Working as a tissue viability nurse in offender health

KEY WORDS

- Ageing population
- Offender
- Substance misuse
- Wound care

This article outlines my journey from tissue viability specialist nurse in the community to tissue viability specialist nurse in offender health and the challenges I have encountered along the way. Since coming into this post, I have concentrated on pressure ulcer risk assessment, leg ulcer management, documentation and staff training. The patients I have been involved with have a variety of wounds that can be quite complex in nature. Intravenous drug use is an ongoing problem and, as a consequence, some of our patients have complicated leg ulcers. Although the service is still developing, progress has been made and we are now looking to expand the team.

RACHEL BUSSEY
Tissue Viability Specialist Nurse, Offender Health Directorate, Forensic Division, Nottinghamshire Healthcare NHS Foundation Trust

Prison health care has historically been a 'Cinderella' services, health care was provided by a variety of sources, often by the private sector with few governance arrangements in place. It is recognised that health care in custodial settings can present unique challenges — often staff have not had access to a specialist tissue viability nurse or wound care education.

As of 1 April 2013, the commissioning of all healthcare services for prisoners within England rests with NHS England. They work collaboratively with the National Offender Management System (NOMS) and Public Health England to deliver a framework to reduce significant health inequalities as offenders are more likely to smoke, misuse drugs and/or alcohol, suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population (NOMS, 2014).

Nottinghamshire Healthcare is the largest NHS provider of health care into prisons in England, providing physical health care into 12 establishments across the East Midlands and Yorkshire.

My introduction into offender health (OH) followed a request to co-author a Route Cause Analysis (RCA) for a man who had been admitted to a local hospital with pressure ulcers. The RCA was written and the action plan submitted, but I had been surprised by the lack of knowledge of pressure ulcer prevention. Being a tissue viability specialist nurse (TVSN) within the East Midlands Trust, the use of SSKIN bundles (Surface, Skin Inspection, Keep Moving, Incontinence/Moisture and Nutrition [NHS Midlands and East, 2012]) was embedded into practice within the community section of our organisation, however, on interviewing staff this was not a process they were familiar with. It became evident that few staff had been able to access appropriate wound care training, much of it being provided by the wound dressing company representatives.

Following on from the RCA report, I was seconded one day a week to the OH Directorate to concentrate on three prisons within one small geographical area to look at their systems and processes, interview staff and write a report for the senior management team, identifying what needed to be done to improve tissue viability (TV) provision. By the end of the secondment it was identified that there was a need to employ a permanent TVSN for OH and I was successful in the recruitment process and was now responsible for providing TV support to 12 prisons across four counties.

Of the establishments that I cover four are Category (Cat) B prisons (three of which are remand), six are Category C prisons, three are Category D prisons and one is an Immigration Removal Centre (IRC). To put this into context it

Fig 1. Offenders generally have higher health needs than the general population

means that each 'type' of prison runs in a slightly different way.

The category of prison identifies the risk to the public of the person that is being held and not necessarily the crime that has been committed. Cat B prisoners are those who do not require maximum security, but for whom escape still needs to be very difficult. Cat C prisoners cannot be trusted in open conditions, but are unlikely to try to escape and Cat D prisoners are those who can be reasonably trusted not to try to escape, and are given the privilege of an open prison.

Three of the Cat B prisons in our catchment are 'remand' prisons that mean that as well as prisoners that have been sentenced, they take prisoners directly from the courts or the police cells who have not been convicted of a crime, but who the magistrate feels needs to be held in a secure place (remanded in custody). They also receive prisoners who have been recalled on license (this is generally that they have breached the conditions of their bail/parole and will be recalled back into prison for 28 days). As a consequence, the turnover of prisoners is significant. It is not unusual for up to 60 prisoners a day to be arriving and released from these prisons per day. Some prisoners arrive straight from the police cells and can be withdrawing from alcohol or illicit substances, some have never been in prison before, but most will be requiring support from the healthcare team.

The majority of Cat C prisons in our area are working prisons. These prisoners usually have a sentence of longer than two years to serve and will go to work within the confines of the prison. This is a much more stable client group with between five and ten transfers each day. They will have been transferred from another prison and will usually stay until they are released.

The Cat D prisons in our area are working prisons, some of these are 'open' and prisoners leave the premises Monday to Friday to attend work then come back each evening. These are generally prisoners who are fit and well and are preparing for release back to the community. There may only be a dozen transfers a week into these prisons, again these will come from another establishment.

We also provide health services into an IRC, these clients are called detainees and not prisoners as they have not committed a criminal offence and are waiting to hear the outcome of their claim for asylum. There is a high turnover of patients in these centres with arrivals 24 hours a day, and detainees will need support as they settle into their new environment.

All prisoners/detainees are seen by a healthcare professional in 'reception' before being processed by prison staff and taken to a first night cell. The reception screening process is an operational requirement for all prisoners when being admitted to a custodial establishment to ensure their safety and wellbeing on their first night.

LINK NURSES

My first few months were a whirlwind of key training, security talks and clocking up a lot of mileage as I went round the prisons introducing myself and identifying staff who had an interest in TV. We developed a link nurse forum from the start and due to the geographical area a lot of communication is via email and good practice is shared among the group. The link nurses later joined link nurses from the health partnerships division of the trust (making this a Trust-wide event). This has proved so successful and it is hoped that this will be replicated in the future

intravenous substance misuse. These wounds are chronic in nature and are usually complicated by damage to the deep venous system. These can result in complex leg ulceration often bilateral with multiple ulcers and a mixed aetiology. Our patients often lead a chaotic lifestyle when in the community and this creates problems with continuity in care (Devey, 2010). Nursing staff often feel frustrated that just as they are starting to make real progress with patients and their wounds, they are released from prison, only to come back a few weeks later with their leg ulcers back to where they started from.

One of the advantages of providing physical health care in so many of the prisons across the East Midlands is that prisoners transfer from one of our establishments into another. From a TV point of view this enables continuity of care, wound care that has been initiated in a remand prison will be visible to the next prison on the TV S1 template, e.g. if patients have recently had an ankle brachial pressure index (ABPI) completed and compression commenced it is safe to continue. Many of our patients have been under a variety of healthcare providers over the years and most have been in compression at some time. It is worth spending time with the patient and discussing available care options. Most are happy to try compression therapy and are aware of the benefits of this type of treatment. Staff need to be mindful of choosing an appropriate dressing type — if a patient is at risk of self harm/suicide then bandages must not be used. Many of our patients are suitable for leg hosiery kits, this also gives them control of their wound so they are more willing to concord with treatment options. We have also successfully implemented the Juxta Cures (Mediven) system with good results.

We have recently invested in automated equipment across all sites to enable accurate and timely review of patients. We strive to ensure that all ABPI assessments are completed at least annually or sooner if there is deterioration in condition. There is a recall system embedded in the S1 TV template, which will automatically identify when patients reviews are due. There has been investment in the staff to be able to perform ABPI assessment and accurate interpretation of results. The majority of our patients with leg ulcers are now in appropriate levels of compression. Compliance continues to be an issue, but as the staff become more confident and competent in their leg ulcer management skills, the patients become more trusting of the staff and are more willing to engage with appropriate treatment plans.

We are developing pathways with healthcare providers in the community who work with our patients so that information (with patient consent) regarding assessments and treatment options are shared to improve concordance once the patient has been released. Wherever possible, I try to ensure that patients are in hosiery prior to their release as they are more likely to wear these than attend the drop-in clinics for bandages. Another option is that patients are taught how to change their own bandages — this is risk assessed on an individual patient basis. We have many patients who are in and out of the custodial system and it has been helpful for us and our community colleagues when information has been shared.

Analgesia is a concern for patients with leg ulceration; drug-seeking behaviour is common as is the diversion of medication to other prisoners. Analgesia is 'currency' in prison and it is not unheard of for patients to not want to heal their leg ulcers as they are concerned their analgesia will be stopped. NHS England (2015) recently issued a pain management formulary for prisons, which looks at acute, chronic and neuropathic pain.

NON-ACCIDENTAL INJURIES

Prisoners can present with a variety of 'non-accidental' injuries. Some patients experience assaults, including deliberate scalding, which circumstances they may not want to fully explain. First aid is administered at the time of the incident and ongoing management will depend on the severity of the injury. I do not have much involvement with these types of wounds as they rarely develop into chronic complex wounds and are managed 'in house' by the prison nursing team. The exception to this can be some of the scalds. I am currently working with the East Midlands burns outreach service to develop a pathway for staff to follow that will help identify when a patient needs to be referred out to secondary care and when it is appropriate to

with all the link nurse forums in our organisation (safeguarding, continence, infection prevention and control, and palliative care). It is a great way for staff to meet up with other disciplines and share good practice and ideas.

I implemented a resource folder and gave access and responsibility for this to each link nurse. It started off with sharing some very basic information, but has since developed into something more complex.

DOCUMENTATION

I looked at the documentation available for wound care and pressure ulcer prevention. Drawing on previous experience when working in the community, I got together with our SystmOne (S1) analyst to develop a template — this would encompass key elements relating to TV. Everything would be in one place and easily accessible. A reference guide was also developed to aid staff through the completion of the template.

PRESSURE ULCER RISK ASSESSMENT

With a potentially large turnover of prisoners, we chose to use the screening element of the PURPOSE T (Pressure Ulcer Risk Primary Or Secondary Evaluation Tool) for risk assessment (University of Leeds, 2013). The tool uses two screening questions relating to skin status and mobility, if the patients score one or more, it identifies them as potentially being at risk of pressure ulcer development and, therefore, they will need further investigation. All patients are seen in reception as part of the prison process by a healthcare professional and the PURPOSE T risk assessment tool has been embedded into the reception screening template. Patients who are identified at risk will be booked onto a nurse clinic within 48 hours to have a full Braden risk assessment (Braden and Bergstrom, 1988) and skin inspection completed. Although the PURPOSE T full assessment tool is a validated risk assessment in its own right, we chose to use Braden as this is used across our organisation and staff were familiar with it. If, however, they score 0 on the PURPOSE T, then no further action is required.

People aged 60 and over are the fastest growing age group in the prison estate. The number of sentenced prisoners aged 60 and over rose by 164% between 2002 and 2014 (Ministry of Justice, 2014). This has had a significant impact on the amounts of prisoners who are at risk of pressure ulcers and, therefore, impacts greatly on pressure ulcer prevention.

As discussed at-risk patients with be further assessed within 48 hours using the Braden Risk Assessment Tool. SSKIN (Surface, Skin Inspection, Keep Moving, Incontinence/Moisture, Nutrition) care plans are mandatory for all patients scoring 16 or below and re-evaluation of both their risk and the SSKIN care plan will be completed as per clinical need. SSKIN care plans and evaluation tools have been implemented onto the S1 TV template.

Introducing pressure redistributing equipment into prisons continues to be a contentious issue. The Care Act (HM Government, 2014) requires that equipment required for social care is provided by the local authority; however, the National Partnership Agreement requires that NHS England provides equipment for healthcare (NOMS et al, 2013). After a lot of communication involving our equipment providers, we can now generally access equipment into the prisons at point of need. The biggest problem is that a standard mattress topper will not fit a prison bed (which is 2'6") and we are exploring working with equipment providers to purchase some bespoke equipment.

Staff now have access to patient information leaflets for the prevention of pressure ulcers, SSKIN pathways of care and patient information plans to help them provide individualised patient-centred care. Staff are encouraged to consider pressure ulcer risk and preventative strategies at opportune moments and there is now an acknowledgement that some of prisoners are at risk of pressure ulcer development. Assurance is given to the Nottinghamshire Healthcare TV steering group that any pressure ulcers that have developed within the OH Directorate are reported in line with organisational responsibilities and this information is shared with the Trust Board.

LEG ULCER MANAGEMENT

The large proportion of wound care provided into prisons relates to patients who have a history of

manage them in prison. The burns outreach team will come into prison to see the patients and I may or may not be involved with their care.

SELF HARM

Self harm is another area where I may or may not be involved, depending very much on the severity of the injury sustained. Patients who self harm will be known to and receive support from the mental health team; the physical healthcare team will be guided on the advice of their colleagues. Self harm is a much deeper subject than can be addressed within this short article.

CLOSING COMMENTS

In conclusion, it can be confirmed that prisoners like to engage with health care while in the custodial setting. They enjoy the time away from the wing, an opportunity to speak with other staff and an opportunity to focus on their own healthcare. Most prisoners will be very keen to be seen by the dentist, the podiatrist and also the optician.

Prisoners may have their own specific challenges, but it can also be very rewarding to make a significant difference to their health. The nursing staff are generally treated with dignity and respect by the prisoners and this should be reciprocated at every opportunity. Most prisoners will listen to what you have to say and want to share their care. They are often able-bodied young men who are quite capable of reapplying a dressing under compression hosiery and appreciate the opportunity you are giving them to help themselves.

I have recently had the opportunity to commence a patient in negative pressure wound therapy on a chronic wound to his leg and the improvement to his leg has had a significant impact on his general wellbeing. He is now engaging with the mental health team and has agreed to participate in therapy to look at his offending habits and substance misuse. He was previously so distressed by his chronic wound that he had sunk into depression and was frequently getting involved in fights and altercations. His whole outlook has changed because of the improvement to his wound, and it is experiences like this that make me realise why enjoy doing the job that I do. WUK

REFERENCES

Braden B, Bergstrom N (1987) *The Braden Scale for Predicting Pressure Ulcer Risk*. Available at: http://www.healthcare.uiowa.edu/igec/tools/pressureulcers/bradenscale.pdf (accessed 22.01.2016)

Devey (2010) *Using an Outreach Service to Meet the Needs of Users of Intravenous Drugs with Leg Ulceration*. Available at: http://www.nursingtimes.net/using-an-outreach-service-to-meet-the-needs-of-users-of-intravenous-drugs-with-leg-ulceration-/5015023.fullarticle (accessed 7.04.2016)

HM Government (2014) *The Care Act*. Available at: http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted (accessed 7.04.2016)

Ministry of Justice (2014) Offender Management Statistics Bulletin, England and Wales Quarterly – October to December 2013 Annual – January to December 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/305741/offender-management-statistics-october-december-2013.pdf (accessed 7.04.2016)

National Offender Management Service (2014) *Healthcare for Offenders*. Available at: https://www.gov.uk/guidance/healthcare-for-offenders#eel-decline (accessed 7.04.2016)

National Offender Management Service, Public Health England, NHS England (2013) *National Partnership Agreement between: The National Offender Management Service, NHS England and Public Health England for the Co-Commissioning and Delivery of Healthcare Services in Prisons in England 2015-2016*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/460445/national_partnership_agreement_commissioning-delivery-healthcare-prisons_2015.pdf (accessed 7.04.2016)

NHS England (2015) *Prison Pain Formulary*. Available at: https://www.england.nhs.uk/commissioning/health-just/pain-formulary/ (accessed 7.04.2016)

NHS Midlands and East (2012) *SSKIN Pressure Ulcer Care Bundle Prevention. 2012*. Available at: http://nhs.stopthepressure.co.uk/Path/docs/Prevention%20bundle.pdf (accessed 7.04.2016)

University of Leeds (2013) PURPOSE T Version 1.1. Copyright© Leeds Institute of Clinical Trials Research