When the Tissue Viability Nurse becomes a patient: reflections on a personal journey

KEY WORDS

- Biopsychosocial model
- Carl Rogers
- Mental health
- Person-centred care
- Self-awareness

This paper presents a reflection of my journey as a patient following a breast abscess. As an experienced community nurse with a specialist interest in tissue viability, we daily assess a range of different wound types and are adept at early identification and management of an infected wound. We instinctively know which dressing type to use to manage localised wound infection and slough and reduce pain for patients; however, when the nurse becomes the patient with a wound and has welcomed a new born child into the world, we can suddenly lose the specialist knowledge. This paper reflects on a journey I recently experienced.

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Communicating and listening to the concerns of patients are essential elements of all healthcare interventions, and without these aspects of care there would be a lack of trust in the patient–nurse relationship (McGilton et al, 2006). Understanding the importance of being able to develop communication skills in a two-way fashion with patients is not new (Stewart, 1995; Bowles et al, 2001; Morgan and Yoder, 2012; Blackburn et al, 2019). Ineffective communication has been identified with dissatisfaction and frustration (Blackburn et al, 2019).

Lusher (2020) explores the traditional model of managing physical health in her paper, *"whose wound is it anyway?"*, which is the main focus of treatment, along with psychosocial features is being largely ignored further identifying the concept of wound ownership. This concept has previously been described as being necessary to increase self-efficacy, self-esteem, and feelings of control over the illness (Lindsay, 2000). Communication skills are taught in undergraduate and postgraduate courses; however, these are, or should be, continually developed in the clinical practice areas. At times communication skills, such as listening to the patient, are often not fully embraced. This paper presents a personal case study where there was a breakdown in communication and specialist knowledge between myself (the patient), medical staff and specialist areas.

As a first-time single mother, I gave birth to my daughter on the 22 February 2021 via Caesarean section (C-section). I was not unduly worried about postoperative management following the C-section as I am an experienced nurse with extensive tissue viability experience. At the time, the country was in lockdown as a result of the COVID-19 pandemic, allowing single adults living alone to form a 'support bubble' with another household. Having no family nearby, I had little support aside from my friend who was within my bubble and lived locally.

I wanted to breast feed my daughter but noticed she was very tearful during feeding times; her tongue was white and so were my nipples. The midwife and health visitor were asked to monitor this, but after one month the situation was not improving. The general practitioner (GP) diagnosed thrush and prescribed nystatin for my daughter, which in turn caused her diarrhoea and nappy rash. Throughout this stressful time, I was getting repeated blocked ducts in both of my breasts and, following instructions from the health visitor, was advised to take hot showers. I continued to feed my daughter from both breasts and applied cold cabbage under my bra. I believed the 'blocked ducts' *(Figure 1)* in my left breast were

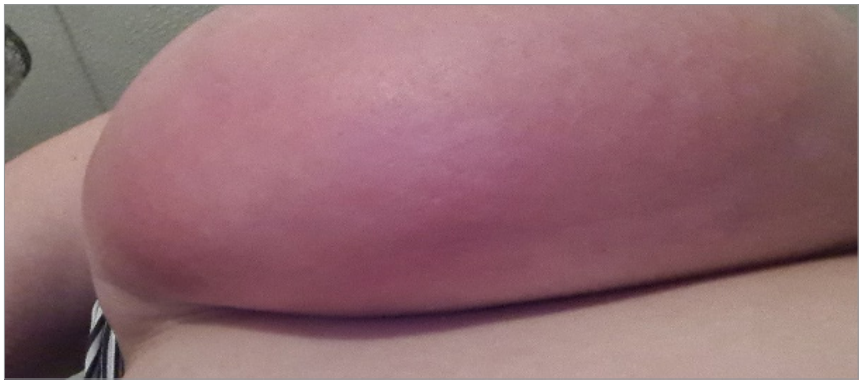

Figure 1. Initial presentation of breast abscess

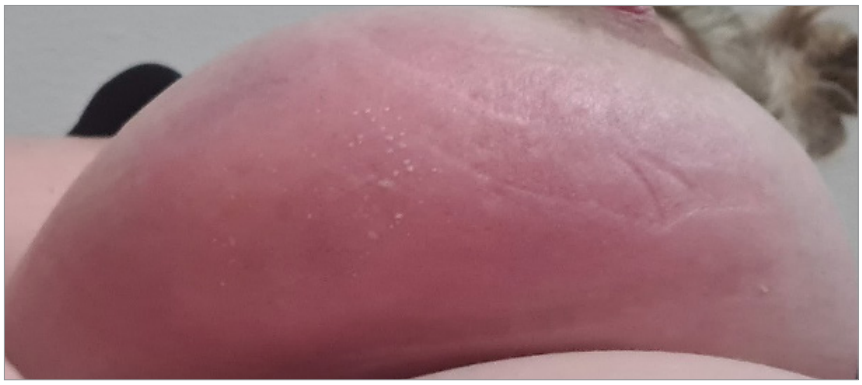

Figure 2. Inflammation of the breast

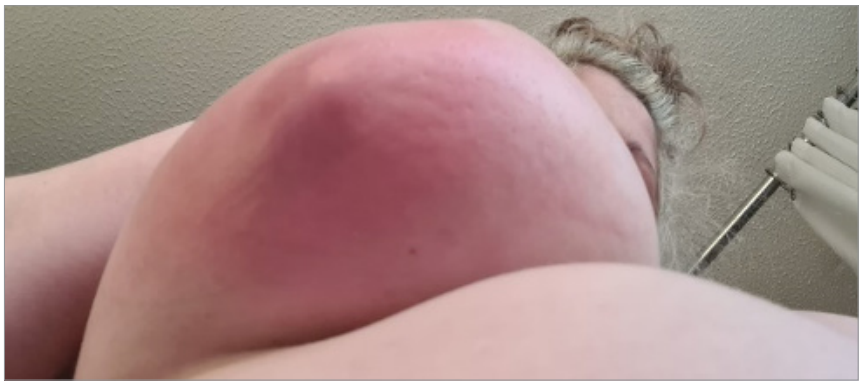

Figure 3. Raised lump and increased inflammation

more than that and felt entirely helpless both as a new mum, and as an experienced nurse. I felt I could not disagree with the multiple disciplines that were assuring me it was blocked ducts and that it would soon resolve.

After 8 weeks, things did not improve and my left breast became increasingly painful. I could no longer breast feed my daughter from my left breast, which resulted in it becoming engorged, more painful and my ability to meet my daughter's nutritional needs was limited *(Figure 2)*. The benefits of breast feeding for the child and mother is well documented. Breast feeding is essential both for the health of the child and the mother, providing optimal nutrition during immediate postnatal life and has been associated with a number of beneficial outcomes in later life, such as protection against obesity and diabetes (Alves et al, 2021; Picó et al, 2021).

I was becoming increasingly worried about my daughter due to being unable to feed, and concerned about the pain and lump becoming gradually more enlarged. Although I verbalised my concerns to the health visitors, they maintained that they were unconcerned as this was simply mastitis and encouraged me to release the milk manually. A friend with no clinical background noticed my daughter's tongue was heart shaped when her tongue lifted, yet the midwife and health visitor assured me there was no visible tongue tie. I asked to see the GP who confirmed my concerns, that in fact it was tongue tie (not visible), and my daughter was put on a waiting list. At this time, the GP also confirmed localised infection of my breast and commenced a seven-day course of clindamycin as I am allergic to penicillin. On the 13 April, I took my daughter to have her tongue tie released privately. She immediately latched on to my breast, with no more fretful feeding, and gained (more) weight quickly. The thrush was in fact congealed milk in her mouth and my right nipple, which had been painful and discoloured. This eventually became less painful and returned to its normal colour.

At this time, the health visitor and GP all informed me the lump and pain in my left breast was mastitis and I was experiencing new mum anxiety. I kept saying to them that it felt different from the other blocked ducts. Despite my daughter being free from tongue tie, I was still only able to feed comfortably and effectively from one breast. As the week progressed, I noticed pitting oedema of the left breast, with excruciating pain when it was touched, and was now unable to manually drain the milk build up. I also noticed a raised reddening area with what appeared to be an abscess forming where the blocked duct was *(Figure 3)*. By this point it was Friday, I was on day 4 of antibiotics with worsening symptoms. I was concerned about challenging the GP and health

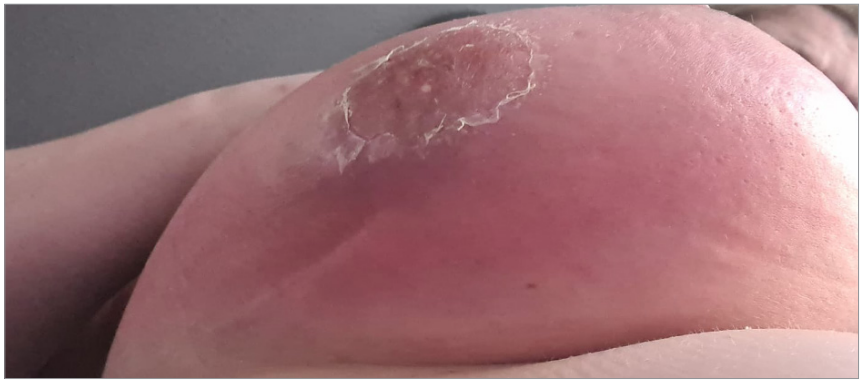

Figure 4. Skin integrity broken

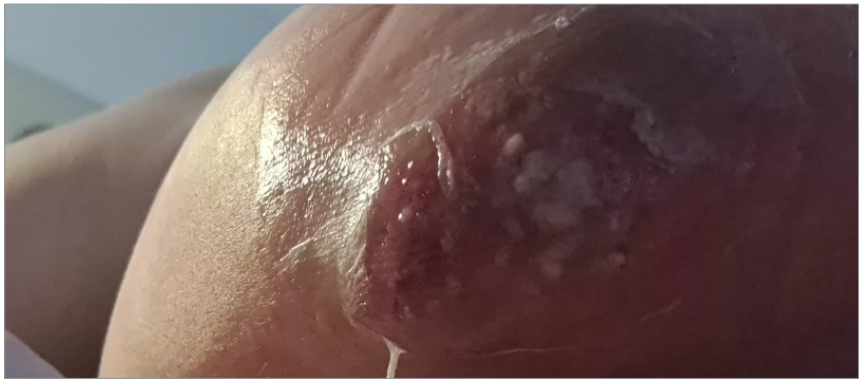

Figure 5. Evidence of deterioration and exudate

visitor's expertise, who were both convinced that is was 'a bad case of mastitis'. My gut instinct told me it could not wait until the weekend. I was concerned about the spreading infection, severe pain, inability to breastfeed and the risk of systemic infection. At this stage I was feeling generally unwell and had no other adults to rely on for support or help.

I contacted the GP but there were no appointments and so instead I managed to see the on-call health visitor in clinic. She reviewed the area, stated she had not seen 'mastitis' this bad and asked for a review by her colleagues. One of the more experienced health visitors assessed the area and claimed she had witnessed mastitis this severe once or twice in her career before and thought it was perhaps a breast abscess. She sent me to an accident and emergency department for a medical review. Within hours the raised lump had broken the skin *(Figure 4)*.

At this point I was terrified and alone and feeling ashamed as a nurse with extensive wound care experience that I had not been able to diagnose myself as having more than mastitis. The duty doctor examined me and wanted to admit me to hospital. He did not ask about my personal circumstances or if I had someone to care for my 8-week-old baby who was still breast feeding. As a single mum with no partner at home, I had no option but to refuse admission. The only support I could rely on was a friend and my elderly frail grandmother, neither of which could care for my daughter 24 hours a day. I was sent home on the premise that I would return the following day. The following day the abscess had broken down; I was commenced on the highest dose of doxycycline and told to return to see the Breast Surgeon on the Monday for prospective surgery. There were no instructions as to how long to take the medication — the doctor had given me 7 days' supply but as a nurse I was aware they are usually prescribed for 4–5 days. The abscess had started to drain, yet I was sent home with a non-absorbent dressing. The dressing was saturated within minutes. There had been no thorough wound assessment or consideration given to the high level of exudate, protection of the periwound area or prevention of further infection. I was becoming increasingly upset and confused about my current health but had to put this aside to prioritise my newborn daughter's needs as her sole caregiver.

Over the course of the day and the evening, the abscess continued to grow with increased exudate levels *(Figure 5)*. On commencing the doxycycline, I decided to stop breast feeding temporarily and switch to bottle feeding as I did not want unwarranted medication being passed over to my daughter. I felt I had failed her as a mother and became very tearful. Thankfully, my daughter took to bottle feeding with ease.

On Monday, I returned to the breast care clinic where the consultant radiographer and surgeon confirmed the abscess had completely drained and no surgery was needed. Due to my wound care background, they allowed me to self-manage my wound on the agreement that I would self-refer should further issues arise. Following self-assessment of the wound, I was aware of the high levels of exudate because of the infection, which was making the surrounding skin sore and macerated. This only added to the pain and discomfort I was experiencing

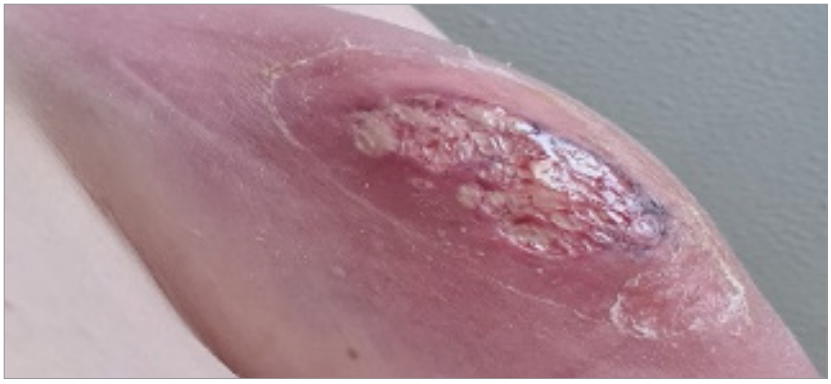

Figure 6. Week 1 of managing with Urgoclean Ag

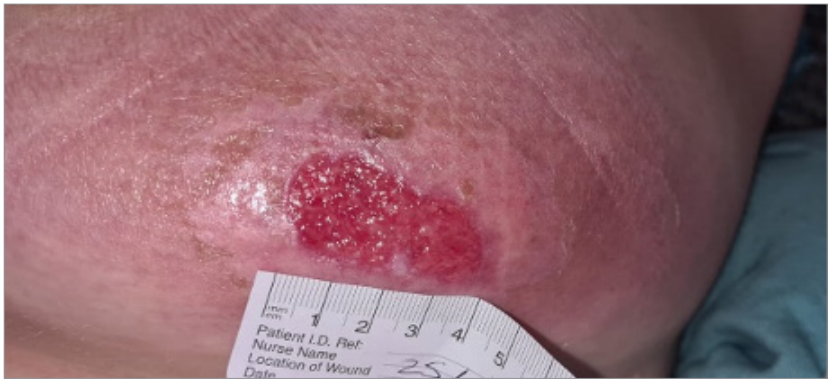

Figure 7. 2 weeks post management with Urgoclean Ag

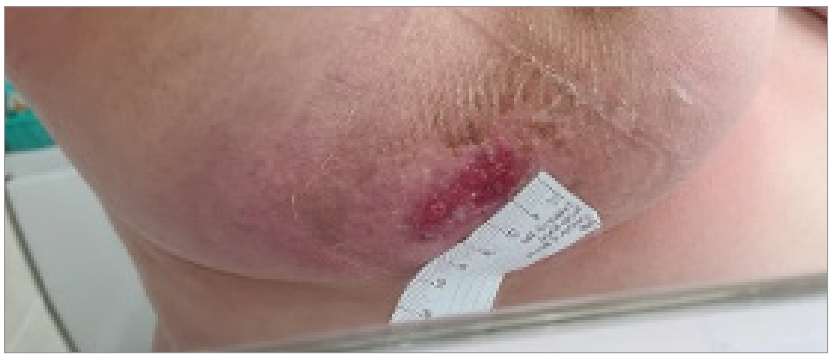

Figure 8. 3 weeks post management with Urgoclean Ag

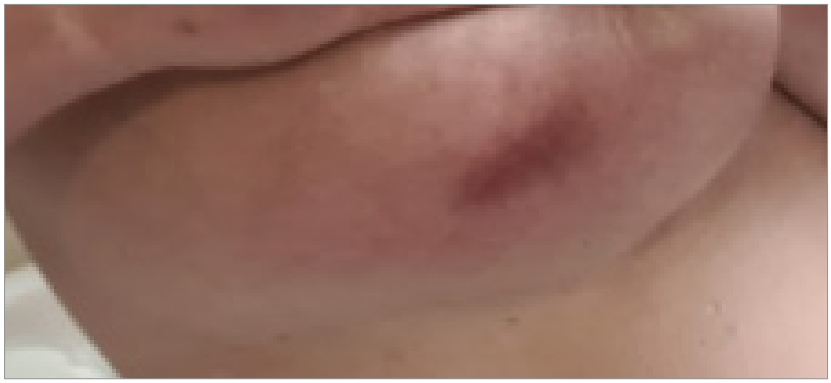

Figure 9. 4 weeks post management with Urgoclean Ag

and needed to be managed to prevent further skin breakdown and deterioration of the wound. I was still hoping to reinstate breastfeeding and was reluctant to be prescribed any further courses of antibiotics, especially considering the global concern regarding antimicrobial resistance (AMR) and risks of taking medications while breastfeeding. Due to previous clinical experience and the difficulty experienced in trying to get a GP appointment, I purchased UrgoClean Ag to manage the local symptoms of wound infection. I had in depth knowledge and experience of this product having used it many times with excellent results in my own clinical practice. The dressing reduces signs of local infection and promotes wound healing in wounds at risk or with clinical signs of infection, regardless of their level of exudate or their wound healing stage. The polyabsorbent fibres mechanically break down the extracellular polymeric substances in the biofilm while the Ag+ ions exert an antimicrobial action (Bisson et al, 2013).

The abscess burst on the 17 April, after which UrgoClean Ag was commenced for a 4-week period. Full wound closure was achieved on the 14th May *(Figures 6–9)*.

The abscess has now healed and, although there is a little itching, it is manageable. On reflection, there was limited knowledge and skills surrounding skin integrity, wound care, and identification of wound infection within the professional groups who reviewed me and the abscess. I also feel a referral to the tissue viability specialist nurse may have helped in supporting me when my ability to rationalise my thoughts and ability to cope as a person were compromised.

UrgoClean Ag was used to manage the localised symptoms of wound infection including reduction of microbes, reduction in exudate and protection of the periwound area; however, this was only successfully applied due to my own knowledge base and having taken the initiative to treat my own wound. This case study, albeit personal, has revealed there is still a disconnect in wound care education for all health care professionals. Midwives and health visitors possess an excellent level of knowledge and skills in caring for the woman and child following childbirth, but have limited education in areas of wound management. There are a range of wounds that these two professional groups may encounter and are expected to care, such as C-section acute surgical

wounds and perineal tears, for which education is delivered. However, when there is an unexpected skin integrity issue such as a breast abscess, there appears to be a lack of confidence and knowledge in how to manage these wounds and about suitable evidence-based products that exist to treat them.

My wound care journey as a patient allowed me to reflect back on a range of points. There was a delay in diagnosis of my breast abscess and a lack of appropriate evidence-based treatment to my wound to address localised symptoms, including a suitable wound dressing. Also, importantly, there was a lack of effective interdisciplinary communication. If I had not possessed knowledge in identification of wound infection and abscess formation I may not have sought medical assistance on that said Friday and believed that I was being an overanxious mother. This could have potentially led to a more catastrophic situation including sepsis in the absence of early commencement of antimicrobial therapy. As a nurse with tissue viability expertise, I was fully aware of the importance of choosing the correct dressing to manage infection and exudate. I did feel as though I had let both myself and daughter down as I had not felt able to challenge the healthcare professionals earlier, despite realising that the diagnosis of 'mastitis' was incorrect. It was the first time I had encountered mastitis both as a mother and a clinician. Yet, I did challenge and demand appointments on that Friday. My concern is that a patient with no clinical experience would have accepted the simple non-absorbent, non-evidence-based dressings supplied. This would have resulted in excoriated and macerated skin, and potentially could have led to further breakdown in the skin and emotional distress. Many would have accepted that the healthcare professionals were correct, not have sought medical advice over a weekend and waited until the following Monday. This is especially pertinent as, at the time, the media were reporting how busy hospitals and health care services were due to the COVID-19 pandemic, which may have led to a reluctance to seek help.

The European Wound Management Association (EWMA; Moore et al, 2014) recommend that those healthcare professionals involved in wound care and treatment should have the appropriate knowledge and skills. In my opinion and based on this experience, there is a clear gap in educational support for clinicians who do not routinely manage differing wound types. Development of a clinical pathway that supports early diagnosis including differentiation of mastitis and abscess and appropriate treatment of breast abscesses would ensure timely and appropriate care. It was not until I became a patient that I realised these gaps in knowledge and development needs of health professional groups. I hope that my experience can go some way to rectifying this situation to support clinicians and the patients in the future. WUK

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