedure for him.

1: The reality of it

3: Yeah

1: …actually if don't know anything about it, you know ignorance is bliss sometimes

5: You’re not likely to see things like that, I mean obviously for us you know we see these awful wounds and that to anyone else they don't know really what a pressure sore even looks like so I think if you show them a picture of a very nasty grade 4 pressure sore on their bottom I think that might shock them into perhaps taking it a bit more seriously and letting us help them.

4: It's training as well isn’t is, you know if you don't have the right training like the carers sometimes, they’re not trained to do, to check pressure areas and that’s why our updates are always important, you know yearly updates.

LS: Yearly updates?

4: Most of, all of our training is, erm well most of it is mandatory, that’s yearly so that’s the individual, each one of us have got to take responsibility to get that completed.

LS: That’s focused on pressure ulcers?

4: Well it’s for manual handling, patient handling, you know all the basic life support and that’s all mandatory, but we’ve got to make sure we’ve got all green lights.

5: Yes you do [all: laughter]

3: That's in the trust, in the bigger umbrella, but for those individuals especially the care agency that are providing the care for those elderly vulnerable people or their families they have not always necessarily got the information and knowledge, some company, care companies will try to get some training to the carers but when we approach the patient or have a joint visit with the carers they actually their knowledge regarding the pressure ulcer is hardly there and they do concern the care they are giving to patients that care for them but they not always can give to them because they are lacking of the knowledge, not they haven’t got enough knowledge from their company, erm, yeah I don't know.

4: I think it is getting better though. I think care agencies are, I think it’s compulsory now that they have to have some training or most of them

30:00

5: I think they’re under a lot of pressure like everybody is with time, how busy they are, erm, you know it’s difficult for us, you know, you’re going to do a blood test but in that visit for which you've been given 15 minutes for, you have to check their pressure areas. It’s never, as we laugh about it, it’s never just a quick bloods you know, there’s a lot we have to do and I think for carers it’s the same thing they might only have half an hour and they’ve got to in that time provide personal care, erm, prepare meals, maybe assist with feeding, maybe change the bed linen whatever so actually to them maybe, not saying it’s right, but perhaps thoroughly checking pressure areas isn’t their priority, it’s the thing they can miss..

4: But it should be though really shouldn't it, it should be part of their everyday

5: Yeah, but I don't think they get given long enough, you know they only get given half an hour and that’s not long enough to do all of the things that are expected of them so, you know, it’s easy for us to say oh the carer is the main person involved in that patient’s care so it's their fault, but looking at the bigger picture it’s not exactly all their fault because they just don't have the time like everybody else.

1: Well, just as we can’t visit them every day, you know, so…

5: It’s just trying the best you can working together really and we do, we do work alongside some of the care agencies are pretty good. There’s a few new ones now isn’t there. We are quite fortunate that there is some good care agencies that work in this area and their documentation is pretty good and I think they do provide the training on pressure area care.

4: But it’s all down to money isn’t it in the end, it’s all down to money

5: Yeah, they’re struggling to recruit people, you know maybe there’s people going into these jobs that don't have that sort of carers, those carer skills and knowledge, erm, but we do offer some carer training, we’re happy to meet with carers, erm again it’s difficult time sometimes, err, we arrange a joint visit and then they’ve already left or they haven’t arrived or they’re late and we can’t hang around for an hour waiting for carers you know we do our best to try and, to do joint visits with them, but it’s not always possible, but we have to really rely quite heavily on the carers, because they are the ones that are going in everyday, potentially they’re going in three times a day so you’d like to think you can put that into their hands that they can contact us if there is a problem and then obviously we will go into assess it, but in the main it works pretty well, carers do contact us, they don't necessarily have it right, they’ll say it’s a pressure sore when it isn’t, but as 1 said sometimes they say that because they know that we will go in quicker.

1: And maybe to them though it’s a sore area that they've just labelled as a pressure sore

5: Mmm [agreeing]. I think everyone’s frightened about pressure sores, I think it’s something that is drilled into us, you know pressure sores must, patients mustn’t get them, we’ve got to do everything we can to prevent them and …

1: It’ll be all your fault…

5: …all your fault, you know with our documentation it’s all about, half of it is about what we’ve done with regards to pressure area care. That’s probably most of our documentation and if we get, we have to go to a pre-panel then we obviously get interrogated they’re all the things that they’re looking for and they'll want to know why we haven’t done, why we haven’t documented pressure areas examined because obviously as you know if you did it and you didn't document it, it didn't happen so, we’ve had it drilled into us enough that I think we’re all pretty good at doing it.

LS: Is there any area where you think it could be improved, the care you give?

1: Well ideally yes it could always be improved we could have more checks being done…

5: More nurses

1: but it would require more nurses, so that would be great to go around checking pressure areas to make doubly sure they are intact, but you’d need a much bigger work force to do that so hence we rely on carers a lot to feedback information and then of course we’d go and check it out, but erm yeah I think that’s really the only thing I think we could improve on as we do a really good job.

5: I think our communication is good. I think our our, it’s easy for us to communicate as you say with other members of the MDT so we can get hold of OTs really easily, physios erm, it’s not difficult to get hold of the care agency. I think communication wise I don't really feel there are barriers for us erm with equipment I don't think really there’s too much problem with that. We can order equipment quite easily erm as 1 said we can get occupational therapy and they can also get equipment for us. I think like again it’s down to numbers, there’s not enough of us to , in an ideal world yes we could go in several times a week, but we can’t there’s not enough of us.

1: And also it is the compliance of the patient a lot of the time as well, so

5: And families, sometimes families can make our job quite difficult by refusing things

3: Especially ex-nurses

5: Oh yeah, they’re the worst aren’t they [all: laughter]

1: But I don't, I don't think as a team and what protocols and things we’ve got in place I don't think we can be doing any more than what we’re doing at the moment, only to be checking them more that we need a much bigger workforce

3: But I think as a team we we are quite overstretched with what we’re having to give to the patients, all the advice and the care we’re giving that sometimes I think from the hospitals, just before they discharge patients they could issue a report or refer patients more accurately

1: That's true

3: rather having the problems, not mentioning the pressure sore at all or on their referral until that’s been left until long after and the relative reported oh the patient came out with a pressure sore, waiting for district nurses to check them out, but actually we never received a referral or the referral has never even mentioned about the pressure sore, which says that communication only for measure sharing was not accurate or up to date delayed the wound healing

1: But that again that just you know goes onto the subject of the NHS being short staffed, you know obviously the hospitals are stretched as well and things don't get done do they.

3: It is but it is also their responsibility, it’s everybody’s responsibility so they could take a bit more on, passing the information right to us straight away.

5: I’d say quite a large amount of our pressure sores are patients have been discharged from hospital with them, erm and obviously if we see that person for the first time admitting them onto our caseload, so we would report that as a pressure sore that was present on admission to caseload, when then also have to notify the discharging ward and their risk team say leave a note at the hospital that they have discharged somebody into the community, into our care with a pressure sore. Again it’s about people taking responsibility isn’t it so that is part of our process as well so we have to report that.

1: We wouldn't have to go to a panel with somebody who came out with a grade 3 or 4 pressure sore from hospital thank goodness

5: Mmm [agreeing], we’d be there all the time [all: laughter]

1: We wouldn't get any work done

LS: So what I hear you say is that prevention is more in the forefront of your care than treatment, is that correct?

All: Yeah, definitely

LS: Do you think that’s the same compared to other teams that work around you?

1: I think probably everyone is keen

2: Yeah, everyone sort of tries don't they

1: I think it's the trusts sort of just know. It’s the trust views, we obviously second that and support it and absolutely prevention is better than cure and we drum it into our patients as well when offering preventative equipment or creams or things like that we’re always saying prevention’s better than cure.

5: I think it is identified though that where there is area where maybe there is a problem with staffing one of the first thing that’s noticed is that the rate of pressure sores goes up, erm, I think that’s quite evident that that happens with a lack of community nurses, lack of staff that that is the first thing they notice. That and staff sickness, but I think the rate of pressure sores goes up quite a lot so I think there is an area within the north east that, there is an area which I believe they have a lot of pressure sores at the moment because they’re having problems in that area with staffing and I think that’s probably why, not going out and monitoring the skin. You know we’re fortunate that we have three surgeries that we look after we don't have a particularly large area so we are very busy, but I think we know our patients quite well, erm, we know the ones that we probably have to concentrate on a bit more, erm, so I think we’re quite fortunate.

1: But I think as 4 said some of the care agencies are brilliant and actually you can rely on them to let us know. Some of them are brilliant aren’t they, oh we’re a bit concerned about this would you mind coming out? Yeah no problem, and we’ll come and do it won’t we. It’s just to try and pick them up

4: I think if you have good communication skills with them they’ll, you build up a rapport with them, they’re very good and it’s down to training again…and money

5: Pressure sores cost the NHS a lot of money, in the community we are looking after patients who are vulnerable, have chronic conditions, life limiting conditions so it’s a challenge for us looking after people like that and we’re having to look at obviously the whole patient, to look at their nutrition because obviously that’s a big part of obviously wound healing so you know we do meet patients, we have patients that don't eat very well so your alarm bells are going to start ringing with somebody like that that they’re particularly vulnerable to developing a pressure sore and most of our patients are like that [laughter].

LS: And do you then bring in a dietician or is it something that…?

5: We speak to the GP, we can give nutritional advice, we would develop a care plan geared around nutrition, we can talk to the GP about perhaps prescribing fortified drinks. They’re not always too keen to do that because those sort of things are expensive , erm and then yes we can ask the GP if perhaps they could be referred to a dietician/nutritionist yeah

1: But there isn’t a community dietician

5: No

1: That’s one thing that could be really useful, you know somebody who was based at the hospital who could do home visits because it could be really beneficial to give patients a specific plan because we don't know, you know.

5: Again, we can only give advice

1/2: Yeah

1: I mean obviously the fortified diet we will encourage but that's really our limit, you know

5: We’re not experts in that area. We can monitor weight and things like that, but it’s not really our area really is it so

6: There’s lots of people who don't connect nutrition and hydration with skin integrity or any of their wound healing or anything, anything with being well. They don't sort of quite get it

5: Smoking as well you know, drinking

4: It’s like drinking isn’t it, a lot of the elderly population may have a drink at breakfast, they might have mid-morning drinking, drink at lunch, afternoon tea, then dinner and that's it, they won’t think to drink between those times and that's, we have quite a problem, especially if they've got a catheter in to try and push fluids, they think oh no, but it’s just that generation, drink at set times

3: Cause you don't then wake up and have all the necessary knowledge from healthcare professional care staff so we’re not necessary to give all the information to the patient sometimes we actually rely on google [all: laughter]. I mean I’ve done it before, pass the information to the relative, but they possibly have done a similar thing already. It’s just some of the things that we could try, possibly that would help us in some knowledge wise before we have a dietician going into the area.

LS: So, that’s about nutrition. I think one of the big problems with pressure ulcers is mobility. Do you call in an OT or a physiotherapist to make a plan or, can you tell me a bit more about that?

2: We would refer, if there are any concerns at all we can refer to those departments and like you said they do joint visits, erm, quite good communication, we also, our system Rio where we do our progress notes, the physios, can the OTs do it?

5: Yeah

2: They can write on there as well

5: They, we can access each other’s sort of visit information, but I also think we, us as ourselves, we have quite a lot of knowledge in that area. I mean sometimes we don't need to get OTs involved because, we’re not OTs, but we have that knowledge, so sometimes we don't need to speak to them, we can think about what equipment’s needed.

2: We’ve got the knowledge

5: Yeah, erm we can order equipment, we know how it works, we can give that advice so it’s not always necessary, but we, it’s easy for us to do

1: As we said earlier I think the OTs get involved if we are facing barriers really, erm as 5 says we can order equipment, but sometimes OTs can order specialist equipment which may be a bit more, you know, a certain patient, for that specific patient that’ll be so much easier to use that specific piece of equipment over other patients which might find a standard one, so that’s where we’d really refer wouldn't we

5: And they do sometimes come up with equipment that I’ve never seen before or heard of before so

6: And also a lot of the nursing care agency won't go into a patient unless they’ve got the right equipment they need. A bed, you know they've got a profiling bed, a lot of them will refuse to nurse that patient if the equipment’s not right.

3: I think for us as we are sharing the same software so we have the information sharing between us and the OT and physio so they could check our progress notes really about a patient’s skin integrity if there was any further assessment needed so an unnecessary visit or assessment could be avoided or and the wheels are…yeah that’s how they do it to share the right information. Potentially we’re going the share the information with surgeries regarding how that kind of thing can help, regarding sharing the information.

LS: Do you also discuss this information in multidisciplinary teams? So if you have, officially you’re doing handovers you know about each other’s caseload, you bring an OT in and you bring a physio in, do you then discuss the patient for pressure ulcer prevention?

5: Well, we our daily handover that is just ourselves, erm, I think where there is a problem we will organise an MDT meeting, it’s not something that we regularly have, but I think when we have a patient that is identified as having input from different disciplines then an MDT will be arranged for that individual, but it’s not something that we just do routinely no. I think it’s beneficial, I mean, a patient recently we had to have an MDT for this patient and it is useful because I think it’s, one, it’s supporting each other and it’s quite good to share your ideas.

6: But you have the weekly meeting

5: Yeah but that's not, that's different, we have weekly integrated care team meetings which are held here every Monday, but they are not geared around pressure sores, they’re patients that identified as having …

1: That's more hospital admission avoidance

5: Yeah, so that's more hospital admission avoidance so they’re not just normal MDT meetings, we don't do those routinely unless there is somebody identified as particularly needing that

1: The MDT meetings we usually then get social services involved and all the other

5: Somebody from the care agency

LS: Do you think it could be beneficial if you have more MDT meetings? I’m just looking at your opinions about MDT and how often?

5: I think, do you know what, it’s too, it’s time consuming to make that time to have regular, you know we all go to enough meetings on top of our documentation we have to do, our care plans, our assessments, seeing the patients, I think it would be…, I don't think it would work very well.

1: It would hinder patient care if we had to do more MDT meetings a hell of a lot

5: I think we know if it’s really necessary we can organise it and I think that’s appropriate enough. I don't think we need to. I don't believe that patient care is being compromised because we don't have them. So we have good relationships with all these other people, erm, we know them well so I don't, you can just ring them, ring an OT and say can you just give me some advice I don't think you really need to arrange anything formal to be able to sort of get to have support or knowledge from somebody else.

6: Once you’re in the patient’s house with a group of people and the family and the patient, yeah it can, everybody’s got an input, everyone’s got something to say, you’re there for a very long time. Sometimes you just don't think you've achieved a great deal, you come out thinking that was a whole afternoon out sitting there. It wasn't much as you say a direct phone call would have been, might have been more..

2: I think also having the, if you was to have the regular meeting some, it’s not appropriate for a lot of the patients we see do listen to what you say, do take on board and get the equipment in so there’s no real benefit to sitting round discussing those patients

5: Yeah, I don't think there’s a high rate of patients that are problematic. We’re going in and saying, giving out all our advice and they’re ignoring it all. We come across those occasionally, but it’s not in the main at all

1: They’re the minority really aren’t they

5: They really are the minority and where there are patients where we have identified patients like that there have been MDT meetings, erm so I think it’s just about us using our judgement really which I think we’re all skilled and knowledgeable enough to do that.

LS: So one of the previous interviews it became clear that some physios and some OTs don't find it their responsibility to take care of pressure ulcers to maybe think in terms of prevention. Do you encounter that attitude amongst the colleagues you work with?

5: I think it’s seen as more of our job, I think it’s seen more as a community nurses role but I think everyone’s got responsibility, should take ownership of that. I think probably the OTs more than the physios I would say

1: Yeah

5: I think physios will go in there when there’s issues with mobility. I don't think they’re probably too concerned with pressure areas, erm, but that’s probably because they know that we do such a good job you see, but I think it should be everybody’s responsibility, but I don't think they probably see that.

LS: Are there any other important issues around pressure ulcers that we haven’t talked about that we missed that you really want to bring to the table?

3: Possibly in the public setting people can share the knowledge that they, that basic knowledge of pressure ulcers rather than we have to get into the patients home and tell them when they are actually at the edge can easily develop a pressure sore and it’s like any other chronic disease most people were already aware of that in public.

4: It’s education isn’t it

3: Education for the public

1: If you’re fit, healthy, mobilising it probably wouldn’t be retained all that information

5: I think they’re probably better now than they were, you know I think people are more aware now whereas probably however many years ago they were probably rife, pressure sores, but they weren’t called pressure sores

5/1: Bed sores

4: It’s amazing how everyone associates pressure sores with the elderly, but that’s not the case anyway, you know

1: for people who have had an unfortunate accident or they were born with physical disabilities and then the young can still get pressure sores, yeah we do try and educate as much as we can but it is not, unfortunately it’s not something that would kind of need to be publically spoken about because it isn’t really that common, it’s not an epidemic.

4: I think if you actually look at our caseload we probably haven’t got that many that are actually, we probably haven’t got that many pressure sores actually on our caseload and the ones we have got are ones that patients have come out of hospital with, so I think we’re, we’ve, we don't have to go to pre-panel that often and I think that the last few times we’ve been they’ve been all unavoidable. I don't think we’ve had an avoidable one have we. We’ve got to take one next week and pretty confident that will be unavoidable as well

1: Oh I think it was

5: I’m pretty sure it was, but I don't think they’re, erm, I don't think we’ve got a lot of them to be honest. It’s the education is a big part of our job, but actually I think treating them I don't think we actually a lot of them. I think it’s more about actually it’s the fear that is put into us about pressure sores

1: Yeah

6: Collectively we worry about them

5: We worry about it as a team

1: Yeah, we seem to have a lot of conversations about [them], but when you do stop to think about the amount on our caseload…

5: There isn’t

1: There really isn’t

6: And when you think every visit we have to ask, some of the patients say No, before you ask, no my bottom’s fine

5: Sometimes I do think it’s too much, I think, you know we do have patients that we see every day

1: Or that come up to the IV clinic

5: And you’re asking someone that’s really mobile, eating really well, is your bottom sore and they look at you like…

4: You’re sort of apologising for asking these questions, but then I’m, sorry

1: But also I think we’re taking away some of the responsibility from the patient, the people who are able, you think…

5: You’d like to think they can tell us if there bottom is feeling sore

1: …because we’re almost bordering on nagging people about their bottoms or pressure areas you know, it’s becoming a little bit of a hindrance I think in our practice, but we, it’s just what we do now

4: But if they've got capacity you've got to remember that you know if they say, you say can I check your pressure areas and they say no then you've got to say okay, you know they've got mental capacity to make those decisions.

5: You need to document that

4: Yeah

4: We just have to write a really long progress note just to really back up the fact they said no [laughter]

1: [joking] You have a half an hour document

5: [joking] I only went in for a blood [all: laughter]

4: But you have a team working don't you, I really, really don't want any pressure sores

5: The other thing we do is if we are just doing a one off blood, we will discharge that patient, we don't want patients sitting on our caseload that are not being seen fairly regularly because obviously if they get a pressure sore it will show that they were on our caseload even though we weren’t seeing them so we’re all quite careful that if we’re not seeing someone regularly and there is no obvious nursing needs then we discharge them. It’s all about protecting ourselves unfortunately.

LS:xxxxx, xxxx, Is there anything that we missed out on?

PW: You said that when you go to panel they’re often unavoidable. You talk about concordance but is that the main reason they’re unavoidable.

1: No a lot of it is silly little things like erm somebody didn't check something, in fact one of them, it was deemed avoidable, it’s a long, long time ago

5: No we’re talking about unavoidable

1: Oh, unavoidable…

5: It’s usually non-compliance

1: Or erm deterioration, a general deterioration in the patient, erm, such as end of life, you know

PW: Yeah, I mean if compliance is a big issue…

5: It is yeah

PW: …how can we change compliance?

2: I don't think you always can though,

1: I think we can only educate as much as we can

2: … especially at the end of life patients, especially if the family don't want you to be moving and turning.

5: we’ve had issues with this when it’s an end of life patient and you know we have gone into patients who are within their last couple of days of life and we’ve gone into turn that patient and actually there are nurses that have had the family screaming and shouting at them all the names under the sun because they don't want you to move their mum or their dad and do you know what

1: And it’s really difficult because you do think

5: …they’re bothered about them being comfortable and pain and they don't want you moving them and I agree with that

1: I agree

LS: So the non-compliance is mostly at end of life or is that?

1: Not always…

5: No

1: …sometimes you get very opinionated patients that just do not want that thank you very much

5: …and they won’t use the equipment, they won’t let you get the equipment, they won’t use it and when you say you need to be on bed rest they won’t do it, erm, you sometimes have families of the patient that are very difficult to deal with you know, refusing to let you in the house or refusing to let you do anything, they’re the sort of barriers that we come up against and you know we cannot make people do things you know and that’s, so, as I say most of us, actually the only ones I can think of have always been unavoidable with our, in our team, haven’t they.

1: We had one avoidable

5: Which was a long time ago I think

1: …a long time ago and that was about capacity, so since then we always

5: You document capacity

1: It’s become a big thing about capacity

5: Every visit

1: Because it could change, could change especially towards the end of life, people are having end of life medication, one yesterday they might have said oh yes that’s fine you can check that, but the next day they might be completely sedated in which case they can’t so…

5: That's very difficult then because we have had that situation and then we are told you have to work in the patient’s best interests, but when you've got a son standing in front of you don't you this that and the other touch my mum, it’s very difficult and sometimes, you know he’s not angry at us particularly, he’s angry that his mum’s dying and why are we there to make that worse because we’re not you know. I think our idea as nurses, that caring thing, will overrule the need to go in and turn someone so they don't get a pressure sore. I probably shouldn't say that but …

1: …but I think that…

6: …we’re all human aren’t we

5: Yeah, it’s about dignity and yeah

6: you put yourself in that position as well…and sometimes they’re aware that you’re having to do this to cover yourself. They know that you’re having to…

5: Just don't tell them that

6: No, no, but they’ll point it out won’t they and they’ll you know. I know you've got to do this and that

5: They don't want to hear you saying that

6: No, I wouldn't say it, but they’re aware, they know and they have said I know this is part of what you have to do, but I don't want you to do it and I know you have to do it and I know you have to write your notes about it but I don't want you to.

5: And I think at the end of life that is the natural process, it’s the body shutting down and they are going to develop these purple, blue, black areas on their body that is their body shutting down and that's when we have a, you know, we don't like the fact that we have to take these to pre-panel, it’s not, I don't think it’s right at all

1: We should try and highlight that

5: We have sort of haven’t we, that is the natural process of dying

PW: You said with one patient you used a shock tactic, took a picture, do you think with the non-compliers we need a bit more shock tactics? Showing them pictures of pressure ulcers because at the moment the information doesn't include that, am I right in thinking that?

1: Yeah I think it’s very patient specific to maybe go down that role

2: You just sort of know don't you

4: Maybe on those pressure ulcer leaflets there could be more pictures on them

5: What, a really gruesome…

4: Well a grade 1, maybe a grade 1 to 4 as we have pictures up

1: We still have to keep these relationships going with these people as well, you don't want to just shock them and then them not even have you in the house with them for anything else. Be useful for photographs on leaflet though, that’s a really good idea

5: Cause it means nothing if you say to a patient you’ve got a grade 4 pressure sore….so

4: If they got a leaflet that they could read in their own time you think okay that’s a one, that’s a two, oh that's a, that’s not very good

5: There are, you know, we have patients that are for this particular gentleman he didn't have sensation so he couldn't feel. He had no pain from that whereas anyone else if you have a grade 4 pressure sore you’d be in a lot of pain, but he didn't feel it and he was bed bound anyway because this gentleman had MS and it wasn't affecting his life because he was in bed anyway most of the time, but he was non-compliant with that he would be hoisted into a wheelchair and would sit in a wheelchair for hours and hours against advice and that’s probably contributed towards him developing this sore, erm, but it wasn't until. We actually said to him a couple of times, do you want to see what it looks like and he said no, erm, and it got to the point where we were actually so concerned about it we spoke to the GP about him actually going to hospital because then he would be in bed, erm, eventually he did

1: Eventually he agreed to that

5: Eventually he agreed to go to hospital

4: Even those charts we’re given, you look at a grade 4 pressure and we all go oooh god, you know, but I think that’s a good idea so a patient can see what a grade 4 is, they’ll think oh god I don't want that to happen and we will make them

5: Yeah I think just knowing what these things look like actually probably would make a difference. I think if they’re shown actually if you don't maybe listen to us, let us get you this equipment potentially you could end up with this. This is what, this is you know when they’re at the grade one, grade two stage you can say this is where it’s going and sometimes you do have to actually be quite firm, but you have to maintain relationships

4: You have to be cruel to be kind

6: And when you think about the smoking aspect now and how many shock tactics they use now with smokers, some of those are quite gruesome aren’t they

4: Yeah

1: With packets and everything

6: Yeah, so maybe it’s time people did just see a few photographs of what might happen

5: You know we’re not here to tell people what to do, that's not our job, you know, people are, obviously with capacity, are able to live their life how they want to live it and you know I do really believe that that isn’t our job, we’re not here to tell people what to do, just educate and guide them and offer support, not to read the riot act. Am I using a big word?

4: Education

5: Education, we’re not here to judge, not here to judge are we, we’re here to just…

PW: We’ve asked a lot of people what happens after it goes to panel so they’ll be an RCA, what do you guys gain from RCAs?

5: I’m doing one at the moment actually, erm, I don't think it changes our practice at the moment because I think all the things. I mean for the one I’m actually doing at the moment I’m really confident from reading everybody’s notes from each visit that we are doing the things we should be doing. I think probably a couple of years ago it raised okay maybe we’re not always documenting mental capacity, maybe we’re not always documenting that we’re examining pressure areas, erm, and if patients are declining we’re not documenting that so I think things have changed but I think as we are at the moment I think we’re doing okay actually, but of course there is learning to come out of these things all the time, we have to say there is learning [laughs].

PW: You say that you’re doing things you should be, but what guidelines do you work by? Are they trust, are they national, what do you work by?

5: They are trust, yeah trust guidelines. Sometimes they’re a little bit wishy-washy as in we thing we’re doing the right thing and then they’ll randomly come out with well actually you need to do it this way, with our documentation haven’t they, they’ve changed the goal posts a couple of times, like with the intentional rounding and we’ve actually got a crib sheet now for every visit.

1: You've got to follow what the crib sheet says really

5: [showing crib sheet] yeah for our documentation, but they’re all the things that we have to mention

1: But that could just be going in for somebody

5: For a blood

1: Blood, to do a blood pressure even

5: Yeah

PW: Are you aware of other national or international guidelines for pressure ulcer prevention and treatment?

All: Not really

LS: As we’ve almost come for the full hour now, Paul could you maybe summarise to let us know what you heard?

PC:

* Discharge from acute care, many PU start there, fewer community acquired
* Compliance of patient, Carers because of a lack of time and staffing are really your eyes and ears, hoping that they will provide that feedback into the team if and when they see something
* Much more focused on prevention and preventing the ulcers rather than actually managing them based on your caseload now as it stands, you’re doing much less dressing of ulcers so the focus naturally moves onto the prevention
* Reporting fear factor of going into that process, sometimes it can feel a bit like an interrogation of your day to day practice when somebody wasn't necessarily there on that day to day. Root cause analysis as you are at the moment doesn't necessarily lead to sustainable change at this moment in time
* MDT, the role of OT, how you refer to OT or physio or other professionals either through a referral or just a phone call for a quick question. Often OT referral as they have access to different types of equipment, more specialist equipment. Didn't feel there was necessarily a need for MDT meeting in a formal setting because it works currently as it is
* Time and staffing barriers
* Responsibility held within every healthcare professional, but also there’s a responsibility with the patient and with family and carers, so everybody who surrounds that patient
* Training and education the main need so everybody knows what they’re doing
* Communication and equipment not barriers to practice, you can get hold of people and chat to them if you need to rather than there being a formalised process
* You can get equipment in a timely manner
* Talked about the whole patient approach and looking at nutrition, smoking, drinking and some of these other factors that surround the patient that might not be necessarily what you are initially in there to see the patient for
* Public education, people a little more aware now than they would have been previously