A DAY IN THE LIFE: WOUND MANAGEMENT IN MENTAL HEALTH CARE

Wound care involving patients with mental health problems requires a different approach to standard wound care. Here, a typical day with the clinical lead for tissue viability at Leicestershire Partnership NHS Trust is described.

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ANITA KILROY-FINDLEY
Tissue Viability Nurse, Adult Mental Health, Learning Disabilities and Children at Leicestershire Partnership NHS Trust

My clinical role has changed a lot in the past few years. I originally covered mental health and learning disabilities, that expanded to include childrens community services and prisons following the formation of Clinical Commissioning Groups (CCGs). In the past two years, my post has 'sat' within our community health services, which has led to me providing clinical leadership to a team of tissue viability nurses (TVNs) and expanding my own knowledge base with therapies not used in my own areas (i.e. negative pressure wound therapy).

As a team, we encounter a wide range of patients across all healthcare settings, except acute secondary care. My qualification as a registered mental nurse has proved invaluable in raising the team's awareness of mental capacity, consent, deliberate self-harm and concordance in dementia. I attend multidisciplinary meetings for community patients with complex mental health needs and a wound(s), as my insights into care and approach draw on my mental health experience; this helps community staff understand the patient's diagnosis and how to best engage with them to maximise concordance. It also provides them with a reference point for support.

Picking a day to share has been really difficult, however, one of my recent changes has been to block time in my diary for patient contact and it is one of those days I have chosen to describe here.

A day in the life of wound care management at Leicestershire Partnership NHS Trust — a combined mental health and community health Trust

8am Arrive in the office and get the kettle on; I can't do emails without a coffee. Because I work on Sundays, there aren't usually too many to deal with on a Monday morning. I tend to flick through and shrink down the ones that I need to respond to then answer in order of priority. All category 2, 3 and 4 pressure ulcers are reported in the Trust via internal systems, which automatically email a copy to the relevant TVN. I review mine to see if there is anything flagging up as of concern (i.e. on a diabetic foot, multiple areas of ulceration, exposed bone/tendon). We use Systm1 and RIO, therefore, I can quickly look at the patient record to get a feel for what's happening;

if it's a category 3 or 4 in our care, I will book a joint visit to verify the categorisation and ensure not only is the care right, but also the patients' condition is optimised for healing.

9am A follow-up phone call to the lymphoedema service at our local hospice. The original referral from a community learning disability nurse was for clarification on what a patient should be using as on transfer between homes a whole range of creams, topical antimicrobials and bandages were found, but no one knew exactly what they were for. The joint visit identified lympoedema, extensive papillomatosis on a grossly misshapen foot and compression hosiery not being worn as the zip had broken. The phone call generates an appointment at the lymphoedema clinic for made-to-measure hosiery.

9.30am Planning meeting with the team. We're split into localities (east, west and city) covering the whole of Leicester, Leicestershire and Rutland, and one of the first changes myself and the operational lead made was to have a weekly meeting to plan the work that had come in and review other commitments. This has enabled much closer team working, increased awareness of referral pressures that can occur and improved sharing of workloads. I'm really proud of the way the team pick up for each other without hesitation if they can help — this may seem minor, but teams don't always operate in this way.

10.15am Data quality check on five patients I've seen the preceding month. The Trust collates the data from all inpatient and district nurse teams; a random selection of patients to check Waterlow/Braden Q is up to date, nutritional screen is complete and, where relevant, advice on repositioning has been given, a pressure ulcer prevention care plan is in place and continence concerns are well managed. This information is fed through to patient safety within the Trust and is used as a quality metric.

10.30am Phone calls to a company representative regarding their dressing going on to Formulary, an occupational th erapist to arrange a joint visit for a patient who may need a roho cushion and a District Nurse (DN) whose patient had misplaced their trial dressing. Check emails that have come in since last done and respond.

11.30am Lunch! I like to take an early lunch and encourage my team to make sure they take their break to suit them. Just half an hour with my book and food recharges my batteries.

12pm Travel to see my first patient. The patient was originally referred to me the previous week, but due to foreign objects being inserted in the wound I advised they needed to go to A+E and have them removed before I could do anything. The patient wants to see me in their room; they have multiple cigarette burns on their abdomen, scars on their arms and a gouged wound on their abdomen. The abdominal wound has again had metal inserted into it; the metal cannot be seen and it is unclear how much and how far it has gone. I explain that I cannot explore the wound to remove any objects and that these will need removing by a medic once it has been established where they are. The patient doesn't want to see anyone and declines antibiotics, despite the infection risk from the dirty metal. There is little I can do except advise on infection markers and explain the risks. I talk to the staff about sepsis monitoring and document in the patient record a summary of my input.

1.30pm Travel to my second patient. I'm looking forward to seeing how their wound has progressed as I'm evaluating the Nanova™ (Acelity) NPWT device on it. The district nurse takes the dressing down and two things hit me — one, the amazing progress in a week and two, the malodour. One of the objectives in using the Nanova was to reduce the infection risk in a high-risk wound. The patient is really pleased with how the wound has contracted, but concerned about the smell so we decide to line the wound with silver before reapplying the Nanova as, in addition to smell, the granulation tissue is friable. NPWT is widely used and we have a joint protocol with our Acute Trust for ensuring a seamless transition between providers. The Nanova may offer a step-down option for those wounds that need negative pressure to closure, but don't exude heavily (i.e. cardiac sternal wounds, hence our beginning to evaluate it).

3pm Back to base to prepare for clinical supervision with one of my team. They've sent me the NHS numbers of some of the patients they've seen and I pick two at random to review. If they don't have something specific they want to bring to supervision, I use the opportunity to look at their clinical input with the selected patients. This provides a forum to give positive praise, as well as constructive criticism and problem solving. Feedback from those who've done this has shown they've found it valuable and it has changed the way they work in some areas.

4pm Jump on the motorbike and home!

Since taking on the clinical lead role, I feel I have to attend too many meetings, reply to too many emails and juggle too many projects in the air! I love my job and I love being able to help people — the greatest satisfaction is making a difference to a patient's quality of life. As nurses, we can't always heal a wound, but we can listen, problem solve, support and do our best to address the part that distresses our patients the most. WE