Interview 2 – Newly qualified nurse working as HCA

2:19

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

P2: Erm, they, obviously I’m very new erm, but if pressure areas are detected erm then they’ll look at repositioning erm, they’ll look at erm aids, pressure relieving devices like mattresses, cushions erm and how they can be used, pressure ulcers are then photographed once a week so they can monitor the progress with the treatment that you’re using.

PC: And when you say they, who is that in the team?

P2: Erm, healthcare support workers and trained members of staff go out and see pressure ulcers.

PC: Okay, erm

P2: There’s also the option of seeking help from tissue viability nurses

PC: So healthcare support workers and nurses. Do you see the therapists being involved in that side of things?

P2: Personally, I haven’t at this point

PC: And what do you perceive is the role and responsibility within the team as regards pressure ulcers?

P2: It’s difficult isn’t is because technically pressure ulcers would be everybody’s responsibility so, and don’t get me wrong I can see, I’ve spent some time with the therapy team so I can see that they interact with one another in the sense that if I was to go out and identify a pressure ulcer I could then refer onto them to source some additional equipment, something like that, arguably I could also refer onto physio for additional help with mobility and so forth and I am aware that if they go out on a visit and they notice something, they will then pop a referral in for us so you could see the integrated working in that sense, erm, but in terms of treating the pressure ulcer I would have said that’s, that’s more the community care team responsibility

PC: Okay, so therapists perhaps more involved in the prevention than the treatment?

P2: Yeah, yeah, yeah, that’s true, in an ideal world

PC: Right okay, so it doesn’t happen?

P2: I think, I think it’s different with community, than it is within a hospital in the sense that you can only prevent things if you become aware of them so when I say, yeah, when I say that’s the way that it’s supposed to work. I mean if we were, if it was highlighted to us that that was likely to be a problem, then yes the occupational therapist would step in preventatively, cause it’s sometimes not like that and we’re not aware until someone comes home with sort of a grade 3.

PC: Sure, and how aware do you think different members are of the team, of pressure ulcers in general?

P2: From what I’ve seen pretty aware erm I think one of the points we’ve been told we need to work on is making sure we’re photographing wounds regularly and seeking guidance where we need to erm that they have a pressure ulcer tracker tool for which I am now responsible for us to discuss everyday so that the idea is that everyday we’re reviewing patients that have been seen that day with a pressure ulcer to work together really, because erm pressure ulcers are notoriously easy to cause aren’t they but very difficult to treat and so that is a long term condition really. So the idea is to bat off each other, get a bit of guidance as to how to treat it effectively.

PC: And so you mentioned treatment there, do you think everybody is as aware with the sort of preventive mindset, you know, before the person actually has a pressure ulcer and identifying the risk factors?

P2: No probably not, no it’s hard, I can only sort of speak from my view can’t I?

PC: Of course, yes

P2: erm, but no I would have said the position that we’re in as a team, it is more, you are looking at it preventatively because if you’re going out and you’re visiting a patient and you’re checking their pressure areas that’s a matter of course whether they’ve got a pressure ulcer or whether they haven’t it’s routine that we check pressure damage so therefore we are proactive in terms of prevention in the sense that to go out and see someone with a red sacral area, we would then look at ordering equipment in erm but if you were to ask me whether everyone had the same degree of knowledge in terms of pressure and so I would probably say no.

PC: Okay, do you think there’s an awareness within the team of the potential role of different professions if you like in pressure ulcer prevention and pressure ulcer management?

P2: Again from my perspective it would be nice to have that consolidated a little bit if that makes sense as to where our role finishes and where the occupational therapist’s role starts if that makes sense. When I went out and I spent time with them, they were very much like well if you put a referral and it’s just for a piece of equipment you could order that piece of equipment on your own without having to do a referral, where I’m quite new and I’m still picking up the ropes from my perspective, it’s quite difficult to define the individual responsibilities in terms of prevention certainly.

PC: So it needs a bit of definition. Is that something that you think that could be achieved locally or would it be better for the trust if you like to put some guidelines together?

P2: Erm, I don’t know, partially I think maybe it would be better if the trust were to put some guidelines together because the thing with, everybody’s under pressure aren’t they, you know, winter pressures and so, and sometimes it can be a bit difficult to take your head out of the parapet a little bit and see the wood for the trees so although I would say it could be handled at a local level if you were to bring in something from xxxxxx [the trust] I think it would probably be more effective.

PC: And again just thinking from a maybe a therapy point of view, if a therapist was to go out and identify somebody who’s you know at risk, but doesn’t yet have a pressure ulcer, would you then, would there then be a referral? Is that how it works?

P2: That’s the difficult thing really is that we wouldn’t, I don’t think our involvement would be there unless they had some degree of pressure damage so therefore if the therapists were to go out to see someone high at risk then they would then take responsibility for ordering equipment and so forth, but till it came to the point where there was a problem, which is why I say that we’re not as involved preventatively because…

PC: Okay, right, and how confident do you think people are in their knowledge of pressure and preventing?

P2: I think it’s really difficult, there are some, in terms of the team I think there are some people who’ve got a very strong knowledge of what pressure damage is. They’ve worked with the tissue viability nurses, you know they’re quite confident. From my perspective, and I don’t feel I’m alone with this, I think you need a bit more awareness in terms of defining pressure damage from moisture damage, from trauma, I think it would be useful if we were able to identify that, all of us, able to identify that more readily.

PC: Often, it’s obviously talked about the complexity of patients, the increasing complexity of patients in the community. Do you feel that that has changed practice, perhaps increased the number of pressure ulcers in the community?

P2: Erm, do you mind asking that again?

PC: Yeah, so, the question I have is really has the increasing complexity of patients in the community changed practice in your team in relation to pressure ulcers?

P2: I think where they’re more prevalent in the community now erm and more and more people are being cared for at home when perhaps so many years ago they wouldn’t have been I think, I don’t know I’d go as far as to say it’s changed practice, it’s certainly made everybody much more aware and more likely to highlight things like that than perhaps they would have been.

PC: Okay, what are your views on collaboration and joint working?

P2: I think in the community it’s imperative to be honest with you erm because the professions as it were, the occupational therapist and physiotherapist and nursing team, we’re often going out to see the same patients and fundamentally we’ve all got the same aim at the end of it so therefore the more effectively we can work together the better and I think it will be more efficient as well and let’s face it you do look at resources don’t you and how busy the teams are and that kind of thing erm I think there probably would be more, we could do it better, does that make sense.

12:07

PC: And actually along with that really what do you think the barriers, what’s stopping that from happening right now?

P2: I think everybody gets quite tunnel visioned in terms of their own workload so it’s easy isn’t it, it’s easy to carry on doing the same thing day in day out because that’s the way we’ve always done it you know when actually if you were to step back I don’t think there’s a lot of time, and again that might be me because I don’t know what goes on at a higher level s, but I don’t, I think the time is sort of focusing on how individual teams are so under pressure where as in actual fact nobody’s sort of taking the time to sort of stand back and say well actually how could we do this more effectively that would make it actually easier on each of the teams.

PC: Yeah, okay, okay, so it’s more of an organisational thing than?

P2: That sounds really bad doesn’t it [laughs], but yes that probably is what I mean [laughs]

PC: Sure, okay, are there any issues do you think with professional boundaries, particularly I’m thinking about obviously pressure ulcers right now?

P2: Yeah I think, certainly I think…it’s more of a knowledge thing so I think you tend to find a lot of the therapy teams would go out and see some kind of wound and not have any background knowledge of how to, or not have a lot of background knowledge, to not feel confident touching it, they feel that that will need a district nurses referral, equally you’ve got your nurses that are going out and it is quite plausible that we could just crack on and order a pressure cushion, but we’re not sure where our boundaries end and their boundaries start so you do it as a occupational therapy referral which, because of their pressures ends up taking so much longer than perhaps if we just ordered the piece of equipment in the beginning.

PC: Okay, okay,

P2: So I think it’s confidence in each other’s roles as much as anything

PC: And just jumping back to the joint working thing erm have you had any experience of joint working slightly wider than the team so I’m thinking about people like TVNs or erm there’s a AHP clinical advisory team or podiatrists or dieticians or anything like that?

P2: Personally I haven’t at this point no as part of my induction period they were quite keen for me to go and spend some time with the therapy team at xxxxxx so I could see how everything linked together which was really useful and I think is a really good idea erm and I know there’s also plans for me to spend a bit of time with xxxx who is a tissue viability nurse, but in terms of how that fits in beyond a local immediate level not really.

PC: So, it’s difficult to say, of course, but that time that you spent with the therapy team, has that meant that you’re slightly more kind of integrated with that team and you understand when to refer to them, when to not?

P2: It certainly helped, I certainly, yeah, it was really useful to me because I could, I had a base knowledge of course we all had a base knowledge of what their role would be and so forth, but particularly I think I understood the physiotherapy role more than I understood erm occupational therapy erm, but no it was really helpful to go out with them and I’m slightly more confident as to where I can now step in and so forth.

PC: Okay, do you think that from a leadership point of view, I mean both within the team and wider than that, there’s a focus on collaboration?

P2: Yes, I mean we’ve got two integrated care leads here and xxx is occupational therapy from background so I certainly think, it’s almost as if the wheels are set in motion and you can see what the aim is, it’s just in some ways that’s not always fully effective, does that make sense? Because we’re very, I was here as a student and when I interviewed and came back to be a permanent member of staff, it is very focused on the fact that it is an integrated team and that we all work well together erm and I think everybody sees the benefits of that I just don’t know that we do it as well as we could do.

PC: Is part of it erm pure location because I understand the teams are split a bit?

P2: Possibly, erm,

PC: Just logistics you know

P2: Yeah, I mean certainly we don’t have as much contact bar your induction period, you sort of meet everybody don’t you within those initial weeks, but then whether, if you were to ask me whether it would be any different I mean if we were all based at xxxxxxx hospital in different rooms would it be any different I don’t know.

PC: Okay, erm, do you think pressure ulcers in general are a focus for leadership?

P2: Yes, certainly from an immediate level in terms of xxxxx and xxxxx [team leaders] erm I mean we’ve been discussing pressure ulcers and how we’re keeping track of them and where we can improve this week even so yeah I would say it’s a focal point.

PC: Okay, and a greater focus on the sort of treatment, the management of the pressure ulcer or kind of prevention do you think?

P2: Treatment and management

PC: Okay, right, have you had any experience with the reporting process?

P2: No I haven’t as of yet I’ve been quite fortunate, but that is something that I still need to be trained in so I haven’t had to do Ulysses or anything like that yet.

PC: Erm, really I suppose I’ve probably got one final question erm and obviously anything that you want to throw in please feel free, but, and it’s kind of a biggie really, but what would an ideal world look like for you in terms of pressure ulcer prevention?

P2: Mmmm, I’m thinking out loud so, but I think, I don’t know, it’s not just the nurses and the therapy teams that need to be involved in it really to be honest with you, you’re going out to GPs and a hospitals, if you had an effective communication process throughout all of them maybe more of the focus would be on preventative measures instead of, we’re not erm, what do you call it, we’re reactive, but we’re not actually, whether there would be something that more that could be done if we, say, had a highlighted list of patients that are at risk of pressure damage so we could be more aware so they could be on the radar before we get to the point where we are treating a grade 3, erm, it’s improving that communication round everybody ,erm, to be honest with you but I appreciate that’s very difficult because again you roll back to resources don’t you .

PC: Sure, but you think that that’s probably the biggest facilitator really?

P2: In my eyes

PC: Yeah, yeah, okay, within that, involving somebody like the GP erm, how do you perceive their knowledge would be on the subject or their awareness of pressure ulcers?

P2: It would depend on their knowledge of the patient really I mean it depends how often they see that patient, I think, when I think sort of like that I think to myself oh well if someone wanted to see the practice nurse in the hospital, which might not normally be somebody we would see because they’re not housebound, if they noticed their mobility was deteriorating or that they were struggling to get out of the chair you can reflect upon their risk of pressure damage can’t you in that moment and if that was then highlighted you could be a bit more proactive about it and I know it wouldn’t be possible in all instances because there’ll be patients that the GPs don’t see one year to the next won’t there so, but I think you’ll often, often seem to find the people who are coming to us and are being treated for a grade 3 or 4 have had that interaction with different healthcare professional s it’s not like all of a sudden they’ve not been seen by any sort of healthcare professional for a year and all of a sudden they’ve got a grade 3, often you find that they’ve recently come out of hospital, they’ve been to see their GP about something different so you feel as if there, there’s more that you could. There is more that you could be doing.

PC: Okay, okay, yeah, and maybe, is that an awareness of the risk factors, you know, identifying somebody who’s sat there in front of you that this person might be at risk of….?

P2: Yeah, yeah, increase in awareness as much as anything, erm, because like I say the main focal point here is to react when there’s already a problem, where it’s whether you could catch it before that point.

PC: That’s wonderful, any further comments from you, any other thoughts on this subject?

P2: Erm, I’m really interested to see where you come, part of my dissertation was repositioning and preventing pressure ulcers so I am really interested in where you come out, but no I probably don’t have any more thoughts on it. I hope it’s been useful to you.

PC: Absolutely