Tissue Viability Nurse Interview 1

LS: Could you tell us a little bit about your role in pressure ulcer prevention and treatment in the community?

TVN: Erm, my role is to act as an educator, an advisor, erm and then I get involved to give that treatment and guidance when they have got pressure ulcers. Sometimes I get involved with some of the more complex patients and those patients we tend to, but its an MDT approach. I’ve usually been pulled in by an OT, physio to problem solve with those really complex patients.

LS: So the OT and the physio pull you in?

TVN: Yeah

LS: Not the nurse

TVN: Not always, very often when it’s really complex I’m pulled in by the therapists

LS: But then there is already a…

TVN: The nurse is already involved, yeah, the nurse is generally involved with managing the wound, erm, and then because it’s so complex I tend to get involved because of the posture management side of it as well and equipment.

LS: Okay, and not so much about dressing the wound or?

TVN: Sometimes, but that, but they, the nurses would refer that to me, but nine times out of ten the nurses are actually okay about that, they’ve sort of got that

LS: So their knowledge is up to speed?

TVN: Yeah mostly, that’s a sweeping statement to say all of them but erm yeah. We might have the discussions because we’ve got live line. So sometimes we have those discussions over the phone

LS: And live line is?

TVN: It’s an advice line for health professionals erm in the community and AHPs, GPs, we have practice nurses phone. Nursing homes try to phone, but we don't give advice anymore, that’s another issue

LS: Okay

TVN: They have to send a referral in and we triage their referrals, erm too many language problems

LS: Okay, erm language in…you mean they don't speak English or language…

TVN: Their language is poor, they’re not understanding us, then we’re not understanding them and when you’re just trying to have a conversation over the phone everything to them is quite bad and then when we get a referral and we see a picture it is not what we were, what the discussion was

LS: Okay, yeah

TVN: So the safest way is to have written referral, photographs, a medical summary for them and then we give advice

LS: Yes okay

TVN: Erm, but yeah, because we’ve got rio now and the nurses or therapists upload photographs we have that dialogue, quite often virtually, and we can give advice. Well, you know, this patient needs some larvae or I think TMP would be suitable or whatever.

LS: And is your advice mainly on treatment or also on prevention?

TVN: Both

LS: Both

TVN: Yeah

LS: So…

TVN: But they call us less on prevention, much less, because they seem to think they’ve got that

LS: Okay

TVN:…they seem to think they’ve got that, that isn’t my opinion

LS: So where do you think it goes wrong, prevention wise?

TVN: Erm, they all acknowledge the fact and they’ve done so much training about the fact that every single one on their caseload is at risk so they need a prevention plan in place from the word go, but they seem to miss that bit out, right at the very, very beginning, because they’re so focused on the task maybe or why they’ve been referred and that sort of comes along. They’re getting very good at doing assessments, risk assessments, skin assessments, erm, but not always following through to that next bit to put the interventions into place to prevent there being a problem.

LS: Yes, and do you, I assume you educate?

TVN: Yeah, we do lots and lots and lots of erm education, we, well we do bespoke training as and when teams need it. We also run the programme at xxxxx equipment service.

LS: I’m new to, so please tell me that?

TVN: Okay, so it’s pressure ulcer prevention and management and we run the morning part of the session talking about how pressure ulcers are formed, risk assessments, grading, we focus on, we don't cover that much about how to manage them. That sort of comes later, but it is all about prevention, erm, things they can do. We look at a patient’s perspective erm regarding that with, we’ve just developed, well I’m, myself and [another TVN] have been developing an e-learning package that will run alongside that at the moment that reflects our guidelines, so everything should be saying the same thing.

LS: Okay, and that’s your responsibility? Responsibility for the TVNs?

TVN: We do the morning and then because our, the equipment changes so much and we’re not experts in using the equipment. The equipment service OTs run the afternoon about the cushions, the mattresses, they do some pressure mapping erm, so it’s a sort of joint…

LS: Yeah, that sounds as a valuable training for…

TVN: Yeah, it’s good. We have quite a lot of therapists who come. I think nursing homes tend to buy the training as well.

LS: And therapists you mean OTs or you mean physios?

TVN: OTs, physios, both

LS: Okay, and is there any attention for nutritional intake during the course?

TVN: Erm, we cover nutrition, but only a small part of it

LS: Okay, so the dieticians don't do it

LS: No they don't, well there isn’t any in [the trust]. That’s a bit of a lack, a lack, erm but we talk about nutrition and regarding the risk assessments they need to complete them. And we talk about, we’ve got, we did a piece of work with some dieticians, I think they were from the north, erm, [person’s name], that is her name

LS: Okay, I don't know her

TVN: Yeah, but she’s done some and we've got some handouts that we give out about fortifying foods and looking at nutrition with wound care, but for sort of self-help for patients or for carers.

LS: Okay, if I would ask you what do you think the problem is with pressure ulcers or pressure ulcer care in the community?

TVN: I don't think people are putting the prevention plans in place early enough, erm and there cou-should be sort of some education even from the practice nurses, the GPs, because those patients that are going there could have a role with educating patients while they’re still well to be aware of their skin. It’s not a sexy subject so nobody wants really to talk about it do they.

LS: Well, we know that from research

TVN: Yeah, it’s not exciting, we almost need, there almost needs to be a public campaign, but almost of a, it’s horrible, but I know there has been famous people that have had pressure ulcers, but somebody who’s quite high profile or their relative to be an ambassador and bringing it up so people are aware. More and more people are being looked after at home, more and more ill people are being looked after at home and the amount of patients that we are looking after that are well over sort of 95 now is quite high, whereas when I started my training I would never, I never saw patients that old. So, are living a lot longer, we need that education right at the word go and everyone to know, but I think the public have got a responsibility as well so.

LS: So what we heard a lot in the interviews is err people speak about non-concordant patients

TVN: Yeah

LS: So you say you should educate the patients more?

TVN: Yeah because, most of them, if you asked them “Do you want a pressure ulcer?” They would say “no”, but if they knew how to prevent it, but people don't know about it so they only know if they’ve had a bad experience with a, perhaps a relative that’s been sick, erm, but if people were made more aware, people then should be looking after their own health and saying I don't want a pressure ulcer I want, I would like a piece of equipment that’s going to help me prevent it. For example people like spinal patients they’re a, once they first get their spinal injury they’re educated from the word go and they know what they’ve got to do to prevent skin damage and how to look after their skin, they use mirrors. I’m not saying that we all need to be obsessed using mirrors, but do you know what I mean, they’re educated and they don't want one so they can be quite vocal and… But if patients were saying I would like a piece of equipment to prevent this in my chair then it would…

LS: Yeah, so in an ideal world patients would co-own the issue?

TVN: Yeah, it shouldn't just be the nurse and obviously there is patients that for some reason that you don't foresee the problem, but they are maybe at risk, but nurses just aren’t seeing that they’re at risk and putting those interventions alright, but then you have the patients which is their right to say no I don't want that and to take ownership of that. Years ago, we’ve had this discussion in the office over a cup of coffee, none of use recall patients saying no, ever. Whether that’s because I’ve been around too long, patients are aware…

LS: What was the difference then?

TVN: Patients are probably more informed and they just say no, years ago we used to go in and I’m not saying that’s right, people used to say thank you sister, thank you, yes I’m listening to what you’re saying or I’ll do that, I’ll do that the nurse, the therapist said and they would do their exercises. People just have their own way, the world is slightly different, I suppose social media, we all, internet, we all know a lot more than we used to.

LS: You would expect that people would be more compliant.

TVN: Yeah, because if they’re informed, but they think it will never happen to them. It’s like why do people still smoke, everyone knows what’s going to happen, the risks if you smoke, but they still do it.

LS: So if we want to improve attention to prevention, what in your opinion would be very important drivers for that?

TVN: I don't know, erm, campaigns erm. It needs to start, all, for everyone, therapists, GPs, nurses, we all need that in our training so everyone knows this is a fundamental. Because it used to be, when I trained, it was a fundamental of nursing, erm, I’m not sure over the years. I think maybe that had dropped a little bit and I don't believe it was a fundamental of a therapists’ training…

LS/PC: No

TVN: Or in GP training

LS: No

PC: I mean within therapy training it’s purely on the basis of if you’re on a placement and you happen to see one or you happen to have a supervisor who’s interested in that area then you get some, but nothing official, no lecture or whatever…

TVN: But if it is implemented in that level it would then filter through and it would become a norm for everybody

LS: And what about the role of leadership in this?

TVN: Well that’s key because it needs to come top and bottom and the two will meet and then we feel like we’re educating, we’re producing material, we send out updates, little bite sized bits of information, but we feel we’re doing it constantly and we’re trying to be the exemplar practice and everything but it’s still. It’s improved, but it’s not there

LS: No, and do you, would you like more leadership on this subject or do you think there’s enough attention?

TVN: No, it needs, I think it needs more leadership. You’re meaning from more education or from managers or…

LS: What kind of leadership do you think is important?

TVN: Erm

LS: Or most important?

TVN: It needs to come from both, education and senior managers within the NHS. It has, years ago we used to cry out for tissue viability to be. People in management didn't even know what it was and we used to think why don't they ever notice us. Now they really notice.

LS: Yes, how come?

TVN: Because of pressure ulcers, because of the incidence the reporting is better, so I’m not saying there is more pressure ulcers, I don't know that, but reporting is better, so now it appears as if there is more pressure ulcers.

TVN: Yeah, yeah and that makes management more aware because of the society that we live in it's the litigation. There’s adverts, we’ve been sent them from patients saying have you seen this in our paper? “Have you have a pressure ulcer or a bed sore.

PC: One of the areas that came out of the focus groups around leadership was this idea of rather than top leadership if you like, you know, the local area leadership and how particularly from a therapy point of view if you had a local leader who was, thought it was the role of their team, the team would be involved in it.

TVN: Yeah, some of the, one of the, well, it used to be my team, but now we’ve just had the areas reconfigured, but my best team, I better not say where it was, but anyway, the leader there was so infectious with her pressure ulcer prevention. They had pressure ulcers but they had done every, there wasn't anything, well they’ve won a few like certificates and that for no pressure ulcers, no avoidable pressure ulcers and I know that definition is going, but they have had some occur but everything has been in place and her leadership was infectious and that carries on. She’s left now, but that’s the culture.

LS: Yeah, so she managed with her leadership, she managed to change the culture of the team, so even now she’s gone the culture’s still there.

TVN: Yeah, because they've all seen the benefit of it and so that hopefully will be there for many many years.

LS: That’s impressive

TVN: So that’s very powerful for one person, but she didn't just empower her team, her nursing team, she empowered the therapists in that area.

LS: Are there more pockets like that across the community?

TVN: Less pockets, people try erm, some teams are still coming together and still in that sort of forming stage of the relationship erm rather than the norming so it’s a work in progress. Erm, It is erm, but erm people like xxx xxxxx, she’s a physio, she’s one of the senior managers up xxxxx area. She’s sold completely with pressure ulcer prevention and, but as a therapist she’s cascading that all down to the nurses and the other therapists within her team so…

LS: Because we have heard therapists say pressure ulcer prevention is not our role

TVN: Mmm, I’ve trained some of the teams for bespoke training and we’ve had some walk out, said it’s not for us. No, no, no, this is for you, this is for everybody, this is everybody’s responsibility.

LS: Yeah

PC: Do you think there’s an element of those people who are doing it, those physios for example who are interested in it, erm, is it because of an interest in it. You know, is that they want to be helpful, obviously they don't want to cause a patient discomfort anyway

TVN: Harm

PC: …or do they actually see it as part of their role? Do they see that the physio, this is what I do in my role, does this fit?

TVN: I don't know, I don't know that to give an informed opinion, erm, whether they’re just conforming with what they believe is the trust’s ideal and that’s how they’re going down the party, you know towing the party line, but that they’re sort of bought into the subject that skin is everyone’s responsibility and maintaining the integrity of that is, obviously we’re not asking therapists to do complex dressings or anything but to have the right pathway.

LS: Yeah, because I firmly believe that if therapists help or see their role in improving mobility as part of pressure ulcer prevention, but do you in your education, you…

TVN: Yeah, we’re currently using the SSKINS erm sort of acronym and obviously we’re sort of focusing in on all of them about keeping the patient moving and obviously we all have a role and obviously the physios will be more of an expert in specific passive or active movements, whatever to get that patient doing it so we need them as much as, but it’s just that looking at the skin and I know some patients, quite a lot actually, refuse. I must admit that if I’d had an operation and somebody came in and said to me…I have had it, I’ve heard nurses say can I have a look at your bum…not the best thing to say really you know. Obviously they could have explained it as we need to ensure that all our patients are looking after their skin, preventing pressure ulcers, have you had a chance to have a look at the skin on your buttocks, is it sore. If they say oh I don't know, most people, unless you look in the mirror it’s hard to look at your bottom isn’t it. So, could I look, which would probably be a better thing than show us your bum.

LS: Yeah

TVN: But, if I’d had my bunions done I probably wouldn't be that keen to show somebody my bottom either.

PC: So is there an identity thing, I know we talked about public health and the patients’ perspective as well and them owning it, but if it’s a physio or an OT asking, do you think the patient then goes well hang on…

TVN: Why do you need…

PC: Do they perceive this not to be their…

TVN: Yes, but it’s peoples job what they believe a physio does, what they believe an OT does, but obviously now things have blended a bit more, but the public don't, aren’t aware of that are they so. You know nurses should be able to assess somebody for whether they need chair raisers, whatever small bits of therapist intervention they should be able to do that. I’m not sure actually all the nurses can do some of the therapist type interventions that would help.

LS: But would it be necessary for the nurses do be able to do that because I can also imagine you lose your own role identity

TVN: Because they’re all blurred, but that’s what is expected of quite a few of them and that’s right if the therapists are going in and looking at somebody’s skin. If you’re as a nurse going in and seeing that that patient needs their chair raised, needs their stick adjusting height whatever it may be that’s, I’m not saying it’s simple but it’s relatively straight forward if the nurse had those few skills to do those things it would save duplication and…

LS: It just looks more efficient

TVN: Yeah, it’s more professional, while I’m here I can do this and why shouldn't they really, but that’s again going back to training.

LS: But do you think that this part of the resistance against this, because you saying it’s going back to training, that they’re not trained for that. Could it also have something to do with role identity and…

TVN: Completely, this is my role, I’m a nurse and this is the line. I’m a physio so this is what I do. It wasn't actually a physio that walked out, it was an OT, erm and just said it’s not my role, apart from I did complain that its, apart from being rude, just to blatantly say that.

LS: Yeah, it’s not giving a good message for multidisciplinary working

TVN: No it’s not at all, erm and I know everyone’s feeling very threatened about, there’s so many things that keep coming in on a weekly basis, obviously you [to PC] work for [the trust] as well and all the things that we are bombarded with on rio and it’s hard for these guys. It almost feels like just another thing when there’s staff shortages and it’s hard for everybody but it’s still, if it became the norm it would be less difficult for everybody.

LS: So if someone develops a pressure ulcer do you think teams consider that as something major

TVN: Yeah they do

LS: or something that is horrible that it happened and they do care.

TVN: Yes

LS: And is that the same for the OT and the physios in that team?

TVN: Yeah, they’re devastated most of them. I’ve had nurses phone up because what they’re supposed to do if it’s a grade 3 or a 4 they’re supposed to phone the TVN, their TVN, erm and I’ve had nurses phone me in tears. “I cannot believe this has happened, we’ve done this, this, this and this. What else could I have done?” They’re devastated, they tend to be the ones that have been to panel a bit more and they realise some of the implications of it a bit more, but no most people are absolutely. I think when all the process first started quite a few years ago when we were actually investigating them doing panels erm I think people were taking it too lightly.

LS: But not anymore

TVN: No, there are, no have we completed care plans for risk, have we done all our intentional rounding, have we done all our assessments, erm, they’re very good. I’ve been out on visits with people with the community nurses and therapists and they’re all so good now at getting the notes, updating assessments, making sure they’ve done everything.

LS: And making sure they’ve done everything or making sure they’ve recorded?

TVN: Both

LS: Both, okay

TVN: Yeah and we’re trying to make that easier for the nurses now because I’ve just worked with rio cause the way they recorded wounds. The wound assessment function on rio didn't work. Well you could put it all on there but you could never close a wound so to the commissioners it looked like we’ve got thousands and thousands and thousands of wounds because that was a computer glitch. And I’ve now worked with rio and we’ve got something that’s a bit smoother, erm they can close things, they can halt things if a patient gets admitted, so to make it work for them a bit more, to make it quicker they just overwrite on a weekly basis when they’re reviewing wounds now, erm so they can overwrite, erm, they kept going, but I’m deleting it. No, no, no you’re not deleting it because you’ve saved it. It never goes, panic not and I said commissioners can see that you’re reviewing these wounds, you can see that you’re, the wound, it’s started off as 6cm by 5 but now it’s 3x2. That’s really powerful for a patient. So trying to make technology work for them a bit more.

LS: and making sure you’re still keeping the track record to show whenever you have to go to panel or…

TVN: Yeah and obviously our panel process has changed

LS: How?

TVN: Because we’re not using the avoidable/unavoidable definitions anymore, that’s gone.

LS: Since when?

TVN: 3rd May

LS: Okay, so that’s a new development

TVN: Apparently we’re behind, but I don't think we are with the rest of the country. We’re now using levels of harm and the impact on the patient and we’re, I’ve got to get this right in my head, anything above moderate harm is having a full investigation. If it’s low levels of harm there might be learning there, but then it will be closed.

LS: So you have this diagram with colours I assume?

TVN: Yeah, have you, I can forward it to you.

LS: Yes that would be very helpful

TVN: Erm but it’s not, we’re not using avoidable/unavoidable anymore

LS: And do you think that’s an improvement?

TVN: I don't know, it’s good that we're doing the impact on the patient. The nurses now have got five questions I think it is that they need, when they find a, well and the therapists, erm, if they find a pressure ulcer then they need to ask on a pain score 0-10 how painful is the sore, not how much pain are you in everywhere about how big is the sore, about odour, erm about how much is that, this going to affect their quality of life, erm yeah, I can’t remember all the five questions, but there is five questions and that has to go on, and once they report it that has to go on Ulysses erm as an impact and they fill that in and then within 48 hours now they have to, a pre panel takes place. So it used to be weekly, so we’re not involved in the pre panels anymore, it’s a senior manager, looks at what they’ve reported, looks at the rio notes, has a phone call with whoever’s reported it and they decide on the level of harm.

LS: And why are you not involved in that anymore?

TVN: Erm, well they can if they want to, because obviously there isn’t enough TVNs to be at every panel, every 48 hours, erm in the west they take place, I know this is a bit bizarre, it’s Monday, Tue, no Monday, Wednesday, Thursday, Friday between 3:30 and 4:30, that, why at that time, it’s because they’ve got access to live line so if they wanted to speak to a TVN to gain clarity or a bit more information, they could phone us. I’m not quite sure how it’s going to work, it’s been running since the 3rd May. I’ve had no calls on, when I’ve done live line and I don't think the others have so I think, I feel out of the loop now, so my teams are still phoning me “we’ve had a grade 3, it’s going to pre-panel, whatever, we’ve done the impact. We’re getting everything together erm, but I’m out of the loop now. Whether that’s because I’m a control freak, when we did the pre panels I knew all the ones that were coming to panel cause we’d get the pre-panel report and I’d see everything where you could see the gaps in care were, erm, but now I don't, but this is what the commissioners are asking for and apparently we are behind. When I’ve spoken to, who was I speaking to the other day, xxxxx xxxxxx, yeah, he said he was not aware of anywhere else in the country that was doing this.

LS: This is actually the first time I’m hearing about this. At the TVS conference there was still a lot going on about avoidable and unavoidable and so

TVN: We’ve been fed the line that we’re behind, but then when I spoke to xxxx the other week he was like.…..you’re ahead, erm, yeah. Or maybe we’re backwards I don't know, but, but we’re doing something very different because he was saying to me what he, sorry professors were like. He was going, you need to write this up, ohhh no.

LS: It is

TVN: It is quite

LS: It’s very interesting

PC: are they occurring every 48 hours? I mean are there that many that are…

TVN: Yeah, there are, so they take place. They’re not in the west. I can only speak for the west, but they’re obviously taking place I think in the south, east and the north, east as well.

LS: So it’s panels for more than one community?

TVN: Yeah, there is. There isn’t just one, and it’s senior sort of 8a level that are doing them and eventually, at the moment it’s only nurses that are doing them because we’ve got some mental health, no there’s one that’s a respiratory specialist, but she doesn't really have experience in, so she’s gaining a bit more experience before she can sit on a panel or be the lead, panel chair and there’s a mental health lead, erm, but he’s again gaining a bit more experience before he does. So at the moment it’s only nurses doing it.

PC: So is it the 8a who’s leading it

TVN: Yeah

PC: Or is it the 8a’s who come from the team’s, is it anybody who comes from the teams?

TVN: Yeah. Perhaps they’re 8b’s I don't know, they keep changing their titles, like, they might be 8b’s, oh I don't know.

PC: But it’s not just the managers who come it could be anyone

TVN: No no no no, it could be anyone who’s reported it would come, but a lot of them are happening via lync or over the phone so this 8b whatever, this senior person. It’s somebody like xxx xxxxx, xxx xxxxx, xxxx xxxxx, it’s that level that are the chairs of the panel. Yeah, but I’m only speaking for the west because I don't know who does, I don't know about that, erm, but that’s what’s happening, that process.

LS: So they decide whether it should go to a full panel or…

TVN: Yeah, it is depending on their level of harm

LS; Okay

TVN: I can before we leave today I can get it up for you and…

LS: Yeah, it is interesting to hear, cause we have also in our interviews we had a lot of nurses, they didn't mention. Well, some of them did mention the word fear, but they were very err, so going to panel was really something and they felt that they were really erm er quite scared to go to panel.

TVN: I can see probably why they would feel that, obviously in the west I can only speak, I’ve never actually been to panel, I’ve been on the panel and obviously we try to make it that we’re interested to hear their perspective and, but most of them we try to make it more about the learning, but most of them come to their own, the right conclusion of their own accord as we’re going through it or once we’ve done their full time line and they know where the gaps were, they know what went wrong. Erm I think at the beginning, I don't know, maybe there was nurses crying or leaving the panel, they felt got at.

LS: Yeah, and has that changed the way the panel works?

TVN: Yeah, they’re much more about learning and developing and the thing that I feel from the way the panels, like the full panel, I don't think they close the loop because they develop these action plans and one of my teams, but only one has done it properly. They did a really good action plan, we had weekly meetings, either on the phone or we’d go there and we’d sign everything off. It took about 6 weeks and we go everything done on that action plan and closed it, but that’s not what’s happening everywhere. That was a really good one, erm these action plans are done. I don't know where they go, I think they just sit there and, so I don't, that bit of the loop isn’t carried on or shut to get that learning in place to prevent that from happening again.

PC: Are the pre panels now just for 3s and 4s?

TVN: 2s, 3s and 4s and they determine like I said the levels of harm. xxxxx got a review about it 31st May to see how the process has been going. They piloted it down at xxxx, xxxx, xxxxx, rural xxxx erm, initially and then we had to go out as TVNs completely blind because most of us hadn’t been, train all the teams on how to do it, what was changing, so xxxxx bless her came up with a package and we were going it’s going to be a bit like this and obviously [the trust] have been in quite a lot of the news recently for very reasons, erm and it was then this has got to be done and then it was people were being pulled and xxx xxxxxx was sort of given the project management job of this has got to be sorted by 3rd May end of and it what, the outcome at the moment is similar to what they piloted, but I don't know if it’s right. As a TVN I don't feel like I’m involved anymore so I’m not happy

LS: and you think you should be

TVN: Yeah, I do but again equally I can’t be there every 48 hours because there’s not enough of us, so somethings got to, it’s not right.

LS: So why do they do it every 48 hours?

TVN: Because that’s what the commissioners want

LS: Okay

TVN: So they’re just going to what the commissioners want, but then I think and the teams aren’t having erm 48 hours in a team when they’re flat out most of the time is not time to pull together all the evidence, whereas when they were weekly they could pull all the evidence together to back up that they had given that care and now they’re not. It doesn't feel right but.

LS: are they going to evaluate it?

TVN: Yeah, but I know as its only been running a couple of weeks, but so far I’m not particularly. Xxxxx has asked me to put all my thoughts down erm and concerns, but I get calls from the community nurses saying “we’ve done all the impact questionnaire, reported it on Ulysses, now what do I do” and I said well I think you’ve just got to pull all your evidence together and wait for your phone call and it’s all a bit airy-fairy.

LS: So it will need to settle in this new system

TVN: Yes, I think and it will need to be tweaked quite a bit I think, but it’s all down to levels of harm

LS: So do they call in nurses or do they call in AHPs?

TVN: Whoever’s reported it

LS: Okay so usually the nurse

TVN: Yes, nine times out of ten I would have said a nurse reports it, but if the AHPs been the one to find it then they are supposed to report it. We’ve had I think very few. We’ve had one report, one or two reported from continence. I’ve just seen one reported recently by podiatry. They’re very low reporters

LS: Because they don't see it first or because they don't…

TVN: No they see it, but they don't report it as a pressure ulcer. That’s a bit of conflict. Maybe what they see as a pressure ulcer and what we see as a pressure ulcer. So they’re low reporters

LS: They would say it's a leg ulcer or a…

TVN: Diabetic foot ulcer or neuropathic ulcer, there’s always something. Interesting actually, I didn't think I could talk for this long. Practice nurses are getting more and more. Our link nurses at our recent link day said they’re all seeing more and more patients walking in and they’ve got pressure ulcers, but they’re very ill-equipped to deal with them.

LS: So these are patients that are already in care?

TVN: No, these are patients that are at home, self-caring, erm, they might be coming in maybe for a leg ulcer err or because they’ve had recent surgery or whatever, but they’ve got a number of erm black heels being picked up from hospital admission. Patients self-caring just gone home but when they've come and the patient’s just getting on with it

LS: Do they record this?

TVN: No I don't think they do

LS: Well they should

TVN: I don't think they do. Their systems, they should report it, but each GPs system is very different so I don't know how practice nurses report things. I know they've got a incident system haven’t they in surgeries but I don't think they do report it and then what we, unless they tell us we don't know, but this is anecdotally what they’ve reported what they’re finding, which is bound to happen. They said, again what echoed what I’ve said, they’re seeing more and more older walking well-ish patients whereas before they wouldn't have seen so many sort of eighty-plus’s, they probably would have been under the community nurses, but there’s so many more people that are older, still driving erm.

PC: And are the practice nurses do you think actually asking about it or is it the patient that’s bringing it up or is it just coincidental?

TVN: Coincidental they find it. They don't look and say can I have a look at your bottom or anything, but if they were erm, they might have gone for a leg ulcer and they take the shoe off and everything and go oh

LS: Patients just walk on with that…wow, so…

TVN: But the patient doesn't know that that’s a problem because they’re not educated, so they don't know to say

LS: And it doesn't hurt?

TVN: Some of the deeper ones don't hurt do they as much I believe, not that I’ve ever had a pressure ulcer, but erm, but yeah some of the deeper ones don't hurt and I suppose if you’ve worn and I know you won’t have that problem [to PC], if you’ve worn a stupid pair of shoes and you think oh I’ve got a bad blister and it’s a killer erm they just sort of get on with it. Patients are very stoical aren’t they, but if they don't know that’s a pressure ulcer or a bed sore as they call them.

LS: So in your ideal world what would pressure ulcer care in the community look like? How would it be organised?

TVN: It would be a whole MDT approach and not just AHPs. It would be GPs, practice nurses, you know we have, I know we have pressure ulcer week, but how often in surgery do you see something up about that. You see sun awareness, blardy, blardy, blau, but nothing about pressure ulcers. Just everyone more informed, TV campaign so people are, not for suing, but for making people more aware for looking after their skin so everyone is more informed and clued up.

LS: So how would we be able to pull that off here?

TVN: Here, well we’d need some investment to start with, probably, you’d need a project manager to try and pull things together, some good marketing and communications erm.

LS: Do you think GPs are up for that?

TVN: I think with the MCPs, they’re buying in maybe a bit more.

LS: Okay, so it would be possible

TVN: Yeah, Xxxx recently went to a, I don't know if you went to a thing at marwell

LS: Yes, I think I was there

TVN: Did you go?

LS: Marwell is, no no I didn't go

TVN: The zoo, well it wasn't at the zoo but it was at the hotel

LS: No I didn't go there

TVN: erm and that’s come about from one of the MCPs and one of the GPs and I’m not quite sure who it was, but she’s going to get involved and she believes almost like a project management type role, believes that there’s a solution to every single problem. It might be technology or whatever and she is looking at pulling all these bits together and so xxxxx said it was a really like quite inspiring day so I do believe that maybe in time, particularly with the MCPs now that it might come, all come together, but it is about everybody being informed, not just the AHPs and the nurses, it’s the public as well.

LS: So barriers at the moment is not everyone is informed and there’s not enough money

TVN: Maybe not enough equipment or equipment options, erm you don't know what you need until you know, but you need to know what there is. It’s like I’ve got a spinal patient at the moment erm and he’s on his spinal mattress. He has got quite a significant pressure ulcer that was caused by his erm shower chair. The seat was fitted the wrong way around and he sits on the toilet and he has peristeen so he’s on there for quite a while, about three times a week erm and it caused a significant, we’ve had TNP, we’ve had larvae, slowly, slowly getting there, but he would like an air mattress but on his double bed, he’s now in a relationship, he’s just had a child, that’s not there for him, erm, so equipment and technology needs to improve to

LS: to fit home life

TVN: Yeah, more and that is I would have thought just a simple solution and somebody in a company having the wherewithal and skill to do that and there is clever engineer-ie people out there, Not me but…

LS: No, but you could say what is needed, yeah and advise and it’s things like boots for offloading and sort of repositioning. I’ve got like a patient at the moment, a spina bifida patient, she’s had grade 4, she’s got one on her kyphosis that we’re slowly, slowly getting there, but we’re having problems with wheelchair services, everyone needs to buy in, it’s not just AHPs and that, it’s the services that work with us. She ended up with two grade 4s down to calcaneum. We have done an amazing job with her because they have healed, but by wearing what she says are, they’re the devon heel boots, you know the pink egg shell. She doesn’t like them because she is in her wheelchair. Where she lives is a community home and the wheelchair skills shall we say of the some of the other residents there leave a lot to be desired so her toes constantly get bashed so we need a offloading boot that she said I would wear that would protect my toes. We’ve asked people like xxx xxxxx and she’s said she’s not aware that there is one so, but there’s somebody that needs that and she can’t be the only one to need that.

LS: so we need more clever people involved

TVN: We do that would offload, because we have warned that she does dutifully wear the devon. She didn’t like some of the other products because they were too big. She’s spina bifida, she’s not very big and some of the products are really huge, but they still don't protect the front of her feet, but now we’re going to give her trauma wounds to her toes because of, but she has no grade 4 pressure ulcers now, but so yeah it is everybody working. I know getting consensus is horrendous when you have too many people involved, but it perhaps needs to breed from smaller a fewer people and grow, but that is my thoughts.

LS: If you have a community that’s willing to work that way you could make kind of an example

TVN: Yeah, which is why I think the MCPs might be perhaps the leading way on it.

LS: Thank you, do have any more questions to ask PC?

PC: The only thing I had was just relating to on here [the nurse visit flow chart] briefly, was just in terms of the flow where things are happening. If there’s a care plan for say prevention or treatment being put together by a nurse and visa versa if an AHP was putting together a care plan for prevention, would they routinely in your experience talk to other members of the MDT…

TVN: No

PC:…to say have I missed anything? Is there anything from your perspective with your profession, from your professional identity

TVN: That should be included

PC: Yeah

TVN: No, in my experience I don't see that happen. It’s done more in profession specific

PC: What does prevention mean? What is a preventive care plan?

TVN: To me it’s going to be something that's going to be interventions that maybe or erm movements, whatever to maintain that skin integrity.

PC: So it’s, I suppose what I’m getting at, does it just include, obviously we were talking about equipment there. Does it just include, okay I’ve done braden, I’ve done must and I’ll monitor those and I’ll give you a mattress and I’ll give you a cushion?

TVN: No it doesn't, it’s about looking at their continence. I haven’t mentioned the continence therapists, the continence advisors, but they’re key to this, and the posture management, erm. You probably are aware that we’re merging as whatever we’re going to be. Yeah, whatever we’re going to be called. They want to call us the frailty team, but that’s not right, it’s not right, none of us like it. I’m not saying I don't like frailty, but not all the patients we see are frail.

PC: It’s incontinence, tissue viability, falls

TVN: Falls and posture management. So, and all those are quite key. I can see how we’re all quite interrelated, but no it isn’t just about I need this piece of equipment, it’s about the education you’ve given to maintain their skin integrity looking at the emollients that they may need, so looking at skin, how much they need to drink to maintain their hydration, everything, so it shouldn't be…

PC: Do you see that though actually on the care plans?

TVN: No

PC/LS: no

TVN: The prevention plans are really poor overall

LS: So would it be an idea to make kind of a draft or a…that’s not right…

TVN: Like a core

LS: Yeah, like something every plan should have

TVN: Like a core plan, they've got, they've got those things, they've got like braden vs intervention and what they should need and there’s the erm things that that need to sort of look at…

LS: But they don't

TVN: No

LS: Lack of time or lack of knowledge?

TVN: Lack of time, I think. I know it’s not a defence is it, but it just doesn't. I said to, I keep saying to them when I train them, I said pressure ulcer prevention is not hard at al. I said if I get it, it must be easy, but its, its, its really is not rocket science and if you did probably about ten key elements, you would have done all, you upmost to prevent that patient’s skin breaking down and then, and we’re talking old money, it would be unavoidable. We’re not there with patients, in the community, we’re not there 24 hours a day.

LS: No, no

TVN: So, but the education of the patient is quite key in that and I know we’ve got our leaflets, but it’s not just about giving a leaflet. I know I’ve been given a leaflet from the doctor and I just go home and throw it on the side, depending on what it is whether I read it or not, do you know what I mean?

LS: Mmm, yeah

TVN: It needs to be discussed and explained

PC: Make it relevant

TVN: Yeah, I’ve actually been in a patient’s house once and they were sat on their chair and they were not liking the mattress and I ended up laying on the mattress and showing them what position to get in. They were laughing, but, but I actually showed this is how you’ve got to do it, not talked about it. It’s meeting patient’s needs and patients are changing more as society and culture changes, but it’s just that people aren’t informed enough about. When I trained to be a nurse I never, well I saw one and the lady was at the end stage of her life. That was the only, as a student nurse I only saw one pressure ulcer.

LS: Well you were lucky then

TVN: Yeah, but there was more. I felt there was more nurses on each shift when I worked in the wards erm and we did every two hours, we went round and did the background.

LS: You can’t do that anymore

TVN: No, there isn’t enough nurses and unfortunately we didn't have all the hoists and things, you look back, it was, alright there were things that were quite wrong but, we were doing Australian lifts, but I never saw…We used to take our patient’s ted stockings off every day, but that’s the way I was trained to do that. I’m not saying that was a good way, there were obviously lots of flaws, but

PC: Things change

TVN: Things change, but there is a few like fundamentals. We’ve just had a meeting with the associate director of xxxxxxx hospitals and they’re introducing a scheme called, to the ward staff, I think it’s all staff, not, AHPs as well, called fundamentals which is going back to the activities of daily living and it’s mandatory, all staff have got to do it.

LS: mmm, that has a lot in it for pressure ulcer prevention

TVN: Yes it does and they've transformed all that paperwork and everything and they’re going back to paperwork and not the computer.

LS: Yeah, wow

TVN: Things go full circle

LS: Yeah, exactly, thank you so much