Interview 4 – Community staff nurse

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

P4: Erm, I think we have a very good structure for it and erm a, I think we have a lot of support from tissue viability to support us in identifying what is a pressure ulcer and what isn’t, erm, but yeah, it still is sometimes quite quite difficult to distinguish between the gradings erm and I think we have a lot of, a lot of personal opinion which is a difficult measure to kind of get to grips with erm and yeah, different people’s experience of what they believe something is friction or what is pressure.

PC: Sure, okay, and in relation to, so preventing a pressure ulcer, so before, just identifying somebody who is perhaps just at risk and doesn’t actually have a wound. Who’s involved in that?

P4: Erm, I think it, it’s anybody that makes contact with them from the community team and that should be either nurses or therapists or healthcare support workers. I think it’s everybody’s responsibility to identify that somebody is at risk and make appropriate actions, whether that’s care plans, carers care plans, equipment, advice to patients but also the biggest thing I think we miss out is advice to relatives and actually relatives understanding the importance of prevention erm, because yeah, they could potentially identify deterioration in the patient’s condition more easily than we can because they know them better, erm, and yeah I think any decline makes them at very high risk of getting a pressure ulcer.

PC: So you mentioned, it’s everybody’s responsibility, erm, do you see that happening in practice?

P4: No [laughs], no, I I think, I find we often get a lot of referrals for pressure area checks and when you’ve had either a GP or a therapist or somebody in another medical profession saying that they need a district nurse to be able to go and do a skin assessment I don’t think that’s necessarily appropriate. I think everybody should be able to do a skin assessment because of the nature of the jobs we all do erm, I often think yeah if someone sees that it’s going to be difficult and/or there might be a lot to do it’s almost passed to who they think is more appropriate rather than doing it in the most efficient manner, which is sorting it out when you first identify it [laughs]

PC: What do you think is the reason for that?

P4: Erm, time, I think time is one of the biggest constraints erm, potentially if it’s GP, lack of knowledge, how to order equipment or what would be the most appropriate equipment, but I think really that also comes down to time.

PC: And within your own team, erm, so how many referrals, do you get quite a lot of referrals for that?

P4: Yeah, yeah, I mean I think for a patient that is completely unknown to us we probably get at least one or two a week, which actually in the grand scheme of things is is quite a lot, but they’re not coming to us for wounds or anything, they’re just coming to us for pressure area checks.

PC: And predominantly, where does that come from, what profession group?

P4: Erm, post-hospital discharge I think, erm, yeah, erm that’s something really to check, but yeah, post-hospital discharge.

PC: Erm, just thinking within the integrated team, erm, how do you perceive different roles and responsibilities in terms of prevention?

P4: Erm, I think there is a bit of a concern that maybe, even less experienced members of staff or unregistered members of staff want a registered member of staff to go out and see somebody to almost make that decision whether or not they need, what equipment they need erm whereas I feel yeah we’re more than capable of doing that, but I think it is, it’s also that because of the nature of what pressure ulcers can mean for somebody and the impact that they can have I think there’s also a worry of if they’ve identified it what’s the, and the equipment isn’t in in time or that patient deteriorates, what’s the implications of that and should that be on a registered’s shoulders than an unregistered, which actually it’s on the shoulders of the team and if it was looked at more like that then I think people, I don’t know, it’s one of those things I think people are quite fearful of, you identify a bad pressure sore and people go shhhhh [sucking air through teeth], but you’ve got to look into why that’s occurred in the first place more than anything erm, so I do think there isn’t an equal responsibility taken for it within and in this team in particular, yeah, in general .

PC: You mentioned the implications of a pressure ulcer erm, can you kind of elaborate on why they might be?

P4: Erm, well I mean if if if they’re a particular yeah to their body parts, if they’ve got a grade 4 or something I mean it’s going to, it could potentially affect that person’s mobility in quite an extreme way and even make them housebound if they weren’t before, understandably that person’s going to be very upset, the family is going to be very upset erm, we’ve got to look at what, if we could have done anything before erm, but these are people that kind of happens in our care, I think if if if they’ve come to us with a very bad pressure sore it’s, it’s about trying to heal that. I think we look at them very, very differently within our team, what’s occurred within the team and what’s come to the team. It’s almost I think looked at in two different ways. It’s almost less fearful because they’ve already got it.

PC: So, in terms of the focus, perhaps within the team, but also a bit wider if you can, do you think there is a preventive focus or more of a treatment focus?

P4: Erm, I think, I do see it’s changing, I mean even from the amount of time I’ve been in the team I think there is a much heavier look towards prevention, but I do think what I’ve always kind of known is kind of almost cure, to heal the pressure sores or erm and once they’ve got them erm but I yeah personally feel there needs to be a much heavier, what’s the word, heavier amount of focus on the prevention on yeah, and I don’t think there is…

PC: And just thinking amongst different professional groups erm, what do you think the awareness of pressure ulcers overall is?

P4: Erm, I I I I don’t, I think like with therapy teams, I think they are looking at pressure ulcers but they’ve, they’ve also got so much other things that they’re looking at and I don’t think that skin assessments and things are quite high on their priority, erm. I do find just from personal experience that there’s a lot of ‘patients have reported’ and ‘patients have said that’ their skin’s fine and it’s intact and when you’re dealing particularly in this area you’ve got a lot of older patients and a lot of private patients, but then also a lot of patients with some extent of dementia and not trying to be harsh about the patient but can you really take them on their word of that, actually with a bit more encouragement you might be able to unearth something that is, that they are at high risk for some reason and actually be able to put something in place then. Erm, and also I do find that in in hospitals it’s not, it’s nowhere near as erm highlighted, it’s almost left towards actually more to the healthcare support workers because they’re the ones more responsible for turning them and things and so they come out of hospital and it’s not yeah, I find it, it’s not as identified, but I think quite often heavily and also our palliative teams that we work with, I mean again I don’t think that there is a big, big erm push from them to be checking pressure areas and I don’t know if that’s a rece, sad in a way, mentality that it’s almost inevitable that they are going to break down because they’re end of life or if it’s, if it’s thinking that actually they’ve got enough going on, let’s get the district nurses to do it, but I don’t know.

PC: Kind of within that do you think that different professional groups have confidence in their own knowledge in how to actually prevent pressure ulcers?

P4: Erm, potentially not erm, I mean I don’t think that they’ve got the same access to tissue viability, live lines and things like that and here we just have, all we’ve got to do is upload a photograph and make a phonecall to a mobile and somebody nine times out of ten somebody will be on the end of that phone and after a ten minute conversation with them you have your answer, you have got your care plan and you’ve got what actions need to be taken forwards and it’s a very quick and efficient thing and I don’t think that other, I don’t think say therapy/therapists would necessarily pick up that phone and think I need to call tissue viability to get some advice from them erm and it’s not yeah, something that I’ve experienced other teams say that they would actively use erm and equipment ordering, to be honest I think equipment ordering is, there’s just so much of it, it’s almost over complicated. The system that we have for ordering equipment people just, I think there is also that dread of having to get onto that [laughs] equipment website erm and there is only a couple of people here that are trained up at the moment because it has been such a challenge to try and get everybody trained up on the new system and I’m not trained up on it yet and that makes a big difference and you do worry if that does cause delays but you’ve just got to ask other members of the team to do it [laughs], which I am always constantly doing.

PC: So, do you think there is an awareness of how erm each other’s role might impact pressure ulcers and actually that kind of communication between different professional groups.

P4: Erm, I don’t think the communication is anywhere near as good as it could be and I think we do a lot of duplicating erm, I think there is the awareness, but it’s almost I feel like people are kind of covering their own backs a bit, erm, that it doesn’t , doesn’t take three different teams to come out and visit for the same thing because they want a second opinion, it takes a conversation over the phone, erm, so I think there is the awareness of what everyone’s role and what others can provide I just don’t think it’s used as effectively as it could be.

PC: Okay, do you think there’s any issue with, so in some of our focus groups and interviews previously some identified professional boundaries if you like and professional identity as being an issue in terms of being involved in pressure ulcer prevention or not?

P4: Erm, yes I think in a way, yeah, I can see that, I think that our community team over where our therapists are have got a much better rapport with them than we do, erm, and I think that’s purely down to locality, if they’ve got a problem they can pop downstairs and have a conversation with them and just know them on a better professional level, erm, and have more informal conversations with them and I think that makes a real difference erm and yeah you end up with the rapport that you have with somebody erm, which I think we almost lack here in a way that we are all a little bit isolated in that way.

PC: Yeah, because I understood that you are in two different locations, in a rural locality, erm, how much impact is that in terms of working collaboratively?

P4: Erm, I think it does quite often cause a bit of, well quite a bit of friction particularly when the staffing’s not appropriate or there’s a problem with the staffing or someone’s gone off sick and we don’t find out until four o’clock in the afternoon that that person’s gone off sick and its its, we get, I’m sure a lot of people in the team as I do get quite frustrated of thinking, but it only takes a phone call whereas if you were all together you would automatically know that erm, yeah it is, I think you always, yeah, always going to come, come across and we are, we are supposed to be one integrated team, but we are effectively two different teams because we don’t have an overlap of patients, we don’t even have the same overlap of the same working system, we’re rio they’re system one, we don’t even, if I’m working on a late I can’t just look up what patient somebody’s going to see because at the moment I still don’t have access to that. It’s it’s it’s small things like that, that actually they put up quite big barriers. There is band 6 meetings and things like that but there hasn’t been a band 5 meeting so you just, I don’t do really know any of the staff, erm, so I think from that point of view, yeah, when you are trying to get support and advice it does make it a bit more isolating.

PC: Just jumping back to something that you said a little bit earlier, just about obviously receiving referrals for example from therapists to go out and check skin, would they have been out already and seen it and they just want you to double-check?

P4: Potentially, yeah, or or they’ve been out and assessed for something else and they would like someone to go and erm give a second opinion, erm, but what we often say within the team is if you’re pretty sure about something and you’ve taken a photograph and you’ve got someone else who can also confirm that with you then there’s no need for a second visit. It’s, it’s almost like a waste of resources, you’re doubling up, if someone’s properly viewed the skin and they have got a sore and they have photographed it they can always call us for advice, erm, but often they’ll say no you need to go in and assess as well and I can understand that for the the maintenance and the care of that because we would be the team that would be going in the same visa versa if therapy are going in on a weekly basis, there should be no reason why actually they couldn’t do that as well. We wouldn’t expect them to do complex wound care or anything, but if there’s not even a dressing it just seems a bit of a waste, waste of, yeah, resources.

PC: And when this occurs is there ever a time when you would go out jointly?

P4: Erm, not really for something like that, erm the only experiences I’ve had of joint visits is when it’s been a palliative patient, so we have done a skin assessment but they’ve needed a full overhaul of all equipment that is with outside of my knowledge of what to order but then I’m also signing in medications which is outside of what the therapists order, and actually to stop the family from having to repeat which I really think we need to be doing so much more of, otherwise the family are just repeating themselves twice, everything, with, I’ve joined up with someone and gone in together and so then I’ve written half of the assessment and they’ve written half of the assessment and they can do a much more detailed one and I can do a much more detailed one and it’s, yeah, much bigger benefit all round, erm, so actually if it was appropriate for that, yeah, it would be much better that we were joining up more, erm, but again it’s, it’s the way, them being over, and not here, it’s just even trying to link up with them, they have timed and set visits and we can’t do that here because of the nature of yeah, what we’re doing, we cannot give anybody any timed visits because you just don’t know how long the last patient’s going to have been [laughs].

PC: If there was somebody who you had a referral in and on paper that person looked quite complex erm and you don’t know necessarily whether they’ve got a pressure ulcer or not or whatever but you know, there are a number of risk factors. Is there ever a possibility of maybe like a nurse and an OT for example going or a nurse and a physio or whatever?

P4: Erm, yes, but again due to constraints I think we find that the OTs and therapists can’t get out there immediately sometimes, whereas if we had concerns of somebody having a pressure sore we would say within 24 hours they need to be seen erm and then if they needed a second opinion and there wasn’t a photograph then that would have to be done within 24 hours so you’ve reported that within 48 hours of that person landing on the caseload, erm, so we have to be quite strict about that and that means that sometimes you can’t, if the therapist cannot meet you until three or four days later that’s no good because they could have deteriorated and then it would be within our care [laughs].

PC; So, but it might happen three or four days later still there might then be a joint visit then?

P4: There could potentially be, yeah, erm, but again it is something that we could really do with trying to utilise and doing more of, it’s just I think everyone being on the same page for that.

PC: I mean you’ve identified obviously some barriers there to kind of collaboration if you like, are there any other barriers that are sort of burning away in your mind?

P4: No, I mean I think, I think it is everyone finds it, but it is, it is time that is, time and resources, erm, I know we’ve had quite a few issues being very frustrated with ordering equipment and equipment not turning up and that has been addressed and that has been being sorted, but, but it’s erm time, and caseload complexities. I mean, we’re getting patients in the community now that you never would have tried to care for in the community before even five years ago. It’s, it is very different erm and I think that stress puts people kind of, everyone puts their barriers up cause everyone is feeling pushed and it’s, yeah, that that doesn’t help.

PC: With those kind of identified complexities you know it’s well documented that there is increasing complexity in the community, erm, has that changed practice at all in terms of the different types of professionals who are going to see that particular person?

P4: I think I’m seeing a lot more specialist nurses supporting people in their homes, erm, which is really interesting to see erm, but they’ve, again they’re covering such vast areas. I met somebody last week and they’re from xxxxxxxxxx hospital and this was as far as they come over this way, but they say that they cover a patch and they were going up to xxxxxxxxx and xxxxxxx and up to xxxxxxxxxx and so you just think you’ve got one maybe two nurses to cover that entire area and actually is that, is that being effective enough. If they actually put more resources into that you could have a lot more people like this individual at home and that would, that would be really good, because they’ve just spent five months in hospital and they wanted to come home and it’s, its great that you could actually see that actually being able to be facilitated erm, but yeah, but again there is also that worry that you’ve just got, she had only had input from specialist nurses by that point and actually was unknown to us and so if something was to happen on the weekend or something we didn’t know them at all, so just us being aware of them, someone with this person’s very, very complex needs being on our radar and effectively what we say ‘being in our patch’ if we’re going to get an SOS call out it is quite yeah, the thought of walking into the unknown [laughs], that’s a big part of community nursing, yeah.

PC: Probably just another couple of questions if that’s alright with you, just thinking about the wider MDT if you like, do you link in with I understand there’s a geriatrician that’s aligned to the team, GPs, podiatrists, dietician, anything like that?

P4: Erm, I go to a monthly meeting with the GP practice that I look after, erm, there is always someone from therapy there and then someone from our palliative trust will always be in attendance and our geriatrician will attend the MDT meetings as well, the practice ward, erm, and that is a big benefit erm but we also again, it’s usually only the very complex patients and the people that are the red as we would say that ever get a chance to get talked about and actually sometimes that’s really not a benefit when someone’s almost sat on the border of being at risk of pressure sores or deterioration or if they’ve just become generally unwell in themselves and actually the GP needs to be getting a therapy team out there to reassess for equipment to stop them from deteriorating anymore or to stop their mobility from deteriorating or the geriatrician to review them from a diet point of view, but actually they are almost getting missed and the only way that they end up being at the top of the list is if they’ve ended up being in hospital or they’ve had a long lie and as a result have become very unwell, so it’s almost, there is a window we’re kind of missing.

PC: So it’s a bit more, would it be fair to say sort of reactive in that sense?

P4: Yes, yeah, yeah, definitely

PC: Okay, and I suppose really the last question and it’s a really big one if you like, erm, what would an ideal world look like for you in terms of pressure ulcer prevention?

P4: Erm, I guess, I guess it’s the same of, for me rather than, yeah, rather than healing pressure sores it is a much more efficient prevention scheme. I mean we have for leg ulcers, we’ve got our well leg clinic and we’ve got that so it’s almost like why isn’t there almost like a well skin, and awareness, greater awareness put in by GPs and post hospital discharge, erm, I think that’s yeah, and maybe also resources really, I mean it’s always going to come down to that, erm, but there almost just needs to be a standard that, fine maybe it’s not everyone gets a pressure cushion, everyone gets this, but there is a, a lower threshold as it would be for saying, intervention is now needed, maybe.

PC: Okay, that’s great, thank you so much, was there anything else that you wanted to express?

P4: No