TVN Interview 3

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

TVN: The difference with myself is that I’m the lead tissue viability nurse specialist, as you know, so therefore I cover the whole of [the trust] strategically, but clinically I cover half of the xxxxxx and nursing homes, practice nurses and xxxxx community hospital, erm, and also cover live line, so that can be anywhere and will deal with any generic email advice as well which could be anywhere, but I will also sit strategically across the organisation and link as well across xxxxx, erm, so I have quite a diverse role. Certainly I have clinical experience but I then have the further on knowledge to make sure that everything at the top gets cascaded through and one of the biggest things that’s happening at the moment regarding pressure ulcers, which is the fact that we’re taking away the unavoidable/avoidable and going into harms (you were at the meeting last time) and we’re now 6 weeks into that so I’m quite heavily involved in that process and the effect it’s having within the organisation, so within PUs and reporting and management, I don't think, the treatment and management hasn't changed, the reporting system has. The follow up, the actions, the reviews have completely changed and I still think it’s very early days on that process and what will happen as a result of our figures and numbers? I don't know, but it’s all changing and the at the moment it’s too early to say, but I don't think we’ve got it right yet, in which case it could actually show the fact that we’ve had these high levels of PUs. Before, as you know, we were recording our grade 3’s and grade 4’s, the avoidables, and that’s what the commissioners were interested in, erm, they’ve started being more interested into our grade 2’s and I’ve just recently done a report, I’d have to pull out the figures and to be able to give that to you, because off the top of my head I can’t remember them, but we’ve had, I think it was between 70 and 100 grade 2s that have gone into grade 3s or grade 4s over a one year period which we haven’t documented for and our, we’ve recorded our avoidables and the commissioners have been interested in the 3s and 4s, but now they’re going to be looking at levels of harm and I don't feel the staff really understand the significance of a 3 or a 4, or whether it’s low, moderate or severe harm. So I really don't know how it’s going to come out the equation because it might suddenly turn around, it looks like we’ve got hardly any PUs when we know we have, so the whole process has been trialled so I’m very heavily involved in that, so although I do very much face to face, see the patient I’m also involved still in what happens in that process.

PC: See the bigger picture

TVN: Yep, so I don't know what else you kind of want in that area cause therefore I’ve been very involved in reducing numbers and from January to January we’ve achieved a 52% reduction in our PUs grade 3s and grade 4 avoidables, erm, our biggest challenges I would say is, is staffing out there, is erm, we’ve now because I have an overarching view, I would say the majority of the community teams now are 80-90% full, they've got staffing so we’ve got very few vacancies, so that has improved. However, it’s the new people, inexperienced, or I’ve come across unfortunately some staff who are experienced, no, they think they’re experienced, but they’re not, which I find quite frightening cause I had a conversation only this week with a band 5 on the phone and she was actually outside the patient’s home and I was chatting to her and I thought god, she doesn't know what she’s talking about and yet she was trying to relay to me that she knew what she was talking about and I was thinking you’ve just provided care for this patient and this is a grade 4, tracking wound and when she was describing and what she was doing, I was thinking you’ve actually damaged this patient and that was really frightening so that’s my concerns that we’ve now got staff out there who are not as competent as we had two years ago because there’s been so much changing over, so I feel the care has changed and I would say, that’s a sweeping statement, but there are also some very good teams out there and there are some teams, not so much and we’ve got some teams that we’re very aware of that don't report. So, how can you end up with a team in a very chronically deprived area with lots of drug abuse and social issues who have had no avoidable PUs and they’ve only reported one in a whole year, doesn't add up. Erm so the diplomat…this commissioners know that and the trust knows that, so they’re diplomatically trying to challenge that and having seen the wording out there it’s been very diplomatically put so the, but what I am also finding is that it’s down to the leaders. So, if you've got a leader in a team, erm, who basically says we don't report this, they’re not reporting it, but if you’ve got a leader who is driven, has got knowledge, has got knowledge of the consequences of pressure damage, erm, they will encourage their teams to report and they will encourage the whole process and there will be good care going on there, but we have got some out there who basically say “no that’s not pressure damage” you know, “that’s a diabetic foot ulcer or that’s a, “they’ve knocked it” or erm, what did I hear the other day, erm, a shoulder wound, “you don't get pressure ulcers on the shoulders”, just that sweeping statement.

PC: But, it's a classification thing?

TVN: Yep, no, they just don't get it, they’ll just turn around and say “that doesn’t happen” and when you’re saying have you seen them in the wheelchair and totally leaning over and their pressure’s going straight onto the arm of the wheelchair, that is damage from pressure from the metalwork from that and so no, no, no. So there’s pushing back and that’s the things that are changing.

PC: Why do you think they would rather classify it as something else?

10:13

TVN: Erm, because it’s easy

PC: Less process?

TVN: Yeah, they won’t have to report it, they don't have to go to the, we’re just about to change the system and I think there’s going to be major fall out soon because 6 weeks ago our process was you report, you’ve got a week to go to pre-panel and then you’ve got quite a long period of time, often weeks before you come to full panel. Now, it’s find it today, 48 hour panel, talk about it and then depending on that there’s internal investigations which hasn't, doesn't have to be a SIRI so I can see people getting relaxed on that and it not being looked into, erm, or it’s very noticeably it needs to go to a full panel. In a few weeks’ time it is going to be, and they don't know this out there, that they will have to report it, 48 hour panel, within 72 hours they've got to provide all of the documentation. If you’ve got somebody who’s going to say “ah, we haven’t the capacity to do this”, they’re going to turn around and say “that’s not pressure damage”, therefore one of the things that we found that’s been really good is that when you, as soon as you find a pressure ulcer, erm, everything happens. So, it doesn't, it’s improved, there will be very little happening, you find a pressure ulcer and suddenly documentation is happening, they’re doing their risk assessments, they’re getting their equipment in and visiting, they’re offloading, they’re doing all the relevant things, erm, my concern is that suddenly they’re going to have this amount of work and it’s going to be such a nightmare to report, that follow up period won’t happen and we’re going to have a deterioration wound and deteriorating patient and the consequences to go with it. That’s my theory at the moment.

PC: So you think those 2s, to 3s and 4s are actually going to end up going up?

TVN: I think there’s a potential, it’s a very negative feeling, but it’s the new process. I think it’s actually going to make the situation worse and it’s all being led by the new SIRI process and the commissioners driving it and it’s not [the trust] that are doing this, it’s all the commissioners, not the providers, there’s the expectation, and also because we’re under scrutiny as [the trust], erm, as you know mortality has been the big thing and ligatures, it’s, CQC are coming in next week again and they’re going to be looking at governance and they’re going to be looking at incidence and they’ve been looking at the deaths, which is absolutely appropriate, they've been looking at the deaths and because they’re going to go hang on we’ve had deaths here and pressure ulcers here and suddenly you've changed the process and suddenly it’s done this, they’re going to go why and if they start looking I dread to think what they’re going to find because there is, the problem is the staff’s capacity. It’s all about capacity, I don't think there’s any nurse that goes out there and means to do any harm, I honestly feel that, it’s called documentation, capacity to complete all the expectations and at the moment to do a full RCA takes a minimum of 4-5 hours of clinical time. If you’re going to do, erm, the 48 hour panel, the expectation you’re going to have a certain amount of documentation. I know at the moment that the 8a’s that are doing the 48 hour panels, certainly in the west, are spending 2 hours every day prior to 48 hour panels to review those patients to see that they’re not missing anything. Well the impact clinically is huge and now we’re going to be asking them within 72 hours they’re going to have to provide lots of documentation so that’s going to take people away from the clinical and the knock back is going to be, and that will be driven by commissioners, not by clinicians.

PC: Do you think they’ll be a relaxation then, you mentioned a relaxation from both sides, the clinicians who are case-holding

TVN: Yeah

PC: And from those 8s, band 8s who are having to classify whether that was a, you know…

TVN: It depends on the area. I think that’s area driven, erm, it’s certainly very interesting that the north east of Hampshire that had high pressure ulcers, in the last 6 weeks have had no pressure ulcers, it doesn't make sense and it’s the new reporting process. So, the new reporting process is having significant impact in our evidence supporting the grade 3s and 4s out there and the 2s.

PC: Is there then a perception that well, we’re here to work with patients, you know, this is what comes first and that other stuff isn’t important in the scheme of things.

TVN: I think in the vast majority they do feel that way, the more senior you are the more you realise in actual fact that’s all got to be done, it is all governance, it’s all, also for the nurses it’s their NMC, they've got to remember their code of conduct in all this and sometimes they have to be reminded, but yeah when you’re out there they put the patients first. To them the patients come, and even this week I’ve had, where I was in with a team and they were going I’ve got this number of patients and I don't know when I’m going to be able to fit in all the rio. Rio is the big demand, it’s so much time it takes and you’re ending out with people working late into an evening, taking stuff home and it’s just too demanding so I think we’ve created an industry with documentation and it is reduced the amount of time to see the patient and it’s just, it’s had significant effects and you’re also expecting staff to go in and do so much in such a short period of time and you’re expecting them to do a risk assessment, you’re expecting them to check all the whole skin out and you’re doing that and the doctors don't get it at all, is that they’re saying I want you to go and do a blood and then we’re turning round and having to say well if they’re at home and having a blood, they’re obviously unwell so therefore it makes them more vulnerable to skin damage, therefore we do need to check the skin and doctors just don't get it and the classic statement I had from a medical director a few months ago who probably was in his fifties turned round and said to me “I thought pressure ulcers stopped when I was a houseman”. So, the medics do not get it, erm, GPs do not get it and I think with the changeover as well erm with better care and our MCPs, they’re going to really struggle and what they’re suddenly going to expect nurses to do, again I think it’s all going to change and I don't know the impact on pressure ulcers. I think there’s risk going on out there that it’s going to be on the increase again.

PC: Do you think there’s any potential that the teams who are going in, rather than thinking, you know this takes such a long time, we don't have time to actually do the reporting, because you mentioned about everything starts after they find something, will that then put a focus more onto prevention?

TVN: No,

PC: No?

TVN: No, that we drive, the only thing I’m optimistic is we have drip drip drip drip drip for years and it’s now pretty embedded, erm, it’s the new staff that will be the challenge. If you’ve got old staff they will carry the new staff through, erm and prevention is something that we talk about all the time, all the time and one of the things I’m aware of within the tissue viability team is it’s so reactive because of the nature of what is going on, and that's not what I want it to be, but we don't have a choice and that is the number of pressure ulcers that are actually out there, erm, but we’ve put into place things like the moisture pathway so people can look at the difference between, and I would say we are getting less poorly recognised moisture versus pressure, that now is dawning on people. We were spending a reasonable amount of time actually having to turn around and say no this is moisture, erm, so I think that’s, that’s improved, we put a lot of work into that. It’s been well received I think our PUP cards, pressure ulcer prevention cards, which is the cards you have on a key ring in the pockets and I’m just about to add another card to go onto that and certainly we’ve had, I’ve got, I managed to get 10,000 cards, 6000 staff, in theory every person should have one in their pocket. It’s still getting out there because we’re such a vast organisation. I know there’s areas that probably don't have them because we’ve got an awful lot left so we’re trying to find out who those people are, but there is also raised awareness across the whole division because we only had, I was off last week and one of the things that went right up to the top, it went right up to the director of nursing was a grade 2 on an LD unit, with major mental health issues and as I say the fact it went to the director of nursing on a grade 2, and it’s because they turned round and said they’ve never had one before so we don't know what this is and we don't know how to manage it, erm, so everything’s quickly gone into place and then the realisation that went down to the ground floor and actually found that we’ve actually had quite a lot of work with this team already and certain groups of people did know what to do and it was the others who were on duty at the time who didn't, so it’s that crossover. Though it went up there right to the top it wasn't a very significant grade 2 and the response I would say was more like massive cavities everywhere, but that’s fine because also it means that the whole organisation is aware and they want to do something about it and pressure ulcers are so much in the organisation that some people refer to us as the pressure ulcer nurses because sometimes that’s all that they see us doing and certainly within myself I deal now with more pressure ulcers than I do with anything else in tissue viability, erm, but what will be interesting is to see, we’ve just done our audit, which includes the pressure ulcers. It looks like we’ve had probably about a thousand, a thousand patients have been seen in a week across the whole of the organisation, when I say a week, they might have been seen two or three times or even daily, but we’ve had roughly about a thousand wounds that are being seen at the moment, so what’s going to be interesting is seeing how many of those are going to be pressure ulcers , erm because when we did three years ago what was evidenced was the fact that the nurses in their minds think they have a lot of pressure ulcers, but in actual fact they haven’t, they’d only got three but it’s the fact of how much time it took and how much documentation, the equipment, the process it took, they felt they actually had more than they had and when you looked at it you were seeing in actual fact you’ve got three pressure ulcers at the moment that you’re managing and treating, but in actual fact you’ve got 12 legs, but in their mind all they had was loads of pressure ulcers, so that's the way the focus has gone and that was three years ago so it’s going to be interesting to see what our numbers are like this time. That’s going to be the real data.

PC: With that in mind, has do you think preventive practice, has become a bigger thing?

TVN: Yeah

PC: Like preventing it in the first place, then not having to do all this extra?

TVN: We push and we push and we push, erm we’ve now got and we haven’t celebrated it enough. The whole of the west have now got devon heel boots in the back of their car and they can now get them on OMPOS. So, although it’s not I would say the best of gold standard, when it’s Friday evening and you've found a grade 2 you can do something rather than waiting to potentially not get back in until Monday to order equipment that then takes 5 days and so it takes 8 days to get a piece of equipment. We’ve got it so certainly for heels as our highest number are for heels is we can then do something, so it’s going to be very interesting to look at our numbers in a few months’ time for the west division. So that’s a huge coo, erm, the xxxxx have got the same as well, so they've got it on OMPOS. What I’d like to do is if we can evidence that I’ll get it in the other divisions, but it’s all to do with money as it is always, erm, because I had to negotiate with the company, medicines management weren’t prepared for it to go straight onto OMPOS because suddenly everyone wants this, huge spend, so what I managed to secure was the company have actually provided the initial set up cost with the fact that we’re then going to be going onto OMPOS, so they very much see that if I can put this is, which doesn't take any paperwork or anything else. I’ve found a grade 2, I’m going to Ulysses it, Ive put this devon heel pad in, we get healing, sorted.

PC: What about that, those people pre-grade 2, so people who are maybe doing a braden, or are they doing a braden, erm, and going this person is at risk I can, I’ve identified these factors and this is maybe just redness at the moment or nothing but this person is obviously at risk, that conversion?

TVN: They’re doing that, again, they’re doing that with the devons so they’re going to be using that on the grade 1s and recognising that and they’re…the problem I would say, well it’s difficult because we don't record our 1s so therefore how many 1s are out there. Certainly on the 2s it’s certainly a significant number and we shouldn't really have got to the 2s, but what I find when I’m talking to staff, by the time they get in there it often is a 2, which is the issue, is they might, we are, if they’re going in, if they’re seeing the patients they will spot a, will spot a 1, respond to it, deal with it, some teams are better than the others, but I would say there’s quite a high number. It has come out that we’ve got a high number of 2s and the fact that they’ve got a, it’s over 300 grade 2s, erm and out of that as I say about 80 or a 100 that have ended up being, I mean this isn’t exact figures, but 80 to 100 have ended up deteriorating which is a bit of a worry, erm but they do recognise prevention because we do drip drip drip and certainly we encourage the handover tool, the xxxxxx handover tool and erm it’s something that’s still seen as that should be gold standard practice and you find some teams using it very successfully then some people forget, then we go back and have to remind them and then things improve again so certainly I think one of the things that has been very beneficial has been the handover tool , erm, the red alert stickers have also, are very good in some areas and certainly working with the carers out there, it’s that, I would say the vast majority of patients that we see in pressure ulcers have carers in at some degree because of their vulnerability, whether it is family members or paid carers or residential homes, obviously with 24 hour care. Those carers can really vary, some carers are brilliant and some carers have no idea and I’ve gone into some homes where the carers have been there and I see their handling techniques and my heart sinks and when I realise and I can think of one or two patients in particular, is those carers are going into three other patients, double ups and all four of those patients have got pressure damage and they don't get it and I’ve seen their dragging, it just, you know you just go… and also you go in and the patient is sat bolt upright and all their weight going through and they’re at that beautiful wrong angle and you’re just seeing it and you’re saying to the carers just take a step back, have a look at this patient, you know where the damage is, look how they’re sitting and when I say just put your hand underneath and see what they’re sitting on and they go oh, yes there’s nothing there is there and I’m going no, and they just don't get it and that’s the worrying effect, you’ve got , so you’ve got patients out there who are having carers who’ve got no understanding and yet this week I went into a live in carer who was absolutely fantastic. She said, oh, I contact the community nurses but it took them 8 days to respond, which is a concern. I realise, I recognise this as a grade 1, it’s red damage and then I saw it as a grade 2 and I got really worried, kept phoning and kept phoning and now it’s a grade 4 and she said that I’ve done this this and this, what am I doing wrong and when you talk to her she was going yeah, course that’s why, but she’s a carer so it was, it’s really worrying and we depend an awful lot on carers so we’ve got to train that bunch as well and that's so dependent on what training they have, erm, certainly social services carers have a lot of training erm we input into that and I’ve got a workbook I need to look at to see whether it’s what I want it to be, erm but it’s the individual and also the biggest challenge is when you, they pay for their care, erm, so we’ve got no real comeback. If the patient is paying for their care and just getting their neighbour to do it we haven’t got the same sort of comeback and certainly I have found that there are a number of patients who have that type of direct payment carer who have pressure damage, so how do we tackle that group. So, the problem is we are so dependent on other individuals and it should really be not just an MDT, but it’s an overall health problem that needs to be looked at, erm, because it can’t just fall totally on the medical model.

PC: In terms of the trust, in terms of community teams what does, for them, for what you’ve seen out there, what does prevention look like?

TVN: Prevention to them is not getting worse to put it simply, they see that they’ve obviously go to do, also in their minds is documentation, erm, what I would say is that braden is occurring, erm, certainly in our spot checks, audits, risk assessments are occurring, however it doesn't necessarily mean that they understand them and I had to go through braden again with a couple of nurses this week because they are seeing it as black and white, rather than taking a step back and saying their braden cannot be this because they've got pressure damage. Just think, your clinical, that this can’t be right so therefore they must be, and also that realising that if they’ve got, you know if the score is a high one, they’ve got to go to the high end rather sticking oh I’m not sure so I’ll put it on this one and also then what they do with it, so although we’ve got a very good braden and equipment of what you should do at a certain level I think they’ve forgotten that, it’s just another piece of paperwork, and that's the other thing I think that happens is you get used to this so you forget it, so in another way, what we have to do is relaunch everything again and remind staff, especially with new ones. Prevention is certainly something that they want to achieve, but I think they also get frustrated, erm, because it’s the nature of the patient they are dealing with, we’re getting more and more patients out there who are getting more and more, they’re going to the frail model, more and more complex, more and more staying at home. We’re keeping them too well so they are living longer, too many nurses think there is a kennedy ulcer so I’m seeing that battened around all the time at the moment, “oh it’s a kennedy ulcer, that’s end of life”, I’m thinking…erm, don't go there, so it’s, they can see the importance, but they also get frustrated with what they have to do and they also lean too much on equipment, they think when it comes to prevention, put a piece of equipment in and they don't think of the bigger picture. So they think I’ve got a risk assessment, erm, they don't feel it’s something that, it is their problem, but at the same time if they get that cushion it will be sorted, they don't think the extra step, which is why we spend a lot of our time, for example like this week I was working with a member of staff and I was unzipping cushions and I was looking at mattresses with them and you could see her face, it was like oh, I hadn’t even thought about that, because there’s a cushion there, they don't think the bigger picture and they don't actually, I mean I was getting her to take steps back and say look at their positioning, does that explain why we’ve got the problem is, and they’re going oh yeah because it’s very much like they’re task orientated, they’re given 20 minutes, get in, do that, do that and therefore prevention is, they think sometimes it’s just a leaflet and they just literally throw a leaflet at somebody and think that is prevention.

PC: And then document it?

TVN: And then document it, ‘given leaflet’, but they haven’t necessarily said given leaflet to discuss and highlighted with the carer and patient how they, what they could do, it’s just given leaflet. So they go one step, but they don't get the two or three steps and that’s where I feel a lot of our role is, going in, reminding them, making them think each time, so therefore as they walk through the door they’re looking and thinking and responding and they’re not saying things like “how’s your weekend”, I mean, you’d say that in passing, but they’re also, I get really worried, but I’ve seen less of this, but the patient knows more about the nurse and what they’ve been doing, than the nurse knows about the patient. That has changed I must admit, it is changing, erm, but I would say it was only a year ago I was experiencing that and therefore the nurses are taking the maximum amount of time and certainly taking opinion of every visit counts, that is something I think is indoctrinated into their minds. So, prevention is, yeah, it’s difficult to know with the new lot of staff though and that's that's my new challenge, is, we’ve got so many new staff. I know it’s indoctrinated into the staff that are there, but the new ones, what message are they getting from existing staff and there are some teams that I know we just haven’t been able to get into because our capacity to actually get a feel for their knowledge and what they’re being educated on. So we’re having to do a lot of rolling programmes, but we end up doing programmes and there’s been an issue, which again is not what it should be, I should be going in and saying to the rest of my team and saying okay we’ve got new teams here, these are the teams that you need to be the ones that you are putting the time into, but we are firefighting because you've got this other team that have got major issues, they've suddenly got three grade 4s and when you look at why those 3s and 4s have developed and when you look at prevention it’s all hit and miss, you can see some that actually they did this this this and this and you’re thinking yeah that’s really good, why have we suddenly got, why did this happen and there’s usually some pivotal moment when you can see there’s been a twist round and it’s usually been a health change, hospital admission so with a health change, changing carers erm. There’s a huge variety of stuff, we keep going on about documentation, but in reality just because we didn't do a braden doesn't mean that that’s why they got a, and that's the other problem is that you get senior management that focus on the fact that they didn't do a braden and you’re actually saying yeah but you can see that in actual fact they gave the advice. It doesn't matter what their braden is, it’s the overarching, although then sometimes you go, they didn't do a braden, they didn't do anything else either erm and it is so variable, so variable about where you go and again it can vary within the residential homes. One of the things that I’ve noticed, realised recently is that one of my teams they have one of the highest numbers of residential homes in the country and we were having a lot of damage in there, in these homes. Erm, we’ve put a lot of input into these and a lot of it is the fact that it is the knowledge of the carers, but now we’ve got really nervous so we’re going, we’re only visiting because we’re worried about these homes and we’ve also had another home over the xxxxxx that low and behold has closed and there’s major pressure damage in those homes and it’s taken a while now and it’s one of many things, but yeah you find pressure damage in homes there’s usually other poor care that’s gone on as well.

PC: So for those staff in the trust in the MDT teams who are acting preventively, you know, are they doing it, you mentioned the xxxxx tool as a sort of intentional rounding type tool essentially of things to consider, is their focus actually prevention or is the focus on, being aware of what the reporting process is, and in old money making it unavoidable?

TVN: It varies on the teams, I would have said a few years ago it would have been particularly one way, but I would say it’s only a small group now, I think it's a small percentage and it’s usually the leader in the teams, but I would also say we did have the issue before of therapy and we would have kick back from therapies turning round and saying no this isn’t our job and now that models changed, there’s very few teams now where they don't realise it’s part of their role. So I do feel that has changed. That has changed over the last year and I’m seeing more and more involvement with therapy, nurses, medics, if they are geriatricians we’ve got several people who come into teams and certainly I will, I mean this week alone I’m say with a group of patients. I saw three of those patients I turned around and said you need to get therapy back in here because we’ve actually had, one of them had no therapy and I said you need therapy and the other two, they’d had therapy in, they put everything in, but things have changed so I said we need them in to review and to readvise as to what is required now because they've done a really good job, for example, there was one patient that was very contracted, putting in our great PCM cushions and repositioning and giving them they've now relaxed, but as a result of that everything’s now slipped down and they’re now getting heel damage, yet before we were getting IT damage so you know it’s just them thinking well okay we need to get them back in again to review because it has changed and that’s totally acceptable.

PC: So is it TVNs pushing that agenda or are teams considering that as well?

TVN: Teams are, I think it’s everybody, it’s everybody. I think there are, there are a couple of teams where there is a bit of resistance, but it is a small number, it’s a small number. I think now it is seen that with the therapy view you need to get that true balance, you’ve got to work in partnership to get this right and like one of the nurses said to me this week I know about sitting and sitting at the correct angle, I don't really know anything else so I can do that bit, erm, you know, she was reflecting on it which I thought was great and she said do you know it would really useful if I actually went out with the therapists on this occasion together because then I might get an understanding of what I can do for the next patient and they reflected on that, realised that so that was one individual member of the team, but it’s erm, and certainly I’ll get therapists that will phone me now which 2 years ago I wouldn't have had, erm and I think one of the benefits as well is that we have a few therapists who are leaders of the teams so they’re driving it as well and also they’re driving it within their peer groups, so they’re turning around and saying well erm an integrated community lead or another as a community matron, erm, but I’m an OT background and I see the importance of this, you should see the importance of this, so there’s peer pressure as well to change things and erm I think it’s also, what’s had a very good effect is xxxx team, because xxxx had an effect on therapists that have realised, but again we’ve had so much movement. There’s been so much movement.

PC: And by therapy do you mean OT and Physio?

TVN: Yeah, both

PC: Equally?

TVN: Yeah, I think that there’s been more resistance from physios than there has with OTs, but some of those physios have now left and the physios that have come in are bought into the system more, erm, OTs seem to, yeah, they, I’ll say generalisation, but more OTs I’d say can get it than the physio side, whether that’s training or education, the way that they've been brought up. You know, when I chat to physios it’s, I’ve found it really useful and you just, just as you’re chatting away you suddenly see the light bulbs going, in actual fact this is linking with this this and this, yeah I can see why that would be of benefit and yeah I can see why I do need to look at that bottom, although I haven’t come into do that so we are getting less and less coming through that’s been missed opportunities by therapy, there are still a few, but it’s not as many as it used to be, before it was certainly a higher number. We’d see the only people who’ve gone in are therapy and then oh we’ve ended up with damage and that is certainly a smaller group.

PC: Okay, so therapy are actually seeing their own role within pressure ulcer prevention or is it a towing the party line?

TVN: Varies I think to be honest, I think it’s both, I think it’s both, I think things are changing erm, but it’s both and I think it’s what job they've come into whether they understand it, cause if they’re a specialist physio it’s very difficult, you know if they specialise in shoulders and they suddenly come into a, as a more of a generic role they find that difficult so it really does depend what their background is and whether they think god it’s [the trust] or whether in actual fact it’s an MDT approach and my thinking is just as useful as yours and we can bounce off. Some of my best prevention, it’s been when I’ve gone with therapy, cause you’re coming from different perspectives and it’s just so useful and I learn so much as well because I go ooh yeah, I hadn’t thought of that.

PC: And what about the, because you mentioned earlier about newly qualified or staff coming in new to the trust. Are you seeing that same thought process with the new staff coming in?

TVN: I think it’s so early days to be honest. I think they’re a bit like rabbits in car headlights to be honest, I don't think, no, I don't think they’re even thinking that way, they’re just coping and functioning and the teams are going oh we need you to be able to do IVs, you need to be able to do syringe drivers, we need you to be able to do these tasks to be able to share the workload so if you’re on on a weekend you can do the work as much as I can and that’s their thinking rather than not thinking oh okay we’re all working together and this is all important, just seeing that this is one of many things I’ve got to do, erm and when it comes to being on the train as well erm it varies at what stage, how long they've been in the organisation to how quickly they come on the training and whether they actually get it and one of the things that we’ll be pushing on our newbies is any day now we’ll have our e-learning package and we’ll be saying to them, because that’ll be a quick win and reminder because they can do that and it will take 40 minutes, which to be honest a lot of people say how do I manage 40 minutes, but I’ll just be saying that it’ll be half a morning otherwise so.

PC: Part of the reason I asked is that in one of the previous groups there was the comment of come new or new staff in have barely heard of what a pressure ulcer is, let alone seen one or acted to prevent or treat one, so you know, I just…

TVN: Was that, but then, was that therapy or was that nursing

PC: Nursing

TVN: That’s nursing, which would really surprise me that a nurse has never seen a pressure ulcer. I mean that’s a great thought that they never exposed one but that could well be that one of the things that we have taken on is a lot of newly qualifieds and depending on where they've had their experiences, there is a chance that they might not have had that, but at the same time it would certainly have been exposed to risk assessment in their student education, erm, they would have been looking at skin and maybe part of it is that they haven’t joined the two together and that might be part of it, is what it might be is they’ve been lucky enough that they've never, they've come out fresh and they've never seen a grade 4 because of where they've had their experience and that certainly can happen because where we’ve had students out erm, they go wow I’ve never seen this before and it’s because they’ve all been on cardiac or you know, yeah. That’s usually it when you ask and then other people they turn round for example like leg ulcers and say oh yeah I’ve seen loads of leg ulcers and you've gone, oh you've just gone to the community oh yeah on geriatric care all the time and that’s all you've been seeing all the time or in the baster unit, you know, so I think that’s probably the answer to why cause I can’t believe that.

PC: Do you see the involvement of any other, so obviously we’ve mentioned nursing, physio, OT , carers, anybody else within the wider MDT getting involved with this?

TVN: I mean it should be everyone’s if we’re realistic, but the people who are involved I would say, you’ve got the very close people who certainly are the people who do the face to face care, but you've got the slightly extended people who for example medicines management who are very aware because of dressing costs and dressings related to pressure ulcers and also when we start using things like PICO, erm so they’re going okay that’s expensive, why, so medicines management are certainly aware and are involved. Medics, it really varies because I have actually challenged one of my areas and I actually had three medics in a room and it was to do with a whole pressure ulcer day and technology and I got so excited I had to really control myself because it was, they had invited me I know as an afterthought, but it was a realisation that in fact I carried the day because so many people were just ignorant in the room so the trainers afterwards came to me and said I’m so glad you were there because they had so little knowledge and I had three medics the whole day where I was drip feeding the whole time about pressure damage and they had turned round and said we have whiteboard meetings with our community care teams, why aren’t these patients on there and there was two matrons there, area matrons, who turned round and said that they should be on there so maybe you’re missing them and one of the other area matrons was saying well I know they’re on there and I know you come along. I’m switching off, so the medical profession, so when I say medical profession I mean the GPs, the medics, they, the GP element don't see it as their problem, they don’t see that there’s necessarily an issue, erm I will drag a GP out to actually come and look at something because I’ve had GPs who’ve walked into a room and said oh it stinks in here antibiotics, rather than realising it’s the wound itself and it’s totally inappropriate and I so wanted that GP and said I want you to come and see this, erm but then saying I’ve also been to coroners court where the GP was the one who was hauled over the coals thank goodness, by the coroner, because his failure when it came to, and we had, the patient died from pressure damage and he had massive cavities in his sacral area, ITs and erm the GP, his understanding was not good and he tried to put total blame on myself and fortunately it fell totally back on him, so I think that GP has learnt, but I say, that’s one and I’ve seen three. We’ve got hundreds so I feel the medi, they should be involved, but they aren’t involved. They see it as a nursing problem, erm, but then we’ve got other medical directors, erm for example in xxxxxx hospital, certainly the the consultants there are aware of pressure damage and aware of consequences because we have patients that come in with that they are aware within that sort of acute environment than you will do as a GPs. We don't have dieticians, it’s fundamental, it’s on the risk register, there is talk about dieticians all the time, only a few weeks ago we were pushing about dieticians so again they need to be heavily involved, erm, it’s everything you can think of.

PC: What about podiatry?

TVN: It’s a real controversy, controversial one this because we have quiet email conversations with podiatry because of they turned round and said diabetic foot, they will turn around and say nearly everything they see could be pressure, so if we started reporting all the patients we’ve seen you couldn't cope with it so we’ve, I’ll be honest, we’ve kept quiet about it, because it will be a minefield because we’re then really having to look at that individual patient to say was this caused by pressure or was this the whole dynamics of the foot that has contributed and resulted in, erm and I do have frequent conversations with senior podiatry about what is pressure and what isn’t and it’s, it’s sitting on that fence, but certainly one of the things we do when it comes to prevention I’m often using my podiatry friends for offloading , but not enough, because at the same time that’s myself and I’ve got other team sat there who probably should be using it more than they are so yeah tackling things for the lower foot and it tends to lead more with the diabetic podiatry than podiatry, but also podiatry, but then there’s podiatry podiatry cause we also have private individuals podiatry. They don't, they don't understand pressure damage because there’s been a few times when I’ve had conversations and they don't get it as far as their dealing with, dealing with calluses, skin removal and nails so they’re looking after the foot, but they’re not that specialist in what they’re doing.

PC: I suppose as we come to an end really, what’s the role of the public and the patient in this?

TVN: This is something that we’ve often talked about because it should be everyone’s job but people don't know what it is, they still talk about bed sores, they therefore still think that it’s bed, erm, they don't understand what can cause it, but when we start telling people they go oh god yeah, you need to talk about blisters and shoes and then go oh okay. It should be everyone’s responsibility, but it’s not, it’s not sexy, it’s not out there, it’s one of the things we’re always talking about, having an advocate, we need, we keep talking about a way of getting into corrie and eastenders and having someone in there who’s got pressure damage because we need a high profile figure for it to happen on and although we’ve had you know some high profile figures, it’s not out there at that sort of level so I think until you have somebody significant who has a voice and shouts about it, it won’t be in the public eye and they won’t see it as important and although we’ve talked about providing prevention stuff to joe-public I think we’d also open the flood gates and we couldn't cope with the capacity of suddenly everyone turning around and saying, you know, my auntie’s got his, my uncles got this, my daughter’s got this and certainly it seems to be that more and more people are coming from different echelons of life so I’m getting things from specialist units now, erm, eating disorder units, mental health areas that are recognising that in actual fact this is pressure damage, so there is obviously a filtration of stuff that is getting out there and therefore it affects the peoples home lives because if you’re a clinician and then you go home you pass the message on to a certain degree. So it’s filtering, but certainly that it should, it should be everyone’s role and we’ve all got a passion for this so it should be, but we also know it’s not, it’s not sexy, therefore it’s, and as I say the way we’ve got to do it, we keep saying it, we need to know a writer for corrie or put in so they've got a story line in and then probably our workload would triple, but that sort of thing is what’s going to, I think, is the only way it’s going to get into the public’s eye and they’ve also got to see something gory and horrible cause they don't realise, they do not realise and that’s sometimes why we have to do shock treatment, you know, this is what you’re going to get if you don't do what we say.

PC: Do you think in terms of the patients that you’re going to see or whoever is going to see in the community, obviously we’re much more aware that it’s trying to be a bigger sort of MDT thing and get different roles to be asking about skin and inspecting skin, erm, but from a patient’s perspective is there some kind of confusion over whose role it is to be doing this?

TVN: Yeah, they still think it’s a nurse’s role, err, that’s the NHS model. We’ve made patients expect that if you’re from the NHS you’re doing for them, they’re not used to doing for themselves, we do for them. I mean the classic where I can say that is, I was for a while a community matron in the old model and I was one of the newbies so I went in in my mufty and the patient would respond then – would say yes I’ll do this, I’ll do that, as soon as I put a nurses’ uniform on they expected me to do it for them and that is an expectation, so it falls back to the somebody elses, but saying that we also have patients, spinal patients who, they've only had, they've had damage once and if they’re with it they see it as their responsibility so they’re a completely different group and especially our young wheelchair bound, yeah, that’s theirs and they know that and I’ve had people who will say I’ve taken myself to bed, you know put myself to bed for three days cause I know what, cause otherwise I know what’s going to happen and I thought yeah they've taken responsibility, so I think that’s a separate group, but the vast majority of people that we see are of the elderly area, I mean there is that proportion of under sixties and low, but you know you have a lot of neuro patients, some of the neuro patients see it as their responsibility or what they see is it’s their carers responsibility, but I would say the vast majority falls onto my carer. My carer looks at my skin or my nurse looks at my skin, but I don't look at my skin.

PC: So, if there was, for example an AHP going in, asking, do you think that the patient is a bit sort of?

TVN: No, not anymore. I think because they’re quite used to it, quite used to it. A number of times you get oh you want to look at my bum again, everyone wants to look at my bum, you know it’s a common, it’s, you can always tell especially when you've been in acute. Come out of the acute and we suddenly say oh you know we’d actually like to look at your bottom and they say ah yeah they did it all the time in hospital and you think that’s good, we’ve conditioned people, erm, so you will have it that some therapists, if they've gone in and saying it’s like a post hip and you've got a rehab system going in and asking, you will get oh why do you want to look at that so there, that challenge because I think it’s the nature of the illness of the patient. If they’re a rehabbing patient then they don't understand, but if they’re recovering from an illness or they are ill they will accept it.

PC: And I suppose finally, if there were no barriers, for you, what would an ideal world look like?

TVN: Everyone will take responsibility for themselves, it would be right up there on the agenda, erm, it would be back to ownership, it would be back to patients looking after themselves cause we don't have capacity. It would also be the fact that we have, if we went back to the avoidable, unavoidable, we have no avoidable pressure ulcers, but I don't think that’s reality, I think we’d have a bigger stronger TV team, because certainly there is evidence that when we get involved there is changes, but there’s not enough of us to cover the size of the area we’re doing, so I would say in a wonderful world if I had another full staff it would have a huge significance because we’d be spending all our time going round going drip drip drip, educating, educating, seeing this patient, seeing this patient, getting that message over and not firefighting and certainly when you look at other organisations that manage to reduce that they've also got large tissue viability teams, so to be a bigger team.

PW: Cause I know you've moved away from the avoidable, what was the primary reason it would be classified as unavoidable, what are the typical examples of why it would be classified one way or the other?

TVN: Erm, we have a whole list of criteria, so it’s just not one element, erm, but it’s usually just the fact of that everything has been put into place to be honest. It’s unavoidable if you’ve got evidence of education, conversations, equipment, risk assessment, documentation, erm speaking to a wider people, speaking to carers, looked at nutrition, looked at pain, erm, if you covered all those elements and you've done everything you could, but basically the patient has just decided that that night they’re going to sit in their chair and it’s a hard wooden chair, we couldn't stop that.

PW: So it comes down to more of a compliance issue?

TVN: Mixture, so it can be that the patient just doesn't get it, but you’ve also got xxx out there that you've got patients who don't understand or you've got some people who are belligerent, they’re going to do what they’re going to do. We have got a particular patient who’s got so many holes in them and he should be dead and everybody knows of him and he’s going to live with it, he’s spinal , he can’t feel it, not bothered and everyone else around him erm so, but we’ve got to make sure that we’re still doing things all the time because it could that he’ll get another one. He must have six by now, erm, so we’ve still got to make sure that we keep our finger on the pulse with him, but you've got other ones that it might be unavoidable just because there’s been a long lie, fallen over, long lie erm or erm or it might be unavoidable because we’ve never known them so they've never had any input and then we come in and that day we find straight away it’s a grade 2 and actually that next day it’s a grade 3 so he did have a grade 3, so again that would be unavoidable because the damage was already there, though we might have only been in for 24 hours , see what I mean, so there’s different criteria, but certainly we have an expectation that health provides x, y and z and also if they've got 24 hour care. If we’ve done our health bit and they've got 24 hour care it should be the primary care giver, not the primary care visit, [the trust] is not the primary care giver, it’s that residential care home, yeah, so there’s various elements of what fits into avoidable and unavoidable and we’re really quite tight on that compared with any other organisation, the trusts around us are completely different.

PW: And part of that, the ones that are a bit belligerent and not-concordant is that because there’s this lack, this public eye image that pressure ulcers is a real issue and it could really cause them harm or is that perhaps that they’re just being so passive in the care?

TVN: It’s both, it’s both I mean they, some of them are again it’s very generous, but some of them, we have a lot of dementia and therefore they just don't understand and you might have the carers who don't get it either and it’s not until something major happens just the caring understand but the patient still won’t understand what’s going on, erm, but you've, yeah it’s, yeah it’s a mixture yeah.

PW: Yeah, it’s difficult isn’t is, how do you effect something like that

TVN: A lot of it we will do the shock treatment , I’ll be honest and I will often say to staff, have you shown them a gory picture.

PW: Do the leaflets have any grade 4 pictures on them?

TVN: We, yeah our, our erm PUP cards do before we have a leaflet, yeah and it was a pretty nasty picture which everyone had in their diaries, but now people don't have diaries so that’s all changed so they have got pictures and that’s one of the reasons again, the cards in the pocket so they can turn around and say look this is what you’ve got now, flick, flick, this is what you’re going to get and if they don't see it we’ll say next time we’ll bring in a nice big picture of what it’s like and that will, will have an effect on some patients or on their family member and that’s sometimes a turning point, of the shock. Sometimes for the more educated I’ve actually pointed people to some you tubes to see some disgusting photos, pictures to say look this is what I want, there was actually one patient about 6 months ago when I arrived was actually on the computer and was being very belligerent so I said do you mind if I just borrow your computer and started putting youtube on playing in the background whilst I was talking to him and his eyes were kind of going like this, oh this is what you’re about to get and he got it then, so that’s a subtle way that I got him to see what was going on, but it’s a real challenge and we have a lot more of that group than we ever used to and we do also have fresh spinal patients who don't give a damn, they've had a really bad life shock and this is nothing, so they don't care what you say, they’re not interested and when you’re suddenly saying right you’re in bed, they’re kind of sticking two fingers and smoking their marijuana and they just don't, you know, they’ve turned their back to the wall, but that’s the other thing and recognising that area of mental health and depression and I think that is a gap. I think that is a gap, we don't always recognise that one, saying actually address the mental health and we might actually be able to work with the patients.

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