

WOUND CARE PROVISION IN AN OUT-OF-HOURS DISTRICT NURSING SERVICE

In England and Wales, more than 2.6 million people receive care from a district nurse each year (Queens Nursing Institute [QNI], 2009) and an often unreported area of this service is the out-of-hours service provided from 6pm to 8am daily and at weekends. The complexities of such a service are clearly described by Wilson and Taylor (2011), who explain that, during the night, patients are often very frightened and vulnerable due to the limited availability of healthcare provision. This article will, therefore, define what is meant by out-of-hours nursing service and explore the complexities of delivering wound management during the night to patients in their own homes.

Out-of-hours district nursing is a resource that allows patients access to a qualified nurse, to support them with their complex nursing needs when these are considered 'unscheduled' and not within normal service hours (Department of Health [DH], 2000).

As defined by the British Medical Association (BMA) (2006), an out-of-hours service is one that is provided from 6pm to 8am on weekdays, the weekend, and bank and public holidays. This often equates to a reduced NHS service. However, during this time it is reported by McWalters (1999) that patients feel most vulnerable and are more susceptible to crisis interventions. These are likely to occur when sleep is disturbed due to ill-health and night time becomes a period where thoughts are intensified in relation to pain, loneliness and having no one to share worries with (Ohman et al, 2003). According to the DH (2009) community-

based nursing care is in the position to respond and deliver high-quality care, when and where the patient wants it.

Through clinicians reacting and resolving these crises, patients are left with positive experiences and high levels of satisfaction (National Coordinating Centre for the Service Delivery and Organisation [NCCSDO], 2010).

Included in this unscheduled service is the provision of high-quality wound care, which is of great importance to the nursing agenda detailed in documents such as the *Essence of Care Benchmarks* (DH, 2010a), *Equity and Excellence in the NHS* (DH, 2010b), *Your Skin Matters* (NHS Institute for Innovation and Improvement, 2009a) and *Commissioning for Quality and Innovation* (CQUIN) payment framework (NHS, 2009b). However, the cases encountered by any overnight nursing team are diverse, challenging

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and complex. According to a study by Brown and Brooks (2002) 'things seem twice as bad at night' for the patient and this requires a skilled practitioner, who is often left to make lone clinical judgements within a time-defined interval of care.

The current population of the authors' clinical area is 211,800 and includes eight District Nursing Clinics across the borough. The out-of-hours night service is provided by one nursing sister and one auxiliary nurse, both of whom work from 9.45pm to 8:00am each day. The community nursing out-of-hours service is available for people that require any nursing intervention, which occurs outside of normal working hours. This may be a planned visit or an unexpected care need or crisis. The out-of-hours nurses cover a vast geographical area and, therefore, handover of patients in the locality is a mixture of person-to-person meetings, notes, telephone calls and faxes.

Common duties include the provision of end-of-life care, catheter care, administration of medication and enteral feeding management. As noted by NCCSDO (2010), the role also includes integrated working with social care staff, effectively communicating whether a recent referral is considered a nursing duty or social care task, with appropriate follow-up and feedback. A manager is on call for further support for patients with complicated issues, such as safeguarding or mental health capacity concerns.

This small team of dedicated nurses responds to all referrals and calls from residents of the local community with any social care and nursing need or condition, however, a recent rise in referrals has come from patients with complex wound care needs.

In relation to wound care, common concerns include:

- ▶▶ Pain originating from the wound
- ▶▶ Leaking dressings
- ▶▶ Bandages that are too tight
- ▶▶ Maggots escaping during larvae

treatment

- ▶▶ A bleeding wound
- ▶▶ A deflated mattress
- ▶▶ A topical negative pressure pump's alarm going off.

Cook (2003) suggests that the management of these unplanned calls requires an expert practitioner who can deliver progressively complex care to patients in the community.

Complexities in the provision of wound care at night

The provision of wound care at night generally involves patients who are anxious about their wound, their dressing or general management. Other visits, such as the provision of pressure relief for patients requiring end-of-life care, tend to be planned. Unexpected referrals include one-off circumstances like a patient with a palliative wound contacting the service regarding a bleed, excessive exudate or discomfort and pain.

As an autonomous practitioner on nights, making house calls for wound care management issues, the District Nursing Sister can come across many diverse challenges, including having to develop a therapeutic relationship with the patient quickly to provide holistic care. It is well documented by the QNI (2011) that in order to develop a therapeutic relationship, trust is required.

According to Goode (2004), having a dressing changed, especially in an intimate area of one's body, can be uncomfortable and embarrassing. Although Goode's work focuses on fungating wounds, this can be transferred to other wound types, as any wound can have an effect both psychologically and physically due to alterations in body image and sexuality (Fauerbach et al, 2002). Therefore, seeking consent as a guest in the home of the patient, especially at night, who has plucked up the courage to call for help can often be fraught with tension (Bailey, 2007).

For example, in the authors' locality, one 46-year-old woman, at the end of life,

who was part of a planned visit, asked the District Nurse to assess her sacrum as it was painful and had a grade 2 pressure ulcer (National Pressure Ulcer Advisory Panel [NPUAP], 2007). This required skill and tact as the family was present, as well as diplomacy regarding how information was relayed back to both patient and carer in the middle of the night (Bach and Grant, 2009). A balancing act is required between the information given and the time that the visit occurs — best interests play a large part in this process.

As the patient was at the end of her life, she had to make a decision as to whether to lie on her side to aid pressure relief of her skin, or sit upright on the pressure ulcer causing potential further damage. She felt she could not see her children when she was lying down. What quality of life meant to her at this time was the opportunity to be able to talk and discuss the photographs on her iPad with her two children in the evening. She felt this took priority over wound healing. Although the team all knew it would be better for her to lie on her side, this patient felt 'trapped and powerless', even though she looked comfortable. She was dying and the fear of not being able to share her last moments was overwhelming. A judgement was taken against best practice and documented. Over the period of time before this patient died, the pressure ulcer did not worsen, but nor did it improve.

Timely and appropriate clinical decision making

Most referrals from patients with wound management problems are a case of meeting the patient for the first time, usually through emergency interventions. This means a lack of continuity of care where the patient and their type of wound have never been seen before. Therefore, an issue arises in regards to not being able to measure the improvement or deterioration of the wound. According to Brown and Brooks (2002), to provide consistent and effective care there needs to be continuation of care — in the

community, this would normally take place within a caseload (QNI, 2011).

Economically, this is not feasible on nights, so the clinician has to learn to develop skills in quickly assessing wounds and providing effective management. An example of this comes from the authors' own practice, when they received a phone call one night from a very distressed and hysterical patient asking for a nurse to 'come and get these things off me'

This woman had commenced larval therapy that day and as night fell, she had time to think about the about the treatment and that there were maggots on her leg. This was the first experience of larval therapy for both patient and nurses and, therefore, the 'yuck factor' (Courtenay, 1999) was a joint concern. On reflection, prior knowledge of all patients in the locality undergoing advanced wound management, such as larval or negative pressure therapy, would have been useful, so as to better prepare for this type of situation.

Also, clinicians must remember to employ layman's terms before using larval therapy (Sharp and Baxter, 2002). During the night, patients have time to digest information given earlier in the day and, on this occasion, this patient realised that 'larval therapy' actually meant maggots and, therefore, felt this was not what she really had consented to. According to Hallell et al (2000), well-informed patients adhere better to treatments and are less likely to ring in crisis.

Access to members of the multidisciplinary team

Many services available during the day are limited at night and when making wound management decisions as a lone practitioner, the clinician quickly has to rely on intuition and draw on past experiences (Benner and Tanner, 1987; Campbell et al, 2008).

Time is limited as the nurse is a visitor in a patient's house in the middle of the night, so providing wound care that is safe and of a high standard in these

circumstances is sometimes all that can be offered.

Using the larval therapy case previously cited, the nurse could not call upon the Tissue Viability Nurse or company helpline for advice on larvae removal, but quickly had to scan nursing documentation and company literature in order to get on with the job. This patient's emotional wellbeing took precedent. She needed to have the maggots removed and a suitable replacement dressing applied.

Removing the maggots could be seen as a waste of resources, however, the circumstances required a balanced assessment of the situation — either attend to the patient's mental wellbeing or continue with the treatment? It is well documented that quality of life issues, such as elevated stress, can affect wound healing (Ebrecht et al, 2004), therefore, the patient's anxiety was a factor and in this case, the necessary action was the removal of the maggots.

Resources to carry out the dressing can be affected during out-of-hours service delivery. This is dependent on many variables — where documentation is kept in the house, where wound dressings are kept (home or clinic), the dressing prescribed and what is actually available (it may not be in stock in the pharmacy), as well as the storage of other equipment by patients and their carers.

A recent case involved a visit to a patient whose dressing had leaked and required changing during the night. The patient was adamant that the District Nurse on days had taken her notes back to the clinic, however, after a lengthy search, the notes were actually found inside the yellow pages. Situations like this do not *Release Time to Care* (NHS, 2007), but instead add pressure to a busy workload and delay treatment and management.

Psychological support and reassurance

The provision of psychological support is one of the biggest challenges to the delivery of care during out-of-hours

nursing (Bailey, 2007). A therapeutic relationship has to be developed quickly as it is night, dark, and the patient and carers often want to get back to bed. This can be compounded by the patient waiting for the out-of-hours nurse to arrive, not knowing the nurse, as well as the search for documentation, dressings and equipment.

This is all before the nurse has to make an informed clinical decision based upon the wishes and consent of the patient.

As most of the visits for wound care are crisis interventions, the patient is already anxious prior to the nurse's arrival and these extra activities can add to this apprehension. Skill is, therefore, required to gain trust, allay the fears of the patient and significant others, while taking account of the situation and the care to be delivered. Despite this, evaluations of out-of-hours nursing services are often rated by patients as satisfactory or above (NCCSDO, 2010).

Response from the family or significant others

During out of hours, the response from family or significant others can often affect the initial development of the therapeutic relationship between nurse and patient. Expectations of the out-of-hours service are often unrealistic or distorted (QNI, 2009), for example, relatives either believe that they have woken the nurse up as she is on call, or that the nurse should arrive immediately. Others think the nurse can offer the same service as a doctor or other emergency or on call domestic services (fire, water, gas, electricity).

The reality of the service delivered is based on clinical decision making and prioritisation of need. This is a complex process to negotiate over the telephone, as the explanation of a patient's needs is often dependent on the relative's prior experience and knowledge of the service (Worth et al, 2006).

Cases that highlight this complexity are calls from patients who have told the

nurse that they are bleeding profusely from a wound. This requires the skill to determine how serious the situation is and the actual service required. On arrival, it is often found that the patients who were frenzied on the phone have small wounds requiring little or no intervention; whereas those who were calm during a call have wounds that are significant enough to require hospitalisation.

Conclusion

Out-of-hours care is a very complex and challenging area of nursing. The geographical area that is covered and the number of patients who potentially require the service is vast. The issues that arise from offering this type of service are multifaceted and include difficulties in predicting the needs of the patients during the night and offering a service that is timely, appropriate and based on best evidence. Patients and their relatives often feel most vulnerable at night and, frequently, their needs in relation to wound care are heightened, creating a crisis situation.

The skills of the out-of-hours district nurse are paramount in enabling a quick and efficient response in relation to the management of a patient's wound, be it pain relief, pressure reduction, a dressing change or the removal of maggots. From taking the telephone referral to arriving at the house and managing the wound, the autonomous practitioner is required to quickly develop therapeutic relationships with a variety of individuals and make informed clinical decisions, with limited resources. An out-of-hours nursing service is often an 'invisible army', delivering a vital service across the community — a valuable feature of a modern community healthcare system (QNI, 2011). **WE**

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