Tissue Viability Nurse Interview 2

PC: Can you just tell me a little bit about your role with pressure ulcers in the community?

TVN: Okay, so at the moment I am still on the development role as a tissue viability nurse so I obviously started with the team coming from a community nursing background, started with the team just over a year ago and I work alongside another tissue viability nurse in the area, erm, but supporting CCTs, err practice nurses, not so much practice nurses with pressure ulcers but they do occasionally crop up, the leg ulcer clinics and community hospitals, and I also have a mental health hospital, xxxxxx in xxxxxx as well to support them. We’re actually getting quite a lot through now with them as they’re getting more education they are recognising and referring onto us quite a lot.

PC: Okay, so have you seen an increase then in those areas?

TVN: I think so yeah, there’s a nurse on a particular ward, xxxx ward at xxxxxx, so she’s taken a particular interest in tissue viability and she’s seeking advice that’s really, really good, yeah.

PC: So, as it stands at the moment, within the community, within that sort of setting that you describe, what does, who’s involved in the practice at the moment, in terms of professionals?

TVN: So we’ve got, in, I think it’s, I don't know if they've got it in other areas, we’ve got a nursing home and residential home specialist nurse called xxxx, and I work quite closely with her in our areas, that covers the nursing home and residential care. She’s recently got a band 5 working with her as well that helps her seeing all the patients, so that’s one section, then it’s obviously working with the OTs, physios, erm posture specialist nurse, obviously community nursing teams, I work closely with xxxx, the other TVN, but I’ve also recently liaised with people from infection control, pharmacists and GPs very occasionally if there’s a, and then safeguarding teams, they’re quite often involved, particularly in the nursing homes when we’re involved with nursing homes we get safeguarding involved so yeah.

PC: In the community what prevention look like?

TVN: Early recognition is key I think, erm, educating, there’s a massive thing about educating the, particularly with the community nurses at the moment, I’m rolling out a two monthly programme just on very basic pressure ulcer prevention and treatment, not so much treatment, but management with patients that they’re finding at home because there’s such a high turnover of staff at the moment, it’s basically starting from scratch. We’re getting, there’s a lot of nurses coming straight out of university, I was one of them, we don't get hardly any, pressure ulcers was like, I’ve not even heard of a pressure ulcer until I came into the community setting, even when I was in hospital I didn't really hear of them much. It was when I entered the community setting, it was a huge, huge thing, but prevention yeah it’s all, the equipment training and early recognition training I think are the two key parts of it. And it’s just the use of equipment, recognising when you need certain equipment, but also when maybe that, one of the things I’m talking to the nurses about at the moment is if you’ve got a patient who is acutely unwell and they develop a pressure ulcer, a grade 4 pressure ulcer, then they go onto heal, it’s then realising that you don't need that same equipment, possibly that you had before, you can downgrade that equipment because the patient’s no longer acutely unwell, they might be up and mobile a lot more than they were and there’s a lot of air mattresses sat in patient’s houses and they’re not required. So that's one of the key things that I’m trying because provisions are short at the best of times so it’s recognising things like that as well, what, when equipment is needed and what equipment is appropriate I think.

PC: So do you see that kind of reflected if you go and visit the teams, in care plans?

TVN: Hit and miss, it’s very hit and miss

PC: What would be a, this might be an unfair question, but what would be a standard care plan and what do you expect to see, not expect to see, what are you currently seeing?

TVN: We see a lot of erm, I do see a lot of at risk patients do have skin care, sort of, pressure ulcer prevention, skin care, care plan, but then we see possibly that may develop into a pressure, a pressure ulcer may develop and then the care plans seem to stop for some reason. They think that they've got a pressure ulcer care plan, but it’s a pressure ulcer prevention care plan, not a pressure ulcer treatment care plan that's actually going on at the moment, so they’ll say yes I’ve got a pressure ulcer care plan, but realising that it’s not really relevant anymore to what’s going on.

PC: So it’s not updated as things change

TVN: As things change no

PC: Okay, and is that reflected in risk assessment as well?

TVN: Yeah I think so, and it’s also…it’s not across the board, sometimes, sometimes you get very, very good examples of patients erm and it’s always the classic thing you see where a pressure, a patient might be seen at risk and then things are missed erm certain things are not done, which is why I really encourage the xxxxx tool erm with the teams that I go in and see. And then there might be a grade 1 or a grade 2 recognised and kind of bits and bobs are done. As soon as that develops to a 3 or a 4 all hell breaks loose and everything’s done, and it’s just like if you just took that step back and did x, y and z first, and it’s just a vicious circle with the teams, they’re flat out so they’re saying they haven’t got the time to do certain things, but then a pressure ulcer might escalate to a, from a grade 1 to a grade 3 or a 4, that then creates that huge amount of work that they need to do, so it’s kind of a catch 22 and a vicious circle and it’s breaking that routine and breaking that cycle within the teams, particularly within the community nursing teams that if you do this, this, this and this first hopefully it will prevent what might happen.

PC: So it’s a lack of time, it’s not a lack of knowledge?

TVN: No, I don't think so and I think teams are getting on board with the xxxx tool at the handover, the handover challenge, those sort of things we’re putting into the teams, but it’s just really difficult, the culture in some of the teams at the moment is so negative, erm and tissue viability is almost seen as, I have seen it that we go in and it’s almost like we’re a hindrance to the team a little bit because they feel that we’re creating all this extra work for them and they don't realise that we’re actually trying to support them and help them. It’s really difficult and it’s also really difficult to get in the teams at the moment because a patient visit with me will take a lot longer than if a community nurse is dashing about so they’re actually cancelling, if I need to go and help support with a patient I then get a phone call two days before they’re due to go in, or a day before I’m due to go in saying we can’t support you coming because we’ve got no staff, so that’s another big challenge for me at the moment.

PC: And is that relating to the treating or the preventing?

TVN: Erm, bo, err treating mainly I’d say, but also I might do, I might say “oh, I’ll come in and see 3 or 4 patients in the morning, we can do a little training on whatever, but it could be pressure ulcer prevention recognition, that day then gets cancelled, that then gets postponed so it can be both.

PC: So, do you get called in particularly for prevention, do they call you for preventive advice?

TVN: It tends to come out of the SIRI process so if a certain learning is required within a team I will then get, if it’s one of my teams I cover I will then do some, we don't try and do too much bespoke training, but if we need to go into a team and just do some bespoke training for them, just an hour over lunch, we will.

PC: So what does that, what does bespoke training, because that was mentioned in one of the other groups, erm, what does bespoke training mean?

TVN: So say for example out of a SIRI it’s come that pressure ulcer grading, inconsistency in pressure ulcer grading has cropped up and it’s cropped up maybe numerous times within that team I can create just an hour’s worth of training looking, it will follow the same sort of template, but I might do a quiz. I do a quiz with some teams where I have some pictures of different grades of pressure ulcers and moisture lesions and all the rest and it’s basically, is this a pressure ulcer, is it a moisture lesion, is it grade 1,2,3,4 and then I’ll just put them into little groups, they can go through it, and then we can go through it with them, because I find that pictures work really well, that sort of stuff.

PC: But it’s generally, the bespoke stuff is generally related to following a reporting process, you know,

TVN: Yes

PC: …if there’s been a particular problem highlighted

TVN: it tends to be and then I think that because it’s been highlighted that unfortunately across pretty much all the teams in, I don't think it’s just in north-east xxxxx, but just across the board, I just started doing a 2 month rolling training at one of the community hospitals which is just open to everyone so anyone can just turn up really if they want to and it is pressure ulcer prevention and management basically.

PC: And are people turning up?

TVN: Sometimes better than others, I think the first time I did it I only had 4 or 5, but then I did it last month and I had about 12. It all just depends, I’ve tried to steer it away from Mondays and Fridays now because the first one was on Monday, and I’ve been told that Mondays and Fridays tend to be the busier days for releasing staff, but I think it’s just hit and miss when they can release staff.

PC: And which staffing groups will come to that?

TVN: The whole lot

PC: The whole lot

TVN: I’ve had healthcares, I’ve had rapid response teams, some of the ward staff from the community hospital, yeah anyone can come.

PC: And differing roles, so AHPs?

TVN: Yeah I have done one with, I did one with [other TVN] in Basingstoke and it actually highlighted quite an interesting thing and probably for you is that we had, I think it was a mental health nurse was there, but I think it was a band 7 in mental health, she was quite high up in mental health, and she had gone through, had to go through the SIRI process. They reported, I think rapid response went in and saw a patient that was under their care and reported a pressure ulcer, I think that was how it happened, anyway it turned out the mental health team had to go through the SIRI process and she was quite negative and confrontational in the training saying that the whole thing was basically a blame, had a blame culture attached to it. She felt targeted by the investigating panel and just basically felt the whole thing was just pointing the blame at the team saying this was happening and felt that it wasn't their responsibility to be doing skin assessments etc, so that was brought up and that was a few months, yeah that was just before Christmas. But it was just quite interesting because I can understand, I kind of understand what she’s saying , but it’s like me saying I’m going into, because when I go in and do a patient assessment with the teams as a tissue viability nurse I don't just go in and look at the skin, I do absolutely everything, we look at nutrition, we look at the social aspects of what is going on, we look at absolutely everything, equipment to what I know about equipment and if I don't feel confident we’ll seek help, but I don't just go in there and look at a wound, so it’s almost like saying, or if the patients got dementia I’ll look at their mental health and bits and bobs like that. I’m not saying I’m an expert on mental health, but just bits and bobs, and it’s almost like she was saying oh I’ll just go in and look at the fact that they’ve got dementia, I’m not going to look at the, do you know what I mean, it’s just kind of a different culture.

18:29

PC: So it’s interesting actually, in some of the erm focus groups, some therapists were very interested, others absolutely not, you know, did not feel it was their role to be doing this or part of their identity. Does that, kind of…

TVN: But it’s just me going to visit a patient and they’ve got quite advanced dementia and they’re leaving the gas on the hob and all the rest of it, but I ignore that because I’m at tissue viability nurse so I’m just going to look at their skin and their wound, do you know what I mean, it’s kind of that sort of feeling.

PC: Yeah. Do you find that sort of attitude reflected with other professional groups outside of nursing?

TVN: I haven’t had a huge amount of experience with it no, I don't, I don't know whether it’s just a lack of education, rather than just saying I know about it, but it’s nothing to do with me, because I kind of, it’s like GPs, I’ve always said that I think, I feel GPs should also, they do a lot of home visits, they could be part of the early recognition thing, but I just don't think they, I’m not saying all GPs but when I worked as a community nurse in xxxx if I said leg ulcer or pressure ulcer to the GP, they would say antibiotics and that was about it really, no matter what, they wouldn't want to see it because I do joint visits with GPs and they, the patient will say oh we can take the dressings down before I got there and the GP would say well it’s pointless you need wait until, because I don't know. A lot of them said I don't know what to do.

PC: do you think that's a perception from their point of view that it is the role of somebody else?

TVN: I don't know, I honestly don't know

PC: Or are they just not interested or they don't have the knowledge?

TVN: I think that's it, they don't have the knowledge. I’m sure some GPs do , but I know in my experience GPs that I’ve worked with wouldn't possibly go and look at the posture of someone sat in that chair and maybe they need some equipment or an OT referral. I don't think, I just don't think that thought process is there.

PC: So, I mean, just jumping back to the therapists. How much contact do you have with therapists in this area?

TVN: Quite a lot, I do in particularly in xxx and xxx area work quite closely with an OT whose unfortunately left and gone to work in xxxxx, but I used to do a lot of joint visits with her particularly with our MS patients. The xxx team have got a lot of MS patients with quite severe pressure ulcers, grade 4 pressure ulcers which have unfortunately resulted in us putting them into bed long term to try and move them forward and we’ve done quite a bit of work with the Toto mattress, tilting mattresses and I had no experience with those prior so I got joint visits with the OTs and got help with that.

PC: And in terms of just other teams, erm, from a therapy perspective, do you find that they’re being proactive, contacting you?

TVN: yes, I’ll wait and see what happens after this, particularly the lady that I had close contact with has left, but yeah wait and see but also xxx, who’s the posture specialist of [the trust]. I’ve seen, done quite a few joint visits and seen patients with her.

PC: What about physio?

TVN: No

PC: Less contact

TVN: Less, I have less contact with them

PC: And in terms of the referrals that you get from teams, or contact you get. Where’s that mainly coming from? Which professional groups?

TVN: Its, there was going through a period after Christmas where I felt I was just supporting nursing homes and practice nurses and I think it was because the CCTs, it was kind of what we were talking about before, where they’re almost too busy, or they feel they’re too busy to have tissue viability involvement because it will block out a morning slash day of one of the nurses and prevent them doing x amount of visits and it would be less. I think that was what was the barrier, but I’ve kind of just not forced myself on teams, but kind of just visited and done caseload, started to do caseload reviews looking at the patients that they’re seeing every day and a lot of these are pressure, patients with pressure ulcers. They’re going in and dressing it every day and I’m like if I can come in and see them with you I might be able to suggest something that’s going to reduce your visits to twice if not once a week, which in the long term will then improve the patients quality of life and free up your nursing time hopefully. It’s just breaking that cycle, but it’s difficult, it is difficult, but you can, you almost have to, with the community nursing teams at the moment I almost have to force myself in there because if I give them options or say oh well I’ll come… It’s like an example was this morning I booked a day for the 6th June, it’s already been cancelled because she’s, the matron of the team has looked at the rota and they’ve only got a couple of nurses and they can’t do it and it’s just, it’s not related to pressure ulcer, but it’s dopplers. They’ve got nobody in their team who can Doppler patients for leg ulcer management and that is a problem.

24:00

PC: In general, in the trust, in the area that you work in, who has the perceived role in this area? Which professional groups?

TVN: In relation to?

PC: Pressure ulcer prevention, treatment

TVN: Tissue viability nurses

PC: Yeah

TVN: Yeah

PC: And it terms of case-holding clinicians? Would it be just the community nurses then, so…

TVN: Yeah

PC: Okay

TVN: So, we don't actually, we’re not actually case holders, we don't have a caseload as such. The community nurses will have their caseload, that will be the case, but yeah it’s pressure ulcers and tissue viability nurses basically

PC: Yeah, yeah, yeah, okay

TVN: To the point where we’ve actually been called pressure ulcer nurses before [laughter]

PC: Right, okay. In terms of those who are the case-holders of varying roles, nurses, physios, OTs, whatever. Is there one of those particular groups that is the owners if you like of…

TVN: CCT, Community nurses I guess, yeah, I think so. In the area I am in anyway

PC: Yeah, and do you see with therapists that, erm, they see an identity for themselves in this area?

TVN: Some do, like I was saying, the one I worked with in xxx, definitely. She, yeah, was really on the ball and it was good, it was good working with her because she hadn’t seen a pressure ulcer until one time I went out and saw a patient with her and, erm, I think that opened her eyes quite a lot and made her realise, but she was spot on really with the support she gave me as a tissue viability nurse and the community nurses and obviously the patient. Yeah, definitely, but like I say I had a, had a very good working relationship with her. It will be interesting to see what’s happened now she’s left, with that team.

PC: Okay

TVN: But hopefully it will carry, I hope it will carry on

PC: Yeah

TVN: But she definitely felt she had a role, an important role in this, these patients care

PC: Okay, so, I mean, just in terms of looking at this flow really [referring to nurse flow chart], erm, did you, did that look kind of realistic to you in terms of what’s happening?

TVN: I think the only thing that stood out as possibly not was the timescale bit, so the routine visits, so the review after two weeks…I don't see that happen very often, erm and the referring to us.

PC: So does that happen in a shorter period of time?

TVN: Much longer

PC: Much longer

TVN: Dressings can, particularly with reviewing dressings. One of the really frustrating things for me, I thinks it is for all of us, is you’ll go and do a big review of a patient and put a plan in place and you’ll read the rio notes two weeks later and nothing’s changed, even to the point sometimes where the dressing that was being used prior to us changing it possibly, is back on. It was almost like we haven’t been sometimes. It’s not always the case, but you can look through and you can see the same dressing being applied week after week after week, no change in the wound and it’s, we are educating on if something’s not working change it, why carry it on, but definitely two weeks is….as an ideal world yeah, and in some cases it does happen, but I think they’re few and far between definitely.

PC: And the other thing you mentioned about was when a TVN comes in…

TVN: Goes about it

PC: Yeah, or is called in, erm, at what point in the process is that usually the case, is it very early on or is it much later?

TVN: Much later in a lot of cases. I think that is changing, erm, but unfortunately yeah there was a period of time when you were seeing it at crisis point really. The pressure ulcer had reached a really bad state, possibly the whole social aspect of the patient had reached crisis point and the whole thing was a disaster and we almost had to go in and start from scratch. The pressure ulcer was one of many other things that we had to sort out and some of them created a huge amount of work and it was just because we were hearing about it way to far down the line unfortunately.

PC: Okay, erm and in terms of some of those other problems, you mentioned bringing an OT in. Is that something that the teams will have thought about doing. Say it was a community nurse going in, would they have brought and OT in already or is that something that you then…

TVN: Yes, I hope so because that’s something that the xxxxx tool, the pressure ulcer tracker tool should have prompted, so it’s hoping that the teams are not using that as a tick list, but actually doing what, because if all those things are put in place, one of the key things in…I know we are moving away from this unavoidable, avoidable SIRI process and all of that sort of stuff, which I think is a good thing, erm, but it’s not just saying if you’ve done all these things on the xxxxx tool it’s going to be an unavoidable pressure ulcer, I don't think it’s that. If you follow all those things that are grade 1 grade 2 when you found it you hopefully won’t reach that grade 3 or grade 4 pressure ulcer and you’ll stop that process from going on. So, cause I think that tool was kind of aimed at ah well if things go wrong then at least you've done this, this and this and it will be an unavoidable pressure ulcer. That’s fine, but it doesn't mean that the patient hasn't still got a grade 3 or grade 4 pressure ulcer. I think that tool needs to be looked at more as a way of preventing them getting a grade 3 or grade 4 pressure ulcer so we’re losing the whole SIRI out of it all together. I think it should be aimed at that rather than the SIRI process, does that make sense.

PC: Yeah absolutely, erm do you think teams now, I know again that it’s changing, avoidable unavoidable, that is their focus to make it unavoidable?

TVN: Yes

PC: Rather than to prevent…

TVN: Yes

PC: …in the first place

TVN: Yeah I think so. It’s difficult to say that as a sweeping statement across the board, but I think that everyone’s got very hung up on the whole, it’s become a huge part of community nursing now, even. I started in community nursing 4 years ago, straight from uni, and yeah the SIRI process was going on, but it certainly wasn't as much in the headlines as it is now. This whole, we can’t be seen to have caused an unavoidable pressure ulcer blah, blah, blah and I think it’s very, you’re spot on saying that the teams are aiming to get an unavoidable pressure ulcer, rather than focusing on preventing that pressure ulcer in the first place.

PC: So, in terms of use of this tool, the xxxxx tool, do you see that used as a preventive tool?

TVN: In some teams yes, because I know a team that I cover in xxxxxx that they don't even, the used the tool initially and now they don't, they don't even use it now because it’s so in all the nurses heads as a preventative tool that they don't even do it anymore. They don't need to and that team have, touch wood, no pressure ulcers. They don't have any.

PC: So what’s different about that team to a team that doesn't do that?

TVN: Erm, they’ve got long-standing members of staff, they work really well as a team and they’re, it’s quite a new team to me so I’ve only been working with them a few months, it used to be xxxx [other TVN’s] erm. Their caseload is smaller, so I know the whole, we haven’t got time is a big thing that is brought up all the time and I know the teams are, a lot of the teams are flat out so that is, that does play to their advantage because they have got, whereas some patients, patients, some nurses in the teams are seeing, say the busier towns xxxx, xxxx and xxxx, they are seeing sort of 10 12 patients a day and then being expected to do. I think it’s unrealistic a little bit, what’s expected of them. It’s really difficult, but it’s also trying to promote more efficient working I suppose. So this xxxx team have got the advantage, they’re a very rural team, they may only see 4 or 5 patients each a day so they have got that time on their hands to possibly do the work. But I think the whole prevention, having prevention in your head is not time is it, it’s just knowing it and doing it.

PC: Okay, how important is leadership?

TVN: Very, yeah, I think it’s key really, erm, I’ve seen teams who have no leadership or poor leadership and it’s proven I think that the number of pressure ulcers goes up. I mean, have you seen it, it is, it does seem to go hand in hand really.

PC: Yeah, yeah

TVN: when teams don't have a leader, there’s quite a few staff changes recently in the north-east. Some teams haven’t had a band 7, some teams haven’t actually had a band 7 or a band 6 and the whole, yeah the whole sort of working relationships within the teams falls apart and they’re not talking to each other. I had a, it was quite shocking the other day, I went into one of the teams and there was a new band 7 gone in and she said they came up from their morning visits back into the office, everyone’s sat at their computers and she actually timed it, nobody spoke to each other for something like 50 minutes. Nobody said a word to each other about patients they’d seen, what’s going on, all the relationships were just broken down in the team because they hadn’t had that leadership and that focus and that structure. It was basically turn up for work in the morning and see what happens, hopefully someone’s done allocation, hopefully someone’s done that and we’ll just have to, just firefight basically.

PC: And is that just within a nursing, healthcare support worker context or wider MDT?

TVN: Nursing, healthcare support worker, it was a bit of a disaster, and then their working relationships broke down so you lose that communication because they’re not talking to each other and it’s just a recipe for disaster basically.

PC: I mean, one thing that came out from some of the focus groups was erm particularly within AHPs, erm, if your local leader, your local lead there, err, had an interest, you know erm and saw the potential benefit of therapy in this sort of context and really took on the preventive mantel erm, then the rest of the team would follow that, but if the leader wasn't that and actually felt it wasn't a therapy role then again the whole team followed.

TVN: Right, okay

PC: Do you see that kind of reflected with some of the therapists?

TVN: I think we’ve got a new lead in the xxxxx now. xxxx who’s come in now and I’m actually meeting next week to develop. She’s putting on these training days aimed at therapists as well, which again we’re going to have pressure ulcer, she does a bit of everything in them, but she’s very focused on getting everyone working together, I know that for a fact. She does want that to happen and she wants my input from a wound care perspective. She said we can do different focus groups month to month, so one week we can look at pressure ulcers, but then we might look at skin tears or different, different things really, so yeah, she is focused on doing that really yeah. So that is the lead for north-east.

PC: Okay, one of the things that came out from some of the focus groups in general was err, I mean it was mentioned, the word, a number of times, was fear and for the nurses it related to the reporting process and for AHPs it related to a loss of identity, their own profession, you know, and being asked to do something that they thought was a nurses role, for some. Do you get that kind of sense?

TVN: Yeah, I haven’t come across it with the loss of identity of their role, I’ve not come across that, but I definitely, when you talk about the nurses being afraid of going to panel, then yeah definitely, that culture is definitely out there. This whole blame culture attached to the SIRI process and I’m not sure, I’d like to think it won’t, but it will change this whole changing it to level of harm and all the rest. I can't see that that’s going to make a lot of difference really because I think that the avoidable unavoidable is trying to say oh it is your fault, it isn’t your fault, but I’m not sure whether this new process will make much difference to that. I hope it will, but I don't know, watch this space I guess. But I haven’t come across, apart from that example I was giving you earlier about the mental health nurse who was quite. I don't know whether it was to do with fear of loss of identity of her role, but it was just that she didn't feel that it was part of her role.

PC: So, why then, from a pure therapy point of view, I know OT’s probably are little bit more

TVN: Yep

PC: interested in this area, but say for physios, why do you think some engage with this, but others don't?

TVN: Erm, I don't know whether, I don't know, it’s difficult because I was going to say maybe people that are newer to the job maybe pressure ulcers are more prevalent in their training or, as to what’s going on now, but then the physio, OT I worked with from xxxxx. She’d been an OT for 30 odd years so I don't that that is, I don't think actual experience and time in the job is part of it. I don't know, it’s really hard to say, it’s really hard to say.

PC: Do you think potentially there might be, erm, either some kind of a personal interest in it, you know that it’s an area that they’re interested in, erm, or is there an element of just a towing the party line. This is what the trust says I should be doing so I’m doing it.

TVN: Possibly, I mean it is interesting you say that people have a personal interest. I think maybe I, I’m sure I worked with a OT again that has had a family member that’s had a pressure ulcer and that sparked an interest, maybe not an interest, but just a passion for looking at that as part of their job role, looking at prevention, what they can do and they also educate quite a lot of their peers in looking at stuff like that and working, it was maybe if you’ve got a worry, go to the nurses again, but it was having that thought process going on that it is part of something we should be looking at definitely.

PC: But you don't see potentially them thinking, well either they have to do it or this is part of my, I see my own role within this, you know I’m a physio I get involved with mobility, posture, activities of daily living etc etc and as an outcome of that it’s preventing pressure ulcers. Do you think there’s any kind of thought, or connected thought if you like from their own day to day practice?

TVN: I think where physios and OTs are working super close with the nurses I think that is. A good example would be the community hospitals because xxxx and xxxx , their focus is rehab and they do get pressure ulcers in there erm possibly patients who have been very poorly in hospital or an acute trust and then gone in there for rehab prior to going home, they will do a lot of the home assessments and also the rehabilitation in the community hospital and the nurses are in there as well and I’m there on occasions working with them think pressure ulcer management is a big part of their role in there definitely because they’ll look at how much, talk to them about the posture of a patient in the chair in the hospital and then they’ll look at positioning devices and getting stuff in to make that equipment suitable for that patient, and then that will just follow suit with other patients that they’ve seen. So I think that in that setting where everyone is working closer together. I think in the community that’s more fragmented while everyone’s in their own areas of working. Some teams do work closely together so I know some of the teams share, so they have these super teams where OT’s, physios, nursing teams work closely together and I think that is good. I think xxxx is one of the teams where they’re all in one room and they do all talk to each other and I think when, when someone’s in one office and another person’s in another, that communication isn’t as.

PC: So is that do you think that’s one of the key factors then

TVN: I think so

PC: Being close. Within our MDT group that we did, it was a team that was all together

TVN: I think it just makes sense really. I know that in a lot of cases it’s just a case of picking up the telephone, but if you’re in an office and you’re all together that communication’s going to happen a lot more frequently than if you’ve got to fill out a referral form, leave a message on someone’s voicemail or send them an email. It’s going to happen a lot more than if you’re busy doing loads of, a million other things. If someone walks past you that you know is involved in that patient’s care, you just quickly grab them and say this is happening what do you think?

PC: So it’s that informal kind of chat between colleagues

TVN: Yeah definitely

PC: Alright, do you think, in general, professionals of every capacity really, feel confident to prevent pressure ulcers?

TVN: Some do, some don't, yeah, some do, some don't. Unfortunately I think that some do, but maybe aren’t like for an example I can give you is the training, that two monthly training that I was giving out in one of the community hospitals, erm one of the community nursing teams, the two band 6’s. This is a team, I don't want to say a high offender but they have a lot of pressure ulcers in that team , partly because it is the team, it was the team that had fallen apart with no leadership and all the rest of it, but also just that poor culture within the team, no communication going on, erm a lot of new starters in the team, so the whole thing was just a bit of a mess and I was doing the two monthly training and I was mid way through the training session and the two band 6’s from this team knocked on the door, opened the door and said is the rio wound assessment training. I said oh no it’s about pressure ulcer prevention and management and they both turned round and said we know all about that already and just closed the door and went off. I was just thinking this was one of the teams that are struggling with that, so I think there’s that, with some individuals there’s that thinking that they know all about pressure ulcer prevention, but perhaps they don't. They might know all about it but they might not be putting it into practice. I don't know, it's just a bit concerning. That was a bit of a concern and it’s something that’s had to be flagged up because it was one of the things that came out of the SIRI process is the learning for that team was that everyone in the team would come to a pressure ulcer prevention training, so that was quite interesting. But I think you do have really really good confident link nurses and you have less confident and like I say we’ve got a lot of, there’s a lot of new starters and I have link nurses that are new starters and I can’t expect them to know all about pressure ulcer prevention, but there are a lot of keen also mental health. I was saying I’ve got two nurses that are in xxxx [mental health setting] that are really keen and in their minds they may think it wasn't particularly part of their role, pressure ulcers, but they've fully taken it on board and they can’t get enough training and they’re Friday doing training for the wards and understandably they don't know a thing about wound care and wounds and pressure ulcers but they, they’re so keen and grateful of the training so it’s really good.

PC: So it’s about being open then

TVN: Yeah

PC: You know, do you think generally people are open to a more, I use the word holistic approach to it, you know that doesn't necessarily just involve equipment?

TVN: Yes, yeah I think so

PC: Okay, couple of quite general questions I suppose really. If I asked you, what do you think the problem is with pressure ulcer prevention in the community, what would you say? What are the things that come to mind?

TVN: I have to say it because I do, because I’ve not long come out of a community nursing team I do know what they’re up against and I do think that staffing and caseload is a huge issue, it is and I know that some of the other TVNs do get fed up of hearing oh we haven’t got enough staff, we haven’t got time to do it and I agree that that is not an excuse, but I also know the huge pressure that these nurses are up against out there and they've got so many patients to see things do become task orientated which is just the nature of what’s going to happen when you've got, because they might be given a huge list of patients to see in a day, they know they've got all of the associated documentation, referrals, whatever else is attached to that to do, things are going to get missed when people are put under such pressure and there are such high expectations, but at the same time I think if we can educate and give these nurses the skills and tools to do assessments, but also to do them in timely, more timely manner and making them understand that if this early recognition and prevention will save them a hell of a lot of work in the long run. I think we can win, hopefully.

PC: And do you think that’s the same for therapists?

TVN: Yeah

PC: As well, same principle

TVN: Yeah, I think it’s across the board, I think it, whenever you go anywhere everyone’s always saying how busy and how little time they have to do stuff, and I do know. If you go out, and it’s also using things like the tools and also using things, working within your teams, don't feel, what I’ve said to some therapists as well, if you do discover a pressure ulcer or you find a patient that’s a high risk and that does create work that needs to be done don't feel that's, don't put it all on your shoulders to do it, delegate within the team and it’s a lot more manageable. When you go out and you discover that grade 2 and feel that you've got to go back to the office and you've got to do all the equipment, you've got to do all of the referrals, you've got to do all the write up for it, you've got to safeguard it, that's when these nurses crack, they just feel overloaded and things just fall apart basically. It’s trying to, trying to get that across, erm, so I, I don't know, it’s really difficult, staffing and time is a big problem. It’s definitely one of the barriers, but it’s also me getting into the teams to try and support them because they haven’t got the time and staff, they feel they can’t have tissue viability involvement, they just haven’t got the time, the staff to accommodate it

PC: It’s catch 22

TVN: It's a nightmare, absolute nightmare

PC: Okay, so in an ideal world, what would an ideal world look like in the community?

TVN: For me, I think the teams working as an MD, particularly with nursing teams, therapists, but at the same time alongside the GPs quite closely, but I think these mixed, like we were talking about before where you’re all in an office together, or at least in the same building will help I think, erm and it also means for me I can go in and almost know where everyone is going to be at that time and talk to everyone as a whole really, rather than saying one thing to the nurses, one thing to the OTs and the physios, we can all just talk together. I think that is one of the main things, I think that would help a lot, but I know people have got issues with all these super teams that are being created, saying it’s just…I don't know whether it’s to do with the environment, like I know in xxx, all the community nursing teams and therapists have been put into one hospital, which I think great everyone’s together, everyone’s going to start talking, but the idea was great, but the environment they've been put in doesn't, isn’t suitable. So, I’ve been told there’s five healthcare professionals to a chair and things like that.

PC: So it’s those kind of logistical

TVN: Logistics, like the dressings cupboard, they decided to put it in a, where all the computer servers and all that was, so the room was like 40 odd degrees. All of the honey dressings melted and it’s just things like that, it’s not thought through. It’s kind of like the initial idea’s great, but then it’s. And it’s like the poor xxxxx team, they’re, they’re in an office, sometimes up to 10, 12 of them that’s smaller than, smaller than this room. I was told the other day that some of them sit on the floor in xxxx, they have to sit on the floor under the desks, they have no internet there so they can’t do rio and then they’re being, they’re having this pressure on them because they’ve got pressure ulcers and they’re not doing the SIRI process. I went there with another TVN the other day, we couldn't even get on to get to our emails and then we’re going into this team expecting them to do this that and the other, I don't know.

PC: It’s those basic things need to be there before everything else can be built on essentially.

TVN: Yeah definitely. So in an ideal world they need, they need to all work together, but they need to work in the right place all together I think

PC: Within that do you think different professional groups understand erm the potential for another professional group to help with the situation?

TVN: Yeah, I do definitely

PC: so they know, they sort of think okay, they think I’m a nurse, you know I’ve assessed this person’s very at risk, potentially a physio, an OT, a podiatrist or whoever…

TVN: Yeah I definitely that links there, I think that link’s there

PC: Yeah, and then making that link on a day to day basis?

TVN: Some better than others

PC: Some better than others

TVN: Yeah

PC: And probably finally really, what role do you think the patient has?

TVN: A big role, a lot of the patients I’ll end up going to see with the teams they’ll say non-concordant, which I don't really like patients being told they’re non-concordant. They just won’t do what we’re telling them to do. I think at the moment it’s trying to teach, particularly the nursing teams, to create care plans for patients that give them options. It’s not saying that right you've got to have this mattress, this, you have to do this. They might turn around and say I don't want to do that so it’s then, but then it’s not just saying that oh, then coming to a tissue viability, oh we’ve said this, they won’t do it, they’re not having it, that’s why they’ve got this pressure ulcer. It’s like oh did you kind of review those options and start from the beginning and say okay I’ll, okay we can perhaps try this, this and this, or try this but not this, see how you get on. I don't know, because that’s all I do when I go in, kind of, it’s almost like negotiating when you’re with those patients that are less forthcoming with their treatment. It’s, it’s basically talking to them.

PC: And why do you think they’re not, patients are non-concordant or not forthcoming?

TVN: It’s really, that’s really hard, I don't, erm

PC: Obviously varies, but

TVN: Yeah, capacity’s a big thing, I’m not fully, it’s when I start talking to the mental health teams, I don't, to say someone’s got capacity is really difficult, some people, there is a grey area. It’s quite obvious when somebodies got no capacity and it’s quite obvious when someone’s got full capacity, but I have that grey area, particularly with patients with learning difficulties, have they go capacity or have they not and a lot of those with borderline learning disabilities and personality disorders, they tend to be the ones that are less likely to want to do what you’re suggesting and it’s their understanding of a pressure ulcer. I feel mean sometimes, so with a patient that I went to see with MS, I was being told that she didn't want to do anything that the team were suggesting. I actually took a photograph of her pressure ulcer, which was quite a significant grade 4 and I showed it to her, she hadn’t seen it and she burst into tears and didn't know the significance of what was actually going on. She knew she had a sore on her bottom, she didn't realise she had exposed bone and a pressure ulcer that was basically one buttock and it was just, I don't know, it’s kind of being not cruel to be kind but giving them that education, giving the patient that control, empowering the patient really, and giving them that understanding of what’s going on and why we’re trying to do what we’re doing, because I think people quite quickly go in there and say you've got this, oh you need to have an air mattress, you need to get rid of your double bed and put in a hospital bed and I understand why patients are like whoa hold on. I wouldn't be best pleased if I didn't know what a pressure ulcer was and what it was all about, why are you coming in and rearranging my house and changing. So I think it’s definitely patient education, taking that time to educate patients, giving them control of their situations, creating those individual, because that’s another thing that gets my goat a little bit, these generic care plans that kind of copy and paste it from patient to patient. You think creating those individualised patient centred care plans, going through it with them, sitting down with them for 5 minutes and saying look this is what’s going on, this is our part, this is what we need you to do and I think it’s a huge part of it, and also the carers and the family, they need to become a part of it as well.

PC: And what about a wider awareness, when people are well and kind of an awareness of pressure ulcers?  
  
TVN: Defnitely, yeah, I can only help, it can only be a positive thing really, making people aware of it, particularly as we all know there’s adverts in newspapers talking of people suing for pressure ulcers and all the rest of it and it’s part of public health.

PC: Is there anything else you wanted to add? Any other thoughts that you had?

TVN: I don't know really, the one thing I was going to highlight was, these teams that have been put together I think is a great idea, I just think that senior management need to realise that there needs to be accommodated properly it’s only creating more problems I think. Brilliant idea to put everyone together, but if there’s not the facilities to accommodate then it’s a pointless exercise really. It’s caused more friction and problems within the teams from what they had before. That’s one of the things that’s come across to me recently. I feel really sorry for them, everyone is, no one comes to work in the morning and thinks I’m going to give Mrs Bloggs a pressure ulcer, everyone is trying their damnest to to look after patients the best they can and I really believe that, but it’s just, it’s trying to support those teams erm and I always convert back to the community nursing teams, I think it’s across the board isn’t it, it’s therapists, the whole lot, because they’re all going, everyone’s going through the same thing and I also think there’s huge changes happening within the trust at the moment as well, which is, well…

PC: It just sort of reduces the stability of it

TVN: Yeah, I think so, watch this space I guess, but I’m really interested in what you’re doing in the study, I’m really interested, I mean what’s your main, what do you hope to achieve out of it?

End of interview – 1:00:50