# Table of quotations from the General practitioners and District nurses, extracted from the 11 articles and divided into codes.

**ARTICLE 1**

 **Home care nurses experience of providing healthcare to patients with**

 **hard to heal wounds (Aune & Struksnes, 2019)**

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| Responsibility | **Knowledge**  | **Time**  |
| Sometimes you will not meet your goals and see that nothing helps. And you just have to do your best for the patient” (C6) “some of the patients receive good monitoring from the GP while others do not get anything” (A2)“almost all GPs pull away, and the assessment is left to the nurse” (B1)“I often experience that patients have less pain, when there is a “Known” nurse visiting ..and we see a faster wound healing” (C10) | “nurses in home care are good at making wounds heal”“I have experienced successful wound healing and have a general impression that we are good at it “(C11)“Initial good wound care procedures make the wound healing process shorter and less uncomfortable for the patient” (A3)Occasionally the procedures are changed before we have time to see results” (B3)“. Colleagues change the scheduled procedure, without checking up the initial plan” (C7)“The wound care procedure was constantly changed because health workers did not agree” (A1)“We are not good enough to document goals and to evaluate the wound, for instance with pictures in the journal” (C7)“effective co-operation that leads to optimal wound management**” (C10)** | “Those who write worklists do not see the importance of continuous monitoring of a few carers” (B3)“When there are a lot of different nurses visiting the patient, it´s described as “many cooks” (C2)support from the head nurse and understanding that wound care is a challenging field to work with” (C1) |

**ARTICLE 2**

**Community nurses and patients with leg ulcers (Chamanga, Christie, & Mckeown, 2014)**

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| **Knowledge**  | **Responsibility** | **Time** |
| “The leg ulcer assessment process can take upto two hours, including holistic assessment and bandaging…in most cases, it is difficult to complete a full assessment on first contact”  |  | “Per day you can have six to seven bilateral leg ulcers” (AN)“It becomes a daily routine and less thought process is put into patient care” (DN)“The leg ulcer assessment process can take upto two hours, including holistic assessment and bandaging…in most cases, it is difficult to complete a full assessment on first contact” “The initiatives expect to deliver complex care closer to home…but instead of expanding district nursing teams we are downsizing them, merging teams as a way of not recruiting to fill vacant posts” (DN)  |

**ARTICLE 3**

**Feeling confident in burdensome yet enriching care: Community nurses describe the care of patients with hard to-heal wounds (Eskilsson & Carlsson, 2010)**

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| Knowledge  | **responsibility** | Time |
| Yeah, it´s important that she´s in as little pain as possible, I think. Part for my own good, to know she´s now in pain: part for her own sake. And I know the wound doesn´t get better if she´s in pain. So, when I care for it, I try to do it in such a a way that I cause her as little pain as possible. You must be light-handed”.. “Actually, I think I´d do it just the same, I mean, you have your basic values // You have to stay off when it´s needed and you have to be there when it´s needed, but I can´t say you should keep a distance to all your patients, but once again you have to get a feel for who needs help and who doesn´t, and when it becomes too much or too hard you have to ask your colleagues for help”“I think it´s quite natural…. if you get signals// you have to be sensitive, you have to feel like this is almost some kind of role play, working with human beings, you have to feel, for where the boundaries are // you have to feel, like, where´s her integrity, how deep does she want this conversation to be ….how close a relationship does she want to have with me.“She was a bit ashamed of it and didn´t want to be a burden, so then I felt that it was even more important to show her that this is nothing to be ashamed of; we respect your leg as well as the res of you, you`re like a whole, and I tried to explain to her that this is not your fault. So OK, here´s a leg that´s more or less rotten, but its on her, it´s her leg, and then she needs to feel that we respect the whole of her and she’s not to feel like we think this is gross// that, I think is respect…I want her to feel that we do the best we can and that we respect her as a whole person – that, I think is really important. “ You don´t always know which dressing is the best for that particular wound, and at the same time it´s the body and soul that heal the wound, not the dressing” | . . ‘‘The doctors’attitude is often quite tiresome; I think it doesn’tseem as if they think it is fun; often they hand over agreat deal of responsibility to the nurses.’’“It’s like a failure, sort of // I mean, they’re helpedand their wounds were supposed to heal // but Icouldn’t save this one, really, and it feels like whenyou were little and you wanted to be a superheroand fix it, you want it to end well, but that’s notalways the case . . . yeah, it’s like a failure, sort of.Yeah, it´s important that she´s in as little pain as possible, I think. Part for my own good, to know she´s now in pain: part for her own sake. And I know the wound doesn´t get better if she´s in pain. So, when I care for it, I try to do it in such a a way that I cause her as little pain as possible. You must be light-handed”.. “Yeah, you get a lot of responsibility and trust// you almost feel a sort of pressure to do a lot so that all gets really well and yeah, sure you want to but that´s not the way it works, unfortunately, so indirectly you get a bad conscience// you can´t take it.. they rely on you so much when you get there and then, its like they want an own nurse who´s everything to them” “She was a bit ashamed of it and didn´t want to be a burden, so then I felt that it was even more important to show her that this is nothing to be ashamed of; we respect your leg as well as the res of you, you`re like a whole, and I tried to explain to her that this is not your fault. So OK, here´s a leg that´s more or less rotten, but its on her, it´s her leg, and then she needs to feel that we respect the whole of her and she’s not to feel like we think this is gross// that, I think is respect…I want her to feel that we do the best we can and that we respect her as a whole person – that, I think is really important. “  |  |

**ARTICLE 4**

**General practitioners “knowledge of leg ulcer treatment in primary healthcare: an interview study (A Friman, Edstrom, Ebbeskog, & Edelbring, 2020)**

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| **responsibility** | Knowledge  | Time |
| 3. ‘I do not think that as a physician, I am even eligible to take those courses oreven if there are any such courses : : : I think : : : in other words if there areany aimed at physicians. It was really good when I started here, because wehad a district nurse who was responsible for this area : : : ’ (GP 10)‘As I think the nurses take quite a lot of responsibility, and some have specialisttraining in leg ulcer treatment, I pass a lot over to them. They keeptabs on the patient and all on that side of things.’ (GP 15)We have a tough working environment, we have to do everything, and wehave to prioritize. The hospital does what it has to do, and then, the patientsare discharged quite early. There is not enough time. I feel that I do notknow that area [dressings], the nurse should know that area, as has beensaid, and anyway they have more education and information about bandagingmaterials and the like.’ (GP 16) | I think that so little time is given to many of the chronic diagnoses duringmedical school and that there is a lot of focus on the bigger, grander andacute: : : so I think more emphasis could be given to this [leg ulcer treatment]during medical school actually, so that medical students already havebetter knowledge.’ (GP 7)“Usual uncomplicated acute wounds or lacerations do not present a problem but when it comes to, in particular, stasis dermatitis, the development of leg ulcers or protracted leg ulcers then we do not have any background knowledge whatsoever. No, very poor knowledge I am afraid´(GP 4)“sometimes a colleague treats a leg ulcer with the usual Penicillin V, if that does not work, then we have to use antibiotic with a broader effect, and then, it is Flucloxacillin that is the standard ´(GP 14). “I think that I am starting to get a bit more of an idea about the venous and arterial leg ulcers, you know from looking at the pigmentation, swelling, edema, but I still think that it is difficult, especially when it is mixed venous and arterial insufficiency, it is difficult I think, but I will gladly see them and learn more…I think that through seeing more patients, I will build up a basis and then I can read up on the rest….(GP 11)We have a tough working environment, we have to do everything, and wehave to prioritize. The hospital does what it has to do, and then, the patientsare discharged quite early. There is not enough time. I feel that I do notknow that area [dressings], the nurse should know that area, as has beensaid, and anyway they have more education and information about bandagingmaterials and the like.’ (GP 16). ‘I try to see what others say about it, I discuss with colleagues, discuss withnurses and sometimes have contact with specialists, and referrals are sent,and then, you try to learn from the referral report : : : ’ (GP | ‘As we are just called in when there is a problem, sometimes the decisionsare made quickly: : : you maybe would like to have more time to lookthrough things or sit down and have a discussion, follow up the patientfor a period with the nurse or so. It is a question of resources: : : ’ (GP 13). ‘I get a thousand invitations to educational courses but a course shouldalways be chosen based on what is required most, and there may be fivedifferent areas that need to be prioritized : : : ’ (GP 14)We have a tough working environment, we have to do everything, and wehave to prioritize. The hospital does what it has to do, and then, the patientsare discharged quite early. There is not enough time. I feel that I do notknow that area [dressings], the nurse should know that area, as has beensaid, and anyway they have more education and information about bandagingmaterials and the like.’ (GP 16) |

**ARTICLE 5**

**General practitioners perceptions of their role and their collaboration with district nursing in wound care (A. Friman, Edstrom, & Edelbring, 2018)**

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| **responsibility** | Knowledge  | Time |
| “I guess it´s because we are not responsible for the management of leg ulcers, it is in some way the nurses who are. We are of course the patients´accountable GPs but we don´t manage the wound care, as we don´t prescribe the specific dressings etc. The nurses carry out the care on their own…we are therefore a bit more peripheral in the comparison to, for example, the treatment of heart failure “(GP 12).“we are consultants. We are consulted when they think it is not going as planned so that – say, I maybe see a patient with a chronic leg ulcer roughly once a month, no more often that that” (GP 8) ‘the problem we have is that the patients remain with the district nurseand do not come to the doctor for further assessment of the underlyingetiology … my task is to further assess what it is due to and intervene incases of venous insufficiency or arteriosclerosis and whatever can be done…’. (GP 11)11.“I think it is continuity for the patient, often when there is a change of nurse in connection with wound dressing, I notice that it is not as good, that is my personal experience. I think that if the same person does it and there is continuity then its better, everyone does things in s slightly different way, I notice if we have a locum nurse for a few days then it is not as good” (GP 9) 14. “difficult because if. It lacks structure here, right now and, what can I say…there aren’t any such routines. At the moment it is not the same person who sees the patient every time. It´s not the same nurse. Instead, it´s different ones” (GP 6)16. “the team that we had previously is now gone... the Gp is a lone wolf who should see many patients whils at the same time our district nurses have to struggle with home care and try to mee the demands…it becomes a sense of us and them and we have no straightforward way to share work between us as there was before so that I think it is a shame, I hope that the organization will become flatter and that all patient visits give roughly the same reimbursement and that would lead to more teamwork” (GP 11) | .“to assess and diagnose what is the root cause of the leg ulcer, is it an undiagnosed diabetes. It is important to rule out diabetes with delayed wound healing “ (GP 6) 3.“We had a lady here who had a venous leg ulcer…none of us thought that her leg was particularly swollen and so she care here for treatment for a long period of time and another happened, so in the end I sent a referral to the leg ulcer clinic…then we received a referral report stating that compression therapy usually gives good results even if the patient doesn´t seem to have much oedema so they (DNs) bandaged her leg ulcer a period of time and it improved and it was a positive collaboration with the dermatology department who gave sound help and advice and it was a good result for the patient (GP 7). ‘there was a patient who came here for a year for wound dressing, but it wasn’tuntil he sought an emergency consultation that an infectious diseases doctorrealized that the wound had not been assessed and he was then given anassessment and received surgery for venous insufficiency and then thewound healed…so I think we have a huge gap to fill there’. (GP 11). ‘our diagnosis process is probably a bit wanting … how do we do thisexactly? I can in fact say that I do not really know, I think it is very differentfrom case to case. I think some come to the doctor and receive a clearassessment, a clear diagnosis, and a good plan. The collaboration betweenthe GP and the nurse work well, and sometimes they just come in[patients] by chance or drop by or you know and so then it can be a bit hitand miss. There are no good written routines for this’. (GP 7)‘on the arterial side we usually check the ankle index to see if we can givecompression therapy… I think it is difficult … how much compressioncan be given? we do a basic check of the ankle pressure and then decidewhat compression to give’. (GP 16)10.“it is often not that easy as the leg is usually swollen, and it can be a bit difficult to assess the arterial pulse and they often come in for an emergency appointment, so they are not one of your own patients who you know” (GP 6)12. If there are several of us it would be better if we collaborated, I mean in general, when I started as a GP then I was lacking in experience. Just to discuss patients because when you discuss something then you can get new ideas, there can be a lot of problems and it can resolve a great deal (collaboration).. just saying something out loud then you hear yourself and come up with an idea, so I think it is really important” (GP 10)15. “Often it is the duty doctor who has to go and quickly look at the leg ulcer. It is an on-the-spot assessment, so you need to have reasonably good knowledge and a nurse who is experience in clinic work” (GP 13) | 16. “the team that we had previously is now gone... the Gp is a lone wolf who should see many patients whils at the same time our district nurses have to struggle with home care and try to mee the demands…it becomes a sense of us and them and we have no straightforward way to share work between us as there was before so that I think it is a shame, I hope that the organization will become flatter and that all patient visits give roughly the same reimbursement and that would lead to more teamwork” (GP 11) |

**ARTICLE 6**

**Wound care by district nurses at primary healthcare centers: a challenging task without authority or resources (Anne Friman, Klang, & Ebbeskog, 2010)**

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| **Responsibility** | **Knowledge**  | **Time**  |
| ” “If I got reports that a wound is not healing. I make sure to go there soon…so I give it priority…it´s that important “I can´t say that I need them to come in and look at the wound to tell me how to dress it, because I know that better than they do, and they all say that `you know that better´´ and then you get to decide for yourself, that that´s the way it has to be..you can´t jus go on what you learned from books`”“you don´t always need to have a doctor, but a district nurse in training.specialising in skin and wound care, that would almost be better, I think.. I think we could deal with a lot more on our won if they just, sort of gave us further training”“If they have ulcers needing linger treatment. It´s good to have the confidence and trust that arises when you meet regularly. Trust is what´s important”“because I like to see my patient´s wound, and I don´t like it when I need to step in to take care of other wounds because then they may have been dressed in a way I don´t approve of”“Its quite important that several difference people do not attend one patient. Especially not at their home, so it´s the same person who comes..if the patient feels calm and secure, the wounds heal better, too.”“It´s described better if I do it myself, because even if I go to one of our doctors and ask them to write a referral…I can write it better myself, so it´s a clearer and better description” “well, it´s clear now, I think that in general it´s clear…who´s responsible for this or that and so on written routines“dressing wounds at home I sometimes find disgusting. not disgusting but it´s´not optimal because you stand there and you don´t have the proper lighting and maybe not all the things you need, It´s not only the physical aspect.. but it isn´t always optimal, perhaps not clean, but you are forced to if they can´t move.” | “We have incredible experience. I mean, there are four of us over sixty and we´ve worked all our lives... I mean..and together we assess all that sort of thing”“There´s a difference between external wounds if you´ve hurt yourself or something, but when it comes to internal diseases that cause internal wounds it´s crital that you have the knowledge about what causes the wound.”..“I can´t say that I need them to come in and look at the wounc to telle me how to dress it, because I know that better than they do, and they all say that `you know that better´´ and then you get to decide for yourself, that that´s the way it has to be..you can´t jus go on what you learned from books`”“you don´t always need to have a doctor, but a district nurse in training.specialising in skin and wound care, that would almost be better, I think.. I think we could deal with a lot more on our won if they just, sort of gave us further training”“you manager the pain, the circulation, moving around, nutrition.. wound healing come from inside, and socially, in trying to turn the situation around”“Its quite important that several difference people do not attend one patient. Especially not at their home, so it´s the same person who comes..if the patient feels calm and secure, the wounds heal better, too.”“ there´s no point in discussing this question if I´m the one who has more knowledge…then it feels meanlingless…it´s not that I know everything, but it I feel they don´t know more than I do.” | **“**I find it a very important part of my work..yes, definitely I think that..about home care..it´s maybe 30 – 40 per cent so it’s a very important part of my working day.”“Its quite important that several difference people do not attend one patient. Especially not at their home, so it´s the same person who comes..if the patient feels calm and secure, the wounds heal better, too.”“I suppose it´s a disadvantage that you can´t catch up, and that you can´t care for the wounds yourself. you need nursing assistant to help you and then you don´t have time to check on them properly... that´s the disadvantage, “  |

**ARTICLE 7**

**District nurses knowledge development in wound management ongoing learning without organizational support DN knowledge and development (A Friman, Wahlberg, Mattiasson, & Ebbeskog, 2014)**

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| **responsibility** | **knowledge** | **Time** |
| “my earlier work involved treating difference types of wounds after surgery, I know how to treat these as I worked on the surgical ward. but the types of wounds and ulcers that we may have to treat in the future. Well we will just have to learn little by little “ (DN 7)“…they would have to have a great deal of experience and this is improssible, I mean they can´t work for 20 -30 year just changing dressings on a daily basis…they have to focus on other tasks..I mean in principle, I could prescribe antibiotics and order bacteria culture test and provide the letter of referral to the specialist ..but this is how it is..”(DN3“it irritates me that I am not allowed to participate in courses... it should be a matter of course that we update our knowledge continuously...look at the GP´s they just take it for granted...” | “usually, I work with dressing changes on chronic venous leg ulcers… these are the most common. I think that it´s really hard and you are aware that you need to learn more…but most of my experiences comes from these…leg ulcers. (DN 4) “the number of venous leg ulcers has reduced since we received information that compression plays an important role in the healing process.. (DN 13)“ I would like information from highly educated people.. those who work with wound care, but who are not influenced by the companies. their information should be based on scientific research..” (DN 12)  | “it irritates me that I am not allowed to participate in courses... it should be a matter of course that we update our knowledge continuously...look at the GP´s they just take it for granted...” |

**ARTICLE 8**

**District nurses experiences of caring for leg ulcers in accordance with clinical guidelines a grounded theory study (Lagerin, Hylander, & Tornkvist, 2017)**

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| **Responsibility** | **Knowledge**  | **Time**  |
| “it´s hard to get them to a doctor. it´s a slow system. Or if a doctor should go home and look. We´re mostly the ones who take care of things in our own way, I think. That´s unfortunately the way it is in practice (DN 10) “many are very old they have lousy circulation. They´re not fit for an operation. It´s just totally impossible to get the wound to heal” one DN said (DN 19) “We tell them what they should do. That´s easiest, because we´re usually better with wounds than what they are”, said one DN (DN 22)“unevenly distributed competence in and experience of leg ulcer treatment, unclear respnsiblity for individual patient´s wound treatment, unclear policy for ordering materials, and no easy access to treatment plans“We try (to make sure) that it´s the same district nurse that cares for the patient (and) that follows the same ulcer as far as possible” (DN 11)“They believe that the wound will never heal. They have given up” said one DN (DN 12) “ Sometimes I can also think that it feels a little hopeless. You know that the patient has poor circulation because they´ve done a circulation evaluation , but you can´t offer the patient so much. They eat poorly and we try supplemental nutrition drinks but they don´t want to drink it and…it´s slow. It can be heavy. It feels like mothering is happening (DN 25) “Buty many you treat for leg ulcers can be nice, and treating them can be nice bothf ro you and for the patient if you have time. But for some patients, when you tak ethe elevator up, you can feel that you do yoga breathing to calm down…to be a professional person before you ring the doorbell. It´s like that, but usually you can have a nice time. You can have very nice moments and get great relationships . (DN 19) “ it´s important to get to know the patient – that the patient trusts you and understands what you mean. The first they might wonder what´s this crazy stuff (you´re doning), but then things go well and then they notice that it works, they heal (DN 16) | “We tell them what they should do. That´s easiest, because we´re usually better with wounds than what they are”, said one DN (DN 22) |  |

**ARTICLE 9**

**General practitioners’ experiences of managing patients with chronic leg ulceration (Sadler, Russell, Boldy, & Stacey, 2006)**

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| **Responsibility** | **Knowledge**  | **Time**  |
| “It’s an area that I wouldn’t want to see completely removed from my practice. I don’t want to be sitting here saying “you’ve got an ulcer, go and see thenurse”, “you’ve got a rash, go and see the dermatologist”““General practice is the ideal place. The patient is known, it is usually close to their home, and hopefully the repository of skills there is a good as anywhere else.. It is cost effective, it is early interventionist, and it should prevent people from going into hospitals. “:”If [the community nursing service] is dealing with it, I’m not going to see itunless I’m going to do two house calls a week dealing with it, I´don´t know what´s happening wnd I don´t like that. I´m sure they are well trained and well-menaing. But, ultimately, the doctor looking after them is responsible.”  | “The majority are the oldies with traumatic ulcers, and it is a question of developing treatment methods that fit in with their lifestyle, are non-invasive, are comfortable and can allow them to function normally and not spend too much time with us.”“(Ulcers) will just heal up, and you don´t have to get carried away doing other stuff. It depends on the severity of it and how it improves. Commonly, I´d use a very simple approach initially, and it would be the ones that don´t settle or get worse that I´ll need to follow up.”“I´ve found when it´s inflamed and not healing and growing staph or whatever, put them on antibiotica and they´ll be back next week, and it will have reduced in size by one third”“ I think the value of compression has never been sold sufficiently for us to say it is really essential. And most people get better anyway” | “If I didn´t have a nurse, my day would become miserable, I´d spend all my time doing dressings.”“The majority are the oldies with traumatic ulcers, and it is a question of developing treatment methods that fit in with their lifestyle, are non-invasive, are comfortable and can allow them to function normally and not spend too much time with us.” |

**ARTICLE 10**

**The lived experience of community nurses treating clients with leg ulcers**

**(Walsh & Gethin, 2009)**

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| **Responsibility** | **Knowledge**  | **Time**  |
| “Once a GP has taken a wound as far as they ca, they refer the patient to us. I don´t have a problem with that, the majority of times we manage the wounds ourselves ““ | “Wish the support of my colleagues, I have increased my knowledge in wound care”“The best source of knowledge, I think, is your own colleagues who have done wound care courses. We are out there doing dressings every day of the week”“For wound care knowledge, I would always contact the wound care nurse in the General Hospital, or a colleague with specialist education here in the community”“The wound care specialist in the hospitals are a great resource”“I would like an expert opinion in the field. If we could easily get an expert´s sopinion in the community, it would be a great resource`”“I don´t think GPs are really au fait with a lot of wounds and dressings. I mean, a lot fo the time they wouldn’t (dress wounds”)I found that course of great value, we learned a lot about bandaging, assessment and everything to do with wound management”“I think nurses need this education, especially the public health nurses coming out. They wouldn´t have the experience; I think this course would be a great value” |  |

**ARTICLE 11**

**Understanding factors influencing venous leg ulcer guideline implementation in Australian primary care (Weller et al., 2020)**

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| **Responsibility** | **Knowledge**  | **Time**  |
| “We had a very capable nurse practitioner: and she is updated with all the new guidelines. If we have any issue, we go to her (32 GP)“So if there is anything that I´´m not aware of I can just go up to any of the doctors and go what is this how is this. And then they have their own resources, and they will just look up their resources, print me out the paper and then go here have a real. They have their own guidelines (06 PN) “I think my role is very important in terms of managing venous ulcers. Often. GPs are the first port of call for patients “ (02 GP) | “No. I´ve only looked up on different websites what the best management is and all that sort of thing. I didn´t know there are actual guidelines (22 PN)“Look, a lot of times we also look and listen to specialists..I mean if we refer a patient onto a specialist, you follow what they do, and we look at and try and remember what they do, what the wound looks like and their reasoning behind it. And you learn from previous patients too (24 GP)“ I think because we all know our patients pretty well we have an instinct.. yeah its more of a gut feeling” (O1 PN)“ I would be moderately confident in saying this is a venous leg ulcer. But perhaps if it´s not healing at all, then I would start thinking twice and say could this be a malignancy, that needs a biopsy and especially if you´ve been doing all the right things, the dressing and stuff. Trying to reduce the edema and its still not healing like after months (33 GP)How confident would you feel in making a venous leg ulcer diagnosis?“Pretty confident. In most cases, is this venous or it is artieral, in some cases you get mixed up scenarios. This is what we will observe; and I am fairly confident (29 P)“We actually had a nurse come out. It is quite some time ago, probably about 3 years ago, who went thought all of that compression bandaging things with us (10 PN) “Pretty confident. In most cases, is this venous or it is artieral, in some cases you get mixed up scenarios. This is what we will observe; and I am fairly confident (29 P)“We actually had a nurse come out. It is quite some time ago, probably about 3 years ago, who went thought all of that compression bandaging things with us (10 PN) clinic: was that just for a morning?“I wouldn´t call it a workshop, one of our patients here who was saying shy don´t you come down and let them show you how it´s done. We called up the wound clinic and they were happy to actually accommodate us and show us and teach us how to actually get things done, different ways of treating a leg ulcer. So, that´s how we actually learnt it. (06 PN) “I usually go with the duty nurses. They have huge passion with probable venous ulcer” (29 GP)“ I would probably say I´m not as confident as I´d like to be about applying compression because I´m somebody who´s very over-cautious about over -compressin. I can do bandaging. But if they´re getting to the point where they need compression. I´ll offer to refer them to the (hospital-based) Wound Clinic where I can have a really proper assessment done (08 PN) “But as a nurse do you feel confident measuring ABPI ?”“Absolutely” (17 PN)And do you know what recommendations you might give to a patient with a venous leg ulcer when they´re leaving? “We always tell them to elevate, to try and stay off it as much as they can and to make sure they come back to get the dressings changed. (15 PN) “And what sort of things might you tell them? “Usually keep the wound dry, basic wound care management you´d say. If there´s any signs of infection, wetness. Pain around the area come back to us (06 PN) So you don´t usually suggest to use the compression?“No, I rely on the..well, they bring the wound consultants, the RDNS, so I rely on their expertise. (04 GP) “So, the difficult ones (patients) I would refer on to them (specialists) and they can do Doppler ultrasounds. (16 GP) You do (refer) I guess if you´ve got worries that their circulation is not good (17 PN) “We always tell them to elevate, to try and stay off it as much as they can and to make sure they come back to get the dressings changed. (15 PN) “And what sort of things might you tell them? “Usually keep the wound dry, basic wound care management you´d say. If there´s any signs of infection, wetness. Pain around the area come back to us (06 PN) So you don´t usually suggest to use the compression?“No, I rely on the..well, they bring the wound consultants, the RDNS, so I rely on their expertise. (04 GP) “So, the difficult ones (patients) I would refer on to them (specialists) and they can do Doppler ultrasounds. (16 GP) You do (refer) I guess if you´ve got worries that their circulation is not good (17 PN) “Its very much a team effort, which actually works quite well here, because there´s only four of us, four nurse and we all have a different area of interest, so it works quite well (01 PN)“Yeah, I think recognizing that we can´t be an expert in every singe thing, so that supporting team members to upskill. For example, the practice nurse taking a more leading role for wound management (14 GP) “So, it´s easy to go to somebody else as well and go “have you seen this? Do you know? What would you do with thins /in this instance? “ that sort of stuff. So it´s a collaborative approach to the wound care here as well (23 PN) “I think I sometimes do rely on my colleague whoever it may be more experienced in wound management, and also the nurse that I told you about is very good, so we do take opinion from the nurse as well (31 GP) Yeah, probably COPD, asthma, hypertension, diabetes. They´re the big one. I guess it´s probably because we don´t see as many venous ulcers and we don´t get as much education about( 24 GP)“I don´t really have any guidelines, that´s probably the simple answer: I don´t have, as far as I know I don´t have any access to any guidelines” (16 GP) So, you do not have the equipment there to do (ABPI) ?“No, we don´t and the equipment would be about half an hour away “(27 PN)Do you have a Doppler to exclude artieral involvement? You said that you´re not so confident if it is a venous leg ulcer? “Yeah, unfortunately we don´t . Not here. Yeah. We haven´t got one” (17 PN)“We have a small selection of basic venous ulcer dressings which I tend to use” (16 GP) “I think that younger professionals such as myself, there would probably be a greater uptake in guidelines due tot lack of experience, perhaps confidence, or wanting to double-check, as well as being, perhaps. Bought up in a culture or educated in a culture of best practice and referring to evidence-based treatment” (02 GP)“I think that younger professionals such as myself, there would probably be a greater uptake in guidelines due tot lack of experience, perhaps confidence, or wanting to double-check, as well as being, perhaps. Bought up in a culture or educated in a culture of best practice and referring to evidence-based treatment” (02 GP)“In this practice, what my experience is, our treatment of venous ulcers is very successful. We´ve only had probably one or two, possibly there might be one I don´t know of that have been referred elsewhere. So whatever we´re doing. And the expertise we´ve drawing on what is working. (01 PN)“To be really honest just over the years you build up enough experience and you read enough of the GP journals that it´s in your head (16 GP) “We treat them as guidelines, not rules. Some products that we´ve tired, I haven´t seen it anywhere else, but it works. That´s the aim of the game, is to heal the ulcer (12 PN)“General practice as you know is really broad and so we know a little bit about lots of things and then we know a lot about our particular area of interest. An they draw on me for my area of interest around women´s health, and I draw on their expertise for wound care “(01 PN )“To be honest, I´ve never thought that here should be VLU guidelines, yeah. And we should – its just because we don´t deal with any VLU patiens so it´s just something that we´ve not been aware of. I personally haven´t though of it (07 PN) | “Its constant, pretty busy, Particulary in the mornings when we see most of our dressing patients, it´s one to the other to the other to the other. And I suppose with a concern like if you don´t feel that you are not progressing or a wound isn´t healing as quickly as you´d like it to. There isn´t the need to go and seek extra information (01 PN) “Yes, don´t have time to be running around looking for guidelines and reading guidelines. To be really honest just over the years you build up enough experience and you read enough of the GP journal that it´s in your head (16 GP) “General practice as you know is really broad and so we know a little bit about lots of things and then we know a lot about our particular area of interest. An they draw on me for my area of interest around women´s health, and I draw on their expertise for wound care “(01 PN )“Just looking at it is overwhelming to have that many pages for one medical condition and in general practice we deal with hundreds, so I wouldn´t be able to read that (the guideline) for every condition we have” (11PN)“Some of the patients we know very well, and the last thing they want to talk about is their ulcer. And others are very interested and very keen to know what next, what´s the long-term likelihood of this dressing. How long am I going to be coming? How often am I going to come? Patients mostly are concerned about how long it´s going to take to heal “(01 PN) “ A lot of the guidelines are very pointed, you know, like they say Evidence-base C and blah, blah so they can be a bit wordy at times rather than just let´s get to the point and tell you what´s important. I found that a bit annoying about reading them when I read them the first tiem. It was just the way they were written in academic-speak (inquiry) whereas if you want to get to practice nurses you have to talk about tis in a quick, easy manner that´s easy to assimilate. If you like, and to practice. Something that´s practical (08 PN)“ Well, to me just looking at it (the guidelines) is overwhelming, to have that many pages for one medical condition and in general practice we deal with hundreds, so I wouldn´t be able to read that for every condition we have. Yeah it´s not like, if that was my only area, then you. I would go through it and with a fine-toothed comb, but because we have so many different conditions, there´s just no time; and I don´t like reading, truth be told” (13 GP) “There is just a limit to what our brain can hold with everything” (04 GP)  |