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Changes in the provision of effective wound care within the prison services

Nursing in the prison service is an emerging area of practice and the benefits nurses provide to patients/prisoners' mental health and physical well-being is widely recognised. This article highlights some of the common wounds seen in prisons and discusses the unique challenges of addressing tissue viability in this specific environment, where patients often have a range of complex health problems, including mental health issues and drug dependency.

Leanne Cook

KEY WORDS

Prison nursing
Wound care
Substance abuse
Tissue viability
Self-harm

The number of individuals detained at Her Majesty's pleasure continues to increase year on year. According to the latest Home Office statistics, more than 85,000 people are currently in prison, at a ratio of almost 20 males to every female (Ministry of Justice, 2011). All prisons have some healthcare facilities and professionals on site; these may include pharmacies, nurses and general practitioners (Triggle, 2006), many of whom have a special interest or qualifications within mental health. Within the last five years, the provision of health care in prisons within England and Wales has been brought into the National Health Service. Before this, health care was directly sourced by the Home Office. A similar process has

taken place in Northern Ireland, with responsibility for health care in prisons being transferred from the Northern Ireland Office to the Health and Social Care Trusts. The Scottish Government in 2008 announced that health care would best be delivered via the portfolio of the cabinet secretary for health, rather than the cabinet secretary for justice, thus

... it is suggested that 90% of prisoners have mental health problems, substance misuse problems or, indeed, both (Department of Health [DH], 2001). Healthcare professionals currently manage the care of this complex group of individuals against a backdrop of overcrowding, enormous organisational change, and the competing demands of care and custody (Walsh and Freshwater, 2009).

aligning Scotland with the prison service in England and Wales, (Royal College of Nursing [RCN], 2009).

The changes in England and Wales were made to improve the quality of care received by inmates and to ensure that they received the same standard of care and access to services

as provided by the public sector. The seminal document, *Patient or Prisoner? A new strategy for health care in prisons* (HM inspectorate of Prisons for England and Wales, 1996) prompted changes in service in prison, as it highlighted many areas of health inequality: complete loss of freedom is the punishment intended by a custodial sentence, but this should not result in inadequate health care (Shakespeare, 2008). The United Nations (1990) had previously stated that prisoners should have access to equivalent healthcare services available in the rest of a country without discrimination based on their legal situation. As recently as 2010, the Prison and Probation Ombudsmen (2010) reported serious concerns over the clinical care provided in prisons, especially in relation to medical emergencies. Mental health and substance misuse dominate the health needs of the prisoner population; it is suggested that 90% of prisoners have mental health problems, substance misuse problems or, indeed, both (Department of Health [DH], 2001). Healthcare professionals currently manage the care of this complex group of individuals against a backdrop of overcrowding, enormous organisational change, and the competing demands of care and custody (Walsh and Freshwater, 2009).

Prison health care

The focus on health care in prisons is in line with that of primary care,

providing services to promote the health of prisoners and identify, assess and treat health problems. Additionally, the adoption of NHS health care in prisons should ensure that services are delivered in line with agreed national standards and protocols, such as National Service Frameworks (NSFs) and those provided by the National Institute of Health and Clinical Excellence (NICE). Walsh and Freshwater (2009) state that prison itself can be viewed as a community and, inevitably, chronic and acute medical conditions are dealt with by nursing staff, in addition to health screening, supporting GP surgeries and dealing with trauma.

Additional demands are placed on the prison health services as prisoners characteristically make little use of health services outside prison, but make extensive use of the services during imprisonment (Marshall et al, 2001). Currently in England and Wales, primary care trusts (PCT) hold responsibility for the provision of health services for prisoners, however, with the devolution of PCTs in the upcoming months, in line with the document, *Equity and Excellence: Liberating the NHS* (DH, 2010), the future of commissioning and the provision of health care in prison is currently unclear.

Skills required by healthcare professionals working in the prison setting to address the needs of prisoners are wide-ranging, varying from mental health and general nursing skills to skills and competencies in custodial care and security (Walsh and Freshwater 2009). These include skills relating to wound assessment and management. A point prevalence study undertaken in Ireland by McDermott-Scales et al (2009) identified wound prevalence in prisons to be 2.7%, but concluded that even though the number of wounds is small, it is essential that prison nurses have the necessary skills and access to wound management professionals when dealing with problematic wounds.

Common conditions

Leg ulceration

The health needs of the prison

population are much greater than the community as a whole (Prison Reform Trust, 2005), with many having a diverse range of complex health issues including acute and longstanding physical and mental illness, drug, alcohol and tobacco dependency, sexual health problems, suicide and self-harm. In fact, some of the reasons people arrive in prison are related to their lifestyle and poor health-related practices such as abuse of alcohol or misuse of drugs (Watson, 2007). Sixty-three percent of inmates reported hazardous levels of drinking before being sentenced (Shakespeare, 2008), and 60–70% of prisoners entering UK prisons have a history of illicit drug use (Singleton et al, 1999), with 36% admitting to previously using heroin (Shakespeare, 2008).

With the high turnover of inmates in many prisons, it may be concluded that there will also be a huge number of drug users passing through the prison services each year. A history of intravenous (IV) drug use is known to be a causative factor of chronic venous insufficiency (Pieper and Templin, 2001), and it is widely recognised that chronic venous insufficiency and subsequent venous hypertension are the main causative factors for the development of venous ulceration (Mekkes et al, 2003; Anderson, 2008; O'Meara et al, 2009). Within a one-year period, around one-third of drug users reported an injection-related abscess, sore or open wound (Health Protection Agency [HPA], 2009). Therefore, the rates of lower limb ulcerations in prisons are likely to be more prevalent than that of the general population.

Due to a combination of chaotic patient lifestyle and disengagement with health services, many of these patients will never have sourced medical or nursing care for their ulceration while in the community (Pieper and Hopper, 2005). Rather, they will choose to self-care, often for many years, using a variety of methods to manage the exudate and 'dry up' the exuding ulcers through the application of talcum powder, sanitary towels, babies nappies and hand towels (Cook and Jordon, 2010). With addiction populations

also experiencing high levels of malnutrition, wound healing is likely to be slower (McDermott-Scales et al, 2009). Treatment programmes for IV drug abusers suffering with venous leg ulcers should be tailored to treat the ulcer together with general and mental health, including addiction, thereby improving long-term outcomes for both the individual and their families (Cook and Jordon, 2010). It is proven that the most effective way to promote healing of venous ulceration is the application of graduated compression therapy, (O'Meara et al, 2009). However, in the author's opinion, there are often difficulties in prisoners accessing such treatment as few prison nurses are competent in the application of compression bandaging. This is often due to many factors, including difficulty in accessing training and the sporadic number of prisoners requiring compression therapy making it difficult to maintain competencies.

Practitioners need to be educated and trained in the use of compression bandaging and to use their skills regularly to maintain competency. However, access to training and education is not always easy and the opportunity to practice skills can vary significantly. This should not be used as an excuse for prisoners receiving substandard care and solutions to these issues should be found. In the author's opinion, one solution is the implementation of care pathways specifically designed for prison services, involving certain prison nurses undergoing education sessions relating to the diagnosis and management of leg ulceration, to ensure that they are competent at assessment. This would lead to their becoming a form of link nurse who undertakes all initial assessments. This is feasible as the patient numbers needing initial assessment would be manageable for one or two individuals, but this would not eliminate the problems of application/renewal of compression bandaging, as these numbers would be substantially higher. In the author's opinion, the use of compression hosiery rather than compression bandaging could provide a practical solution to the need for compression therapy while in prisons.

Compression hosiery kits provide a sustained graduated compression that is determined by the manufacturing process (Thomas and Fram, 2003; World Union of Wound Healing Societies [WUWHS], 2008), not the individual, thereby eliminating the need for regular application to maintain competencies. This would also remove the need for a large body of trained nurses who needed to maintain competencies in compression bandaging. The nursing teams would still, however, need education on how to measure, apply and care for hosiery and on how to examine the limb for any signs of skin damage. Additional advantages of using hosiery kits are that the patients have freedom of choice regarding footwear and clothing, and are not restricted by the bulkiness of bandages. Additionally, patients are able to apply and remove their hosiery themselves, thereby enabling them to take control of their care, which in turn encourages ownership and ultimately aids concordance (Coull and Clark, 2005).

Self-harm

Mental health problems are more prevalent in the prison population to that of the general population (Brinded et al, 2001; Diamond et al, 2001). Clearly, there is a link between mental health and suicide, with prisons renowned for being a high risk environment for suicide (World Health Organization [WHO], 2000). The skills of prison nurses can be utilised to offer support and encouragement for prisoners, some of whom can see no real hope for their future. Additionally, there are greater social benefits of tackling mental health while in prison, as evidence shows that improving the mental health of prisoners and dealing with drug addiction reduces the risk of reoffending (Holloway et al, 2006).

Self-harm is common in prison due to the combined increase risks from mental health illness and incarceration (Royal College of Psychiatrists, 2010). Ousey and Ousey (2010) remind us that self-harm is poorly understood by many healthcare professionals, suggesting that staff who are expected to treat self-harm injuries are required

to undertake dedicated training to improve both their understanding of the condition and the treatment and care they provide. Every individual that self-harms requires comprehensive assessment, including full mental health and social needs assessment, with evaluation of their social, psychological and motivational factors specific to the act of self-harm (NICE, 2004a).

Wound assessment should include details of when the injury was caused, what caused the wound and if the patient has any preferred treatment method, as many will be habitual self-harmers. Moffatt (2000) explains the difficulties when assessing patients who have wounds caused by self-harm. She states that when assessment has ruled out the presence of an organic cause for the wound, the practitioner is faced with the dilemma of whether to tell the service user that he/she suspects self-wounding. This decision must always be made on an individual basis and with the support and agreement of the multidisciplinary team. Assessment and management of the wound will follow the same principles of other wounds, including assessment of the wound site, wound dimensions, wound bed, amount and colour of exudate, appearance of the surrounding skin, amount and intensity of any pain and treatment options (Ousey and Ousey, 2010). A literature review on deliberate self-harm (Mangnall and Yurkovich, 2008) identified that those individuals who perform the act feel that they have no support, and that there is no one who has the understanding and affection that they require to tackle their underlying emotions. This challenge is compounded even more so when in a prison environment.

Diabetic foot ulceration

Diabetes is recognised as one of the most chronic conditions in our society (Diabetes UK, 2009b). Therefore, this has to be identified as a health issue in all environments, including prisons. As a general rule, prison populations tend to be young, about 60% of prisoners in the UK are under 30 years old (Leivesley and Booth, 2009). However, there has been an increase in the number

of older prisoners in the last decade (Fazel et al, 2004) and, therefore, it is likely that prisons will be dealing with larger numbers of prisoners suffering from age-related and chronic diseases (Condon et al, 2007).

Prevalence of diabetes in prisons varies. Marshall et al (2000) estimated prevalence as being between 0.6% and 0.8% in the general prison population, while Leivesley and Booth (2009) audited a high security prison and estimated the prevalence of diabetes to be 2.3%. Although the numbers appear low, diabetes is 2–8 times more common in prison populations than in the general community (Marshall et al, 2000).

Diabetes UK's (2005) position statement highlights the need to use national diabetes frameworks, which focus on reducing the burden of diabetes from complications such as blindness, chronic heart disease, renal failure and amputation, and aims to set the standards of care that all people with diabetes should expect across the entire diabetes care pathway to ensure high quality care. It goes on to state that all institutions, including prisons, should provide people with diabetes the necessary care to live a healthy and long life, in accordance with the NSF. However, there is little audit data into how successful prisons are at delivering diabetic care, especially relating to the provision of diabetic foot assessment.

Foot complications are common in diabetes, with 20–40% of people with diabetes having neuropathy and a further 20–40% having peripheral arterial disease (NICE, 2004b), both of which can predispose patients' feet to develop ulcerations. Diabetic foot ulceration is estimated to affect approximately 4–10% of people with diabetes, of which 15% result in lower limb amputations (Boulton et al, 2005).

It is vital that prisoners receive appropriate assessment and intervention to prevent and manage foot problems, as outlined in national guidance (NICE, 2004b). This includes annual review of patients' feet, as a minimum, with sensation testing, footwear inspection

and palpation of pulses. Patients considered at an increased risk, where there is evidence of neuropathy or absent foot pulses or other risk factors, should have assessments performed on a 3–6-monthly basis. Patients categorised as high risk, i.e. those with neuropathy or absent pulses plus deformity or skin changes or previous ulcerations, should have repeat assessments performed on a 1–3-monthly basis. A foot emergency is classed as new ulceration, swelling or discolouration and urgent referral to a multidisciplinary foot care team should be made within 24 hours (NICE, 2004b). Multidisciplinary foot care teams should comprise highly trained specialist podiatrists and orthotists, nurses with training in dressing diabetic foot wounds, and diabetologists with expertise in lower limb complications. They should have unhindered access to services for managing major wounds, urgent inpatient facilities, antibiotic administration, community nursing, microbiology, diagnostic and advisory services, orthopaedic/podiatric surgery, vascular surgery, radiology and orthotics (NICE, 2004b).

Putting feet first (Diabetes UK, 2009a) reiterates this by stating that if any person shows signs of active disease of the foot, the advice of a healthcare professional, or team, with specialist skills in the management of the foot in diabetes should be requested. The term active foot disease, which may be either acute or chronic, refers to anyone with diabetes who has an ulcer, blister or break in the skin of the foot, inflammation or swelling of any part of the foot, or any sign of infection, unexplained pain in the foot, fracture or dislocation in the foot with no preceding history of significant trauma and gangrene of all, or part of the foot, (Diabetes UK, 2009a). It is essential that prison nurses are able to recognise the urgency of diabetic foot ulceration and refer in a timely manner to appropriately skilled specialists to ensure prisoners receive the appropriate standard of care.

Accountability

Prison nursing is as unique as the environment in which it is practiced, with professionals facing different

challenges which are both personally and professionally demanding. The secure nature of a prison environment directly impacts on the traditional nurse-patient relationship, and this should be managed differently, both physically and psychologically. The goals of prison are to:

- ▶▶ Provide punishment in the form of custody
- ▶▶ Maintain order
- ▶▶ Control and discipline in a safe, appropriate environment
- ▶▶ Prepare for reintegration into society.

... prison nurses have the unique opportunity to provide professional nursing care in conjunction with a supportive framework, which can enable prisoners to feel valued, cared for and less like social outcasts.

The Nursing and Midwifery Council (NMC, 2008) states that nurses must make the care of people their first concern, treating them as individuals and respecting their dignity. Often prison nurses are torn between these two different cultures: nursing and the caring philosophy and custody and security (Norman, 1999).

Summary

All individuals have the right to the same standard of health care regardless of socioeconomic background, colour of skin, religious beliefs or criminal record. Custodial sentencing should not and must not include the denial to effective and appropriate health care, including access to tissue viability services. Norman (1999) suggests that prison nurses have the unique opportunity to provide professional nursing care in conjunction with a supportive framework, which can enable prisoners to feel valued, cared for and less like social outcasts. Over the last decade, there has been significant progress to ensure that prisoners receive the high quality services required of a modern healthcare system. However, there are opportunities for improvements to

ensure that services are equivalent to the care provided in the community, especially in tissue viability. **WUK**

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Key points

- ▶▶ The health needs of the prison population are much greater than the community as a whole.
 - ▶▶ Skills required by healthcare professionals working in the prison setting to address the needs of prisoners are wide ranging and vary from mental health and general nursing skills to skills and competencies in custodial care and security.
 - ▶▶ Self-harm is common in prison due to the combined increase risks from mental health illness and incarceration.
 - ▶▶ Rates of lower limb ulcerations in prisons are likely to be more prevalent than in the general population.
 - ▶▶ Prison nursing is as unique as the environment in which it is practiced, the nursing professional faces different challenges which are both personally and professionally demanding.
 - ▶▶ Complete loss of freedom is the punishment intended by a custodial sentence, but this should not result in inadequate health care.
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