Interview 1 – Registered Nurse

PC: What does current practice for pressure ulcer prevention look like in your team?

P1: Erm, when we, err, take a new patient onto the caseload we always do a skin assessment, we’ve got a body map that we refer to, obviously we mark down any changes to the skin. If we find erm, well, different grades, obviously we find broken skin, erm, we grade it erm as to different levels. A grade 2 is erm a broken area, erm on a bony prominence, obviously we check everything else that patient is suffering from, erm, immobility and things like that, and nutrition and that is what we, use a erm incident reporting system called Ulysses, erm, grade 2s we just Ulysses them erm so that we can monitor everything that’s been put in place erm, from mobility, erm, pressure relieving equipment, nutrition, we photograph the wounds weekly, erm we monitor the dressings if they’re working and so forth. If it’s a, if it’s a grade 3 which is obviously a deeper wound, sloughier, then that has to be erm monitored by a panel so when we Ulysses it the manager will undertake all of the, making sure that that everything’s being done, carried out properly and then that will go to a panel where there’s erm a band 8 erm manager, tissue viability nurse and obviously somebody from the team erm will talk about that patient and they’ll make sure that, you know, everything is being followed and that we’re using the right techniques and the erm right dressings and everything’s in place. If there’s gaps in that treatment, then that can be investigated further and we have a duty of candour if it’s a grade 3 or 4 which means that we have to write informing them that we are really sorry that this has happened, but we are investigating, that we are doing everything that we should be doing. So it can be a bit, it can be, not tricky, but it can be quite difficult to process sometimes because nurses get very hung up on whether it’s a grade 1,2,3,4, and there’s this other thing as well, deep tissue injury, erm, but I think that we’re quite good at reporting in this team and we’ll, we’ve got much better at actually doing all the steps that we need to do to make sure that patient progresses and and, but quite honestly a lot of the problems usually is actually the patient’s compliance to that treatment plan and engaging in the care plan and also the carers or next of kin that are looking after them that we we have a problem with sometimes, but I think that we’re getting better at trying to erm putting in things that will hopefully encourage them to do, you know, increasingly we’ve got a therapy team that help us out, we’ve got a consultant geriatrician that we talk to at erm the MDT meetings, that which I’ve just been to actually, erm, if you’ve got patients that we’re really worried about and you know there’s other comorbidities or influences from things, you know, that are out of our control really and sometimes the consultant going in, it can change the patient’s perspective of what we want them to achieve, erm.

PC: Okay, so in terms of, you mentioned there about, really the treatment, when there’s a pressure ulcer already existing…

P1: Yes

PC: what about in terms of the risk assessment and the prevention side of things?

P1: Yes, obviously we fill out the skin, I probably went on a bit too far didn’t I, but we did, we fill out the skin assessment, we fill out a MUST tool, which obviously helps with their BMI and obviously how much weight they’ve lost over the last few months and they get scored on that and we do braden, that’s our risk assessment and that comes out to erm a figure as well and that then would deem whether they’re high risk , low risk, medium risk and then that’s monitored as to how often we need to go in and who, what other services we need to get in as well sometimes, and then obviously a care plan is always put in place and we are getting better at that and also a carers care plan, because that’s the other thing, we were, not failing on, we were, you know, we needed to promote actually that we’re not the primary care giver always, it is the carers or it is the next of kin or the wife, you know, or whoever is looking after that patient and actually to work with them along, you know, so that when we’re not there our plan is being carried forward, erm, so that’s what we sort of do, and we have obviously the rio, erm, that’s our, erm, reporting system that we use and we do a progress on that everyday, we do intentional roundings, which covers all the main areas.

PC: So, who’s involved in that, within the team overall, who’s involved with doing those risk assessment scales?

P1: Erm, we try, we try, initially, unfortunately, usually the first nurse, the first registered nurse that goes in usually becomes the key worker because obviously they then take ownership of what needs to be done and follow up. They don’t have to go in all the time, there is healthcare support workers that will support them erm, but we have a handover everyday and we talk about our vulnerable patients, we have a pressure ulcer tracker tool, which we refer to and that tells what needs to be done, what hasn’t been done, you know, so that we’re monitoring it, erm I think the difficult thing that we have sometimes is when there’s no nursing need and there’s no pressure damage, there’s just a vulnerable patient and sometimes they haven’t got care input and it may be a little bit of self neglect and all that sort of thing and that, that’s when I find it’s difficult, you know, how much you can pull away from that, you know you’ve got a vulnerable patient that, their skin could damage at any time.

PC: Do you see, are there patients then who would be on a therapy caseload, but not on a nursing caseload?

P1: Yes, yeah and those high risk ones are usually talked about at MDT, cause therapy are along as well erm and we talk about those patients there, erm, yeah and I mean they’re much better at the erm, erm equipment ordering as well because obviously they, we know the basic equipment that’s on offer, but we normally liaise with them and get them a seating assessment done by the therapist so that if they’re in a riser recliner chair, you know it needs to be a certain cushion, a certain weighted cushions and stuff like that, erm obviously beds, you know you can always put a mattress on it but you’ve got to make sure that patient can get in and out and all those sort of things, erm yeah, that’s the sort of, that’s how we liaise together.

PC: So, how do you perceive role and responsibility with regard to prevention in team? Is there an official idea of whose role and responsibility?

P1: We seem to, I think, we as, as the community team tend to, it seems to be the buck stops with us always, that’s how we feel I think, erm, we’ll get practice nurse patients referred to us because they’ve got a pressure sore and they’ll go to the practice nurse, but obviously we have to review their home because obviously a practice nurse can’t go out and review the home. We have to review their home to make sure they’ve got the right equipment, erm, the right seating err so that can be a bit difficult sometimes, erm and also our hospice, again with end of life patients they usually refer to us because obviously end of life patients you know their skin can be a problem.

PC: And within the team, so within the community team, so the different roles perhaps of a nursing role, a healthcare support worker role, a therapy role. Is that sort of defined within pressure ulcers?

P1: It’s usually the registered nurse that’s the key worker

PC: And then the registered nurse would bring in others?

P1: Yeah, others, other services as needed and obviously they would set up the care plan and like I said they usually, you know, if we’re not the primary care giver then you would do a carers care plan so you’re advising those next of kin or carers to do that certain plan and then we would just review probably monthly or fortnightly depending on what the problems were.

PC: And, within the team again, just thinking about the different roles in the team erm, how aware do you think different roles are, different professional groups are of pressure ulcers?

12:02

P1: I think we’re much more aware erm because we’ve been heavily erm scrutinised, I suppose the word is, by our trust, erm, pressure ulcers are quite a erm, black mark, not a black mark, that’s not the right word, but you know, its its its not a good thing to have a, yeah reporting them, but obviously making sure you’re doing the right things for that pressure ulcer or pressure injury, erm, so yeah there’s so, I think the registered nurse, especially the team we, you know, we’ve got very good nurses that are tip top on pressure and you know that that will be followed through, that plan will be sorted and the patient will hopefully heal.

PC: And within the other professions, so for example if a healthcare support worker was out erm seeing a patient, how aware do you think they are of seeing something and then bringing that back?

P1: Yeah, we’ve encouraged them to photograph, we’ve all got cameras so we encourage everybody to photograph if they’re worried about anything at all, bring it back to the team. We’ve got a tissue viability help line as well, which we can ring, we’ve got erm a TVN trainee erm whose come to join our team next week and he’s some days with us and some days with the other team over in xxxxxxxx and so we can, he’s another person we can turn to if we’ve got problems with wounds and he can refer refer onto tissue viability, erm, so what are you trying to, I think…

PC: I’m just I think I’m trying to, sort of interested in erm understanding really just how the whole team works together really?

P1: Yeah

PC: you know for…

P1: I mean our handovers you know are quite thorough and you know we will talk about a certain patient if we’re worried about them, like I say if a healthcare support worker goes out, most of our healthcare support workers are very good at photographing and you know erm, they probably haven’t got the complex sort of assessment process, but they know that if that’s vulnerable that they need to report it to a registered nurse

PC: And would you say that’s the same for a physio for example? If they’re out and they see something do they bring that back to the team?

P1: Mmmm, yes I think they do and I think they tend to pass it more to the registered registered nurse than actually take it on themselves, some of them will, some of the the physios will and some of the OT, OTs will, but on the whole, if it’s a wound, if the skin’s broken, they’d much prefer us to do or us to refer to tissue viability.

PC: And so the reasons for that? Is that an identity thing do you think?

P1: Yeah, I think they think we’re the experts, where as we probably would be if, we would take on so much therapy work you know equipment and stuff, but we’re limited so we would probably pass on something more if you know we needed more expert opinion, we’d pass it to the therapists. So I think there’s that’s why they feel they go so far with the pressure, you know if it’s just red and they, they can order a cushion or something like that, but if it’s, not quite sure if it’s moisture damage, not quite sure if it’s ulcerated or, they would definitely pass it back to one of the nurses for wound, for wound management.

PC: So do you think that the increasing complexity of patients that we are now seeing in the community has changed practice in the community in your team?

P1: Oh yes, yeah, we get, we’ve obviously we’ve got a lot more obese patients, we’ve got a lot more diabetic patients, vascular problems, erm, immobility, people obviously living longer erm and yeah they, they’re not just one problem, there are usually comorbidities, probably erm (sigh), not always taking the best advice and not always carried, you know, the health, looked after their health as well as as you would ex, I don’t know what I’m trying to get across, but you know that they’re not looking after themselves as you would expect, erm, you see that as well, we’ve got different areas, especially in xxxxxx, you can tell the difference demographics with the the poorer people, not looking after themselves so well, relying much more on the care. Whereas I think that have obviously got money can afford to have you know care input, private carers and things like that, erm and obviously families aren’t around so much are they, they live away so they rely on getting care in for their parents, erm, or you can get the couple that, one’s very poorly and the other one’s you know looking after them, but they’re both, they’re both quite elderly and we get that a lot as well, erm I think quite a lot of xxxxx, we do have couples that, one’s very poorly and one’s looking after them.

PC: Yeah, and is that having a direct link on the amount of pressure ulcers you’re seeing do you think?

P1: Erm, no I don’t think so, no, I think the, the problem maybe is that people. I don’t think they realise how, if they don’t do certain things, how bad their skin can get erm and a lot of them I’d say they go to the GP and that’s how sometimes we get to know, you know, oh this patient’s got a broken sore on their bottom can you go and have a look and they, they don’t realise the severity of it sometimes. We had a lady, and when we saw her she had a grade 4 erm, she was err, she was wheelchair bound erm, but she was, she was quite upset about it, she’d let it go and go, she didn’t realise how bad it was, we actually did heal in the end and she was absolutely ecstatic about that because obviously she was really quite bad with it and she was really quite poorly and of course there’s always the problem with sepsis nowadays, well that seems to be in the forefront of our, people that, but yeah we’ve got much better at looking at the unwell patient erm, but you know even our healthcare support workers taking observations, contacting us or the GP, erm we’ve got the AFIT team which we’re (the frailty team), which we’ll, another service which we can tap into, we’re quite how, quite good here actually because we’re quite linked with xxxxx hospital, we’re quite lucky in a way that if we do to erm we had a patient that was quite poorly and we had to get her into MAU so we’re quite lucky like that here.

PC: So, do you find there’s quite a lot of joint working?

P1: Yeah, yes

PC: So what would you say are the barriers to collaborating together with maybe other teams or other professionals within the team?

P1: Definitely got better, definitely got better with our integrated team, erm we meet much more, we talk about patients much more, erm, referral system’s easy because we can do that quite easily. Erm, obviously therapy have got a waiting list, but they’ve also got a duty person everyday so if there is a real problem erm with mobility erm patient moving and handling , things like that, we’ve you know, they’re usually very good at picking that up. Erm, we’ve got quite a good rapport with our GPs, we have practice wards once a month, erm, but we can call on the GP anytime, leave messages and sometimes we do joint visits if, if it’s really needed erm.

PC: And how aware do you find these other groups are that you kind of pull in perhaps on occasion like the GP or other teams of pressure ulcers and the sort of risks of pressure ulcers?

20:43

P1: Erm, yeah I think they, they know to refer, they, anything to do with pressure, I think we get referralled, you know they will refer to us, erm, I think they expect that we are the main persons to contact, yeah, and someone will get sorted or we will bring services together to get that sorted.

PC: So you end up being sort of the integrating person?

P1: Yeah, I think the only way is maybe if the referral will go to therapy first is if it was a you know, a mobility issue, and then the pressure sore was the secondary problem, because they’re obviously, they’re immobile or they were hoisted or they had other problems but anything like that, anything like continence or anything, catheters or anything like that, that all gets referred to us.

PC: Do you ever refer to or make contact with TVNs?

P1: Yeah

PC: Or there’s an allied health professions clinical advisory team erm do you ever contact, make contact with them?

P1: I don’t know who they are

PC: They’re made up of OTs and physios based at xxxxxxx, but they do joint visits

P1: Oh, no, because I suppose we have our own therapy team over this side, whether they would get hold of those, but obviously if they’ve got any problems with like pressure relieving equipment or anything like that, they then our equipment store up in xxxxxxx, they’re in constant liaison with them about specific or erm specialised equipment for pressure relieving and yeah tissue viability, we’re quite lucky because as I say we’ve got this new role starting next week, erm, he was on our team before, you know, he knows our team really well and then they brought up this role with tissue viability training for two years and then obviously while he’s training he going to be in, within our teams, xxxxxxx and xxxxxxx. Obviously he’ll go out and see the real complex problems that we’ve got with pressure erm but we’ve also got our tissue viability lead who’s on our panels, she also comes out and sees our really complex patients with wound care, not just pressure, it’s complex wounds as well, erm, and she’s really good at doing training sessions and things like that erm because we are having a little bit of problems at the moment with, not problems, but we want to know more about deep tissue injuries because that’s coming to the front, there’s a lot more of that happening erm and I think before we classified it as a grade 4, but there’s no broken skin so obviously we’re trying to do a little bit more education on that, erm how we, erm, how we look after it and how we erm report it and obviously photographing it every week is really important because then you can see the difference a deep tissue injury can go one of two ways, it can just stay there and do nothing or it can really break down quite quickly erm.

PC: So are TVNs ever involved with, say a very complex patient who, who don’t have a wound yet? So they’re identified as being very complex through risk assessment and would you then involve them?

P1: No, only if they’ve got a wound

PC: Right

P1: Yeah

PC: Okay, so just thinking about leadership now within the team and actually a bit more widely as well within the area. Do you think pressure ulcers are a focus for leadership?

P1: Err, I think because obviously everything is reported onto tableau, including pressure ulcers, obviously they’re all graded differently, low, I can’t remember the other ones, and then there’s moderate, there’s one in between, medium I think, and then there’s moderate and obviously high risk erm and catastrophic which is obviously not very good at all, erm, xxxxx xxxxx, yes are quite involved in that because obviously that gets reported up higher and higher doesn’t it, but I think because of the way that, I can only speak for our team, I’m not sure about other areas, but our team, we’ve got very good at reporting, getting the services in place, erm, doing everything that we need to do, risk assessments, care plans erm, carer care plans, whatever is needed, tissue viability coming in, therapy coming in, so that, we’re hoping that everything’s done so that when its, when it’s reported, when it goes to panel, whatever, the powers that be can see that actually even though we’ve got a pressure sore, we are actually doing x as we should, but yeah xxxx xxxxxxx I think because of what’s happened with them anyway, but of obviously they’ve had a lot of problems with their mental health side, I think, I think they want us to obviously report everything and do it right really and like I, obviously their quite in, there’s duty of candour that you know we’ve got to accept that we might have done something wrong, but we’re going to hold our hands up and say yeah we’re going to do something about this and get it right.

PC: Okay, and…

P1: …which I find a bit difficult sometimes, because it’s not, even though we’re saying yes sorry this has happened to you, it’s not always seen, I think sometimes it’s seen that it’s not our fault, you know it’s lots of factors are involved erm, but I think that we’re, because we’re the main, when we’re the main care givers that you know it can be, that can be a bit of a problem when, I think with some of the nurses that you know you think well we’ve tried, well we’ve done everything, but this patient won’t do a,b,c you know, so.

PC: It becomes tricky

P1: Yes

PC: And again from kind of a leadership perspective do you think that collaboration and joint working is encouraged?

P1: Oh yeah, yes

PC: In relation to pressure ulcer or just generally?

P1: Well I think, I think they, I think they realise that an integrated team is you know multitasked, multi-skilled because not everybody can be the, you know, especially because community nurses, you know, we’re jack of all trades, but master of none, but we know where to go for specialist services erm or you might have someone in your team that’s a particular speciality on, they’re quite good at that certain thing you know.

PC: You mentioned obviously that there was a consultant geriatrician?

P1: Yeah

PC: …linked/aligned to the team, TVNs, erm are there any other professions like, I mean, err dietician or podiatrist or anything like that?

P1: The problem with the community is that the, those sorts of services are few and far between but we have got a quite a good rapport with our community podiatrist erm and they will set up a care plan or visa versa we’ll work in you know, we’ll work together, I mean we usually email, we don’t actually sort of meet each other, maybe, but we know to email them and say this has happened we need you to go in and do so and so and they’ll go in and do so and so and they’ll say you need to carry on with this and so we work together that way erm. Dietician erm not so much when it comes to pressure areas that’s more T TVN, we’ll go down the sort of you know vitamin C and those sort of things but erm I think if there was a peg or some sort of eating problem/disorder that they were under the dietician then obviously if they were, then then we would, but I wouldn’t say that happens very often at all. I think we’ve, I think well at the moment I mean it may improve but community diet dieticians is very few and far between and is usually quite hard to pinpoint somebody to help you, so tissue viability nurses usually have that sort of skillset.

PC: Probably really one final question if that’s alright, erm, really just about and it’s kind of a big one if you like, what would an ideal world look like for you in terms of pressure ulcer prevention?

P1: Erm, well a lot of it would be patients compliance, but I think obviously we’ve got pressure ulcer leaflets we give out, but we’re probably not very good at actually using that tool, I’m not speaking for everybody, but erm, but some are very good at explaining it and really unders, you know getting the patient to understand that this is quite important, your skin’s quite important and if you do x,y,z the more likely you’ll be okay, but if you don’t then there is that problem that this is what you need to do and it’s really patients informing us or carers informing us that there’s a problem so that we can get in before it gets too bad. On the whole that does happen and we know, we normally get them when they’re a grade 1 or a grade 2 erm, but we’ve had, we’ve had some really poorly patients recently erm, we find sometimes when they come out of hospital as well, they come out with quite severe sores, not everybody of course but they’ve been in hospital a long time erm and I don’t, I think xxxxxx hospital aren’t too bad for tissue viability, I’m not sure about xxxxx, I couldn’t really say about that erm, yeah, that’s where I say that patient comes home, you know they’ve got a grade 2 or grade 3 on their bottom or heels, not every patient of course, that that can be a maj a big problem.

PC: Any other thing that’s sort of a burning desire to…?

P1: Well I think that having this tissue viability link nurse coming to our team , that’s going to be absolutely brilliant, erm we’re quite lucky that we’ve got very good newly qualified nurses, but they’ve been with us a year, good year now and their skills are brilliant and I think obviously training has improved, [the training programme] have got much better, you know wound care, pressure ulcer care and there’s lots of e-learning that you can do as well on skin and things like that and I think, I think it the forefront, it’s at the forefront of all nurses in our team now, it’s a really good thing that we’re all very good at complex patients, we know exactly what we need to do, yeah, so that’s good, I think we’re quite lucky here from that point of view cause I’m more the, I’m the other end, I’m more the one who’s taking it to panel and making sure everybody’s doing everything. When I first came onto do this, things were not happening because people haven’t got time, but it’s just getting it into the forefront, if we just get it in there do do do do do then hopefully we can stop the worst things happening and we can get it to heal quicker and it doesn’t get bad and we don’t have to worry about taking it to panel and things like that, yeah…alright.

PC: That’s wonderful, yeah, thanks so much