AHP Focus group transcription

1, 2 - OT

3 - Physio

Start: 5’46

PC: Do you see pressure ulcers as a problem in your everyday practice?

All: Yes [laughter]

2: Very definite yes

1/3: Okay

PC: Can you expand on that?

1: Okay, I’m happy to start [laughter]

2: Fire away

1: Yes, I certainly do see pressure ulcers as a problem, erm, mainly for the reasons of, we often don't get to know about them until it’s too late and so we’re managing rather than preventing and the feedback that I certainly have from my, the patients that I work with is that they've often had a long time of nursing interventions around their existing wounds before any other advice is sought…

2: Mmm [agreeing]

1: …Erm, and often feel quite frustrated by that

2: Do you want to say anything 3?

3: Erm, yeah, I mean, I think in my experience its exactly the same as that and also where we’re having a lot of trouble is the sort of generic, non-specific professional type of working where everybody knows a little bit of something but not a lot about a lot and what’s happening is that, you know, our teams are really good, in our area we’re quite lucky actually that they, the guys are starting to spot problems with skin integrity and we call the nurse and they come in as a second observer and manage it and we’re getting a really good rapport going that way but it’s not reversed. The nurses seem to think that the answer to putting, solving pressure sores is to put in equipment, they don't look at the whole psychosocial background behind it, the loneliness, isolation, medication, urinary incontinence unfortunatelyThey look at it as part of the braden score but they don't say well actually you do need to drink more so you go to the toilet more to reduce your pressure sores. They’ll say “oh, we’ll just refer you to the continence team, they’ll put a pad on you and then you sit for longer

2: Mmm [agreeing]

3: …because you don't need to go to the loo now and that I think is the most frustrating thing, is that it’s very much about…the models moved from treatment to care…

2: Mmm, yeah

3: …so everybody’s looking to care for the patient rather than going in and saying right you have to do x, y and z, if you can’t do that then we put in an aid, rather than here’s an aid, now we go and that's causing a massive problem from the patient point-perspective and to xxxx…

2: Mmm [agreeing]

3: …[the] equipment store, sorry. They’re struggling to keep up with the nursing demand for pressure relieving stuff where most of the time it’s not actually needed.

2: I think I agree with the comments you've both said, erm, I think it’s actually often the nurses will go in, there’s damage, we need to put a dressing on, we need a cushion and it’s actually looking at the whole of why did they get the pressure ulcer or even before that as 1 said this person’s vulnerable what advice, what information, what do we need to look at now to prevent the pressure ulcer developing, erm, and I think that’s one of our, the therapist’s frustrations is is the nurses, it’s a dressing and pressure cushion

1: Mmm [agreeing]

3: Yeah, I think we do bare some responsibility in the past and even to this day because to be honest with you what frustrates the hell out of me in in no small measure and I, I’ve yelled at people about this is that I still go and look at investigations and that and I see that the physio’s notes says subjective: have been asked to see patient about decreased mobility, objective: patient struggling walk, treatment: give them a frame and you think well hold on a minute, what about getting them out of bed, what about their nutrition…

2: Yeah

3: They’re not doing holistic assessments. They go on and on about how therapists do holistic assessments but actually if you read it they’re not. So that’s the first frustration I have, is those old fashioned people who are still going in and not doing a comprehensive assessment even though the patient is clearly vulnerable and then the second thing is understanding that we need to communicate in nursing terms to the nurses and in doctors terms to the doctors, now if you go to a nurse and you say I think the patient’s got a pressure sore the first question they ask is what’s the braden score and a lot of therapists are still really resistant to the braden, so it’s also partially our fault in that A: our assessment if you look and you’re brutally honest a lot of assessments are still not multi-disciplinary

2: mmm [agreeing]

3: …even when they've filled in the form on rio and the second is that we just don't communicate well enough or do the basics well enough in a lot of areas and so I think that maybe we should look at practice across area as well.

2: Mmm, yeah I mean I, I think that I agree with the points there, I think partly it just depends on the individual I mean I’ve seen some really good, you know, holistic assessments and some that are very much focused on the task, erm, I think we tried within our areas we’re using the intentional rounding model erm…

3: Yeah

2…so people go out and they do their ongoing visits and then they’re supposed to look at all the key points of intentional rounding…

3: Yeah

2: …again sometimes I think that sometimes it is a tick box, erm, it’s a oh yes it the same as it was last time, fine I’m just yeah, but at other times I think there is true value and meaning to it so I think it…

3: Yeah

2: the practice does vary.

3: And I think you know, one of the things that we’ve found really useful and the guys have started to adopt, it seems daunting at first, I’ve done a teaching session that I used to do at the hospital because in a hospital you didn't have the time so what I did was something called the 24 hour talk through, erm, and the guys helped me refine it and adapt it and there’s two modules, one is actually a 24 hour talk through with the patient and the other one is the prompts that make you think about how they interrelate so for example if the patient says that they go out, well, how often do you go out? You know, and you start off with what they have at night in terms of a good night’s sleep and you go all the way through, now it’s got quite a heavy teaching component to it, but once you start doing it, it becomes very slick and like you said, then it just prompts you. I know the nursing term is intentional rounding, erm, and it’s a good term, I mean I like it, but the problem is we’re using the wrong tools to capture the data, we’re not looking at function

1: I just wanted to go back 3 to the point that you were making earlier about our sort of responsibility as therapists and erm my point about er patients being frustrated about having lots of nursing interventions before anything else is explored and I think it is erm really important for us to acknowledge here that yes as therapists sometimes erm they are very willing to pass the buck to nurses and that’s been quite historical in that as much as our involvement is essential in terms of the holistic assessment and not just looking at nursing interventions, therapists have sometime also been very resistant to oh it’s a pressure ulcer and that’s a nurses job and so…

3: Yeah

1: I do think pictures are changing slightly, erm, but the blame is probably on us as much as anybody else

2: And I think within our, my team we’re trying to move forward and have more of a err okay this persons got a pressure ulcer, you know, what s, have they had therapy input, have they had nursing input, what’s our plan. We’re trying to work, trying to work more, you know, collaborativelyI mean, we’re…

3: Yeah

2: … on that journey, but erm, and I think, we’re, I think I’ve seen a shift in the last 6 months of therapy and nursing seeing a bit more of it from the other person’s view point and trying to move away from that oh it’s the therapists or the nurses issue it’s actually a patient in the middle of it all, and actually how can we all support that patient, erm, but I think, I think some, some people are more able to embrace that than others, I think some people are much more, sort of, traditional. I’m a physio, I go and do the mobility assessment, I’m a nurse I go and do the wound dressing, but actually…

3: Yeah

2: …we need to pull it together and actually what’s going on for this patient

3: And I think that’s the problem, you've got this generic model on one hand which promotes such a lot of skills to the other end which is a very profession specific model and actually neither will work, what you need is okay this is your initial thing that you will do, but these are when you will refer onwards

2: Mmm [agreeing]

3:…and when you’ve got that say for example, you know, when you look at some of the work that xxxxx been doing with the nurses in xxxx and xxxxx I think it is, nursing teams. It’s become very, very good the the response is excellent, but in the neighbouring teams it’s not and it’s just down to that sort of erm loss of professional identity I know it seems a bit of a contradiction that one individuals assessment’s too specific, but at the other end your professional identities err not strong enough and that’s what’s happened is that everybody’s sort of lost site of the value of therapies and in particular OT. I’m really, you know, disappointed because I find that the OTs who are very highly skilled in terms of posture, pressure management, eating, drinking and all that sort of thing are often overlooked and in the pressure to get patients through and off the waiting list, their input’s completely lost. You know we just wind up increasing care packages at the end of the day.

2: Mmm [Agreeing]

PC: Okay, and while you’ve all mentioned role and responsibility, where does role and responsibility come from?

3: Erm, okay, your role comes from basically what you managers decide your role is according to the service specification and in some part of the trust that’s been watered down to severe extent and in other parts of the trust that’s been tightened up to the extent where they become non-functional so for example in one area I worked in we had an OT, sorry two OTs come in to support the team and they literally came in, saw the patient once, gave them standard exercise sheet and discharged them, and two days later we had to go in and review everything because the patients, all their patients had either fallen or phoned in and complained, but in the area that they work normally that was considered good practice so I challenged their roles in that situation, they’re working like physiotherapy assistants, they didn't show any occupational therapy input at all. Their assessments were all musculoskeletal in nature and I was really concerned. I spoke to my OTs about this and they said that’s the way that team works. Our team we look at you know, OTs are very strong and professional about. And then the responsibility, well again that’s down to management, err, you know, because the clinicians can insist up to a point, but after that you will get overridden or your managers will step in and support you so in areas where you’ve got very strong manager opinion that the clinician should be accountable and responsible and they'll support them in those areas you get really strong professional groups, very good rules, boundaries and limitations and the boundaries are very grey because they understand the crossover, they understand just how far they can go across the boundaries, they understand just how far other people can come across their boundaries, but what you've got at the moment is in some areas, erm, there are no boundaries, no one knows what they're doing and they’re deskilling at a rapid rate, they’re just basically backfilling for other staff and I think that’s the strength that we’ve got to pressure ulcer management, you know, it’s all like OTs are very, very key in the beginning looking at the whole situation from the psychosocial model. The newer physios can sort of cover for some of that but I seriously have issues with physios who think that they can do a OT job. And then finally you’ve got the OTs that are falling behind and becoming more isolated as professionals when they’re working in teams where they’re just backfilling for other professions.

19:00

2: mmm [agreeing]

3: I don't know if you guys agree with that, but, you know I’ve been working across the whole of the north of xxxxxx and some of the south and into xxxxxx and that's what I’ve found.

2: And I think we’re lucky, we’ve got some very good therapists. The biggest frustration they find is they have an I, you know, they know what their role and responsibility is, but it’s actually having enough time

3: Yeah

2: …to do the proper assessment, erm, to actually have meaning and to influence things rather than as you say, go in and give a quick exercise programme, actually what are we achieving, where’s the outcomes of that, that actually to do the proper complex holistic assessment, the postural assessment, the follow up, that that per patient is very time consuming and there frustration is I’m being pulled because I’ve got x many of these, but I can only see a fraction of them properly…

3: Yeah

2: …and that’s their frustration.

1: And I think, erm, having worked previously as a community OT I am very aware of how, erm, therapists in the team are sort of, erm, overridden almost by the nursing staff, erm, and given little opportunity to to work outside of the role that is expected of them at that time and that includes things such as accessing training opportunities so people just, the therapists are going in doing what they can do, they’re asked to, for development opportunities, but there’s not time and the nurses seem to get priority, that’s my experience in a lot of the teams…

2: Mmm [agreeing]

1: Erm, and if there’s, I mean there is a lot of excellent training opportunities particularly around pressure care out there, but it would tend to be a nurse that got put on that. I think if you’re a sort of lowest common denominator in a team because you’re the only part-time band 5 OT you’re not going to raise your head above the parapet and try and push the boundaries of your role and your responsibilities and that's worrying.

2: I mean, I think, I think what’s interesting for me is only recently have I taken on managing nurses as well as therapists and I think that actually we are giving therapists more opportunities for training and wanting them all to do the complex moving and handling, the postural management at ISIS, erm, tissue viability training, erm, just starting that and the idea is that they are getting more upskilled on identifying pressure ulcers, taking photographs, can I do a basic dressing on this so that the nurses don't have to rush out so that we are actually doingI think in our area we’ve got a lot more, sort of cross working without trying to dilute, we’ve got, we want to keep the specialisms, but actually we don't need, you know, a patient who is stuck in their chair obviously needs therapy issues, but you get them up and you see actually they’ve got a pressure ulcer, I don't need a nurse to rush out that day, the therapists can do something

3: Yeah, excellent

2: …but what actually, the key issue is not about a cushion or a dressing, it’s about why is that person stuck in their chair, they need the rehab to get them up and overcome whatever issue it is so in that sense the nursing bit is a subsidiary of it. It’s a small part and actually talking to the nurses about that particular gentleman they were saying well actually yeah, what you need is therapy you know actually we’ve seen the photograph of that wound, yes you’ve done the right basic dressing, actually we don't need to go in, and yet a week later that gentleman is up mobile and the pressure ulcers have gone because he’s had the intervention to look at the cause, erm, you know overnight in the chair, yes you can see the ITs are reddening, you know, erm….

3: Absolutely

2: …a cushion is not the answer, but yeah I think…

3: I think that

2: Sorry

3: Sorry, carry on

2: Oh no, I was just going to say that I, because I’m a therapist leading nurses and therapists and we’ve also got older peoples’ mental health, which we’re looking at their role as well because again if someone’s got a mental health problem and they’re not mobilising so much you know.

3: Yeah

2: Are we just focusing on their physical health, we need to consider their mental health as well, you know, you’ve got somebody with vascular dementia, they’re not compliant with instructions and things, have we really got the OPMH management in there, so, yeah, that’s kind of…

3: Yeah, in xxxx I’ve put all the OTs through the complex posture seating…

2: Yeah

3: …and pressure sore stuff and its paid dividends. I mean the nurses are really, erm, they were absolutely astounded at first, they were like Oh my goodness where did you get that and how did you know that, you know, they've now, the OTs have now got their own cameras and everything, you know because they go out all the time assessing, but it was pointless having one camera in the team

2: Mmm [agreeing]

3: …because then you've got two or three OTs going out then it’s pointless them coming back to get the camera to go back out again. So I think it is about if your leader is is focusing on actually this is a bigger picture issue then, you know, you’re doing exactly the right thing that you’ll notice in days that the responses are just so different and you know the other teams that I’m working with, the OTs haven’t been given those opportunities, they haven’t been given the support and what happens in the end is that you just wind up with this hole, so you get the treatment, but none of the assessment and interventions that are needed in the background.

PC: Okay, so I just want to kind of go back just a step if that's okay because some of the conversation there was obviously talking a little bit about management in a way, because you’re talking about going in when somebody has a pressure ulcer already. What’s your feeling on therapists’ view of pure prevention, so somebody they would see who doesn't have a pressure ulcer, but identifying the risk factors for them and maybe implementing something, whatever that may be, before it gets to the stage of actually forming a pressure ulcer?

2: I mean, I think that’s absolutely key, I think you know any therapist assessment you know you’re looking at mobility, how long you’re sitting for or how long you’re lying for, can you change your position, if not why not, erm, you know you’re looking at you know, about the nutrition, can you get your food, how do you get your food, what are you eating, you know are you getting to the toilet in time therefore are you restricting your fluid intake, if you can’t, all of that should be part of that, that assessment, erm, and therefore you should be identifying somebody who is at risk, erm, maybe they've got a kyphosis, you know their sitting, they’re mobile, they’re out and about, but actually the way they sit in their armchair, actually there’s a pressure point there so have we looked at their whole function, their anatomy. In my opinion that, we should be doing that holistic assessment that covers all of that, but I know due to time pressures that’s not always happening, but I think that’s where, you know we have the, all staff are expected to give out the [the trust] prevention of pressure ulcer leaflet, with discussion, I think that’s key, I think what’s sometimes happening I give out the leaflet, but actually have you talked about it for that individual patient, what’s that individual patient’s risk, erm, rather than being a generic keep moving, you know, make sure you have your vegetables, erm is it actually specific to that patient erm, that’s my…

1: I don't know what else I can add really [all: laughter]

3: I think I agree with you because what we used to do when we had a bit more time, so time is always an issue and it’s about being able to be more effective I think there’s two things. One is that we have the literature available because with the, with the pressure care thing if you look at age UK they've got booklets that you can give out that meet each of those things so how to keep mobile…

2: Yeah [agreeing]

3: …how to get, you know, a bit about diet, a bit about exercise, staying steady and strong so they've got those and I used to take a pack out with me which had the pressure ulcer thing, the stuff for exercise and all that, that I knew what was in them and I’d talk while we were doing the treatment we’d talk it through and what I’ve found is that is that as we’ve been moved to this response thing where we’re rushing out to sort patients who are really struggling, erm, we’re not going through those things, we’re not encouraged to go back and revisit them because sometimes on the first visit by the time you've done your assessment most of my patients are exhausted they really don't, they’re not going to absorb anymore it’s hard enough they've had carers through the door, physio, OT and nurses and they've told us all a different story because they know the OTs don't help them with washing, the physios going to hurt them and they’re going to do lots of exercises that are painful and the nurses are going to come in and do something caring for them so they've told us all a different story and I think what we need to do is to focus on actually is when you go and see your first assessment get it right, I mean if you were, had somebody come in and deal with some complex issues for you and then try and teach you about pressure sores, how much are you realistically expected to do and learn whereas if we could send back a band 2 or band 3 who would sit down and go through it with them, erm, you know go to the pressure thing as a dedicated service would that not be a better use of time and money?

2: mmm

1: Good question [laughter] and very possibly, I mean this is, looking at prevention side it certainly could be something that a well-trained band 2 or 3 could go in and spend the time going through, erm, I, erm, not something I really thought about to be honest [laughter].

3: I do know that my band 3s are, to be honest with you, our band 3a are pretty exceptional in terms of drives, they are very highly motivated to stay as band 3s don't get me wrong and our band 4 is very highly motivated to go into OT, but what I’ve found with them is because they are so driven around the patient that they tend to go out and do this without us telling them, they'll see I’m just yeah I’m going to go and give equipment to Mrs so and so, do this, do this, do this and then I’m going off to Mrs so and so and I’m going to go through the pressure stuff with her and the diet and you’re like yeah okay, off you go and all they is they take the age concern literature with them and the [the trust] stuff and they just do it

2: Mmm [agreeing]

3:…the problem is I don't know how often…

2/1: Mmm [both agreeing]

3: …and that's what I’d like to do and have a process but again have you got enough band 3 cover to do that…

2: Mmm [agreeing]

3: …because obviously if they are band 3 they can do some stuff with initiative so for example they could go there and adjust toilet frames and feet and maybe do some falls assessment and other things you know, fill in a trust falls list assessment while they’re there you know, so you’re dove tailing two into one.

2: Mmm [agreeing]

3:…but I don't know how regular it is and I know in some teams its happening with some staff very good and other staff are not so good

2: Yes, and I think that's probably the case for us. We, erm, it's a bit sporadic, I mean I know that within our falls prevention group some of those things are touched on and actually we’ve just started doing a session within the memory matters group which is the older person’s health support. They do a group for people with dementia and we’ve just started talking about falls prevention and mobility and sort of staying well erm

3: Yeah

2: the importance of keeping moving and you know we touched on, just very you know lightly on the impact of, healthy skin was kind of the stance we were taking on, but that's really just quite new, is touching on that, erm, so that we’re also giving, erm, spouses or partners information as well because again if someone’s got dementia they may not be able to take on board all the instructions and information, erm so that's something we’ve just started doing, but I don't think we probably make enough use of our 3s, erm erm in that area, but again its its time….where is our priority and I guess it's a lot of those things is, we were having a discussion this week about the crisis intervention versus the proactive care and actually do you need two separate services so that you can actually really, what’s the impact of being more proactive? Will that then reduce the crisis car? You know, if we do

3: Yeah

2: …more preventive information will we then need less, erm, nursing time to focus on treating complex pressure ulcers, erm, because I think there’s so much time and cost involved in treating, you know, the visits and the dressings and so on for 3 and 4 pressure ulcers if they haven’t got it in the first place, erm, then actually, you know, can we turn the whole module round.

1: Mmm

3: Yeah, and I think you know memory matters thing is one thing that has always disappointed me is we’ve got falls groups for the parkinsons, but I actually think we should have, erm, a therapies session for carers, erm, that runs for the carers themselves that goes through, erm, when I took memory matters I used to find that I struggled because I wanted to go through transfers and when to get help with your transfers so you you’d find lots of people dragging people out of chairs and…

2: Mmm [agreeing]

3: …and it just goes okay just prompt them like this, and they go oh my god if only somebody had told me that a year ago and you think well why didn't you ask and I think with the whole mental health thing, you know, it is a hidden minefield and if we trained the carers to, you know, these are the red flags this is what you've got to watch for or these are really important, this is how you cope with these minor upsets and mostly this is when you call us and we’ll come in early rather than we get a call you know five days later after the patients been in bed for four days, you know it’s like, and you go there and you just help them get out of the bed and they get up and they and everyone says we’re too scared to make them walk…

2: Mmm [agreeing]

3: …and you’re like just ask them and it’s things like that, maybe in the memory matters we need to look with the mental health guys and say you know in terms of training not only for pressure sore management, but is there, is this all included in the carers side because I know I used to go and do the talks to the carers while the the the people with the mental health problems were looked after, erm, but the only things I was able to cover in that time was red flags and what therapists could do.

2: Mmm [agreeing]

3: So maybe that is a good enough thing we need to look at is how do we help them with pressure care and get their mental health people covered.

2: Mmm, and I think we’re just starting on that journey, I mean, we now have cameras for all our staff including older persons mental health, erm

3: Yeah

2: So the idea is that every team member will have a camera, erm, and that a, they can be used for the postural management stuff that all therapy, therapists should have them for that kind of thing

3: Yeah

2: But then if you do see a little wound you can come back and then say what you think

3: Yeah

2: …and you've got that sort of second pair of eyes so I think it’s, you know, it’s basic practice like everybody should have their BP cuff and whatever then people should have a camera.

3: Yeah, and that again comes to where do you draw the line because if you’re going in to do a patient and you’ve got five urgents to see and they’re all complex, erm do you then spend that extra time doing all those peripheral things or do you just focus on the most immediate problem and I think that that’s where we’ve reached is I don't have enough OTs so they’re saying to me yeah by the time I’ve done the blood pressure that’s actually only a third of the problem, the problem is when I come back and I have to record it on two different places in the, in rio and then I have to remember to do it there and it’s like well okay let’s cut out one of those aspects of rio so it’s like with pressure management and all the rest of it is how we’re going to make recording this stuff that they’ve found so that we upskill people, with give them the tools to do the job but actually how do we communicate that, erm because rio’s so cumbersome.

2: Yeah, I think there are several issues aren’t there balancing the emergency care with the proactive care, but then there’s also the the expectations around that in terms of electronic recording or what, what the trust expects it, how things should be recorded, erm, and I think that that's the challenges, is you know, where do you put your focus, what is the trust’s focus. Is it proactive care, is it the reactive care, kind of what, can you do it all or what are the priorities or if you do more of the proactive stuff do you have less of the crisis, I don't know

3: [laughter]

1: Sorry I have gone a little bit quiet cause obviously I’m not on the front line anymore so I’m a little bit out of touch so I obviously only now tend to see people when they've got the grade 3s and 4s and start doing the unpicking of how that occurred so apologies if I’ve gone a little bit quiet, but I don't want to draw too much on my past experiences that are probably a bit out of date now [laughter].

3: Well it would interesting to know if your past experiences are any different to what you’re hearing now so if you do hear something that hasn't changed in the last four years, then just feel free to dive in and say, that’s part of the problem is that we’ve got so many changes going on that actually we can't track what’s worked. We just seem to constantly be trying to do something different and that actually when I look back and I think that you know, but in five years ago we didn't have this number of issues with this part of our care pathway, but we changed several different things around that pathway

2: Mmm [agreeing]

3: …and actually they've made this pathway now useless and I think that's probably happening a lot with the pressure stuff is the focus is drifting from area to area to area with inadequate resources and that's just pulling out of the preventative side of pressure care. It’s much more focused about the reaction to a pressure ulcer

1: Mm, hmm [agreeing]

3: and you know is it proportionate to if you look at the amount of time staff are spending on writing up stuff for SIRIs and that when you find a grade two and all of a sudden you've got a four page report to do when you get back to the office, you could have gone out and done two more preventative visits in that time so I think that maybe that is a serious issue with the trust actually wanting to go and are they going to give us a stable continuum to work on rather than okay you can start on that and two weeks later they change the criteria and two weeks later they change something else, you know something has to stay constant in order for us to monitor if it’s getting better or harder

1: I think what I’ve been really encouraged to hear from both you 3 and 2 is having the team leadership from a therapy perspective and the opportunities that therapists are now having, erm, when I was a community OT I was led by a nurse and I think that’s possibly why some of my experiences are less positive, erm, but really, really nice to hear that OTs are having lots of opportunities and being given the time to as 2 was saying commit a little bit into the pressure ulcer and being able to perhaps put on a dressing and you said 3 about allowing all of your staff to go on the trainings, that's really positive as I certainly didn't have those, but what makes me think is it’s lovely where there’s therapists leading therapists or therapists and nurses but across the whole of the trust that obviously quite a lot of variation over, sorry around who’s leading the team and what their priorities are and that's the difficulty and the challenge that we can’t, it’s great that we’re sat here going it’s all, this is all wonderful, but I don't know that we’ve quite got the other perspective [laughter].

2: You were saying that…

3: I think that because I’ve recently moved across to xxxx which is the xxxxx team in the xxxx and there’s a social worker, physio, OT, nurses and healthcare assistants and we’re going to get some mental health input into that, but the problem that we have is that, erm, well there’s a lot of problems on the team itself but what one of the things that I found was that when they did the allocation in the morning it was really difficult because you've got a team of people, the trust are saying that you've got 1,2,3,4 qualified professionals in there to go out and do these assessments and then there was the follow ups afterwards so we have to, we can keep them on the books for up to six weeks if it’s really bad and then having done all these, so the next day whatever you come in and at handover you've got all your patients are extremely unwell, all your patients are at high risk of falling, developing pressure sores and it’s all very complicated and when you’re dishing out tasks people lose focus of the fact that Mrs Jones is primarily a physio patient because she’s got to work on her mobility and strength is effected because of a big haematoma so she needs somebody to go out and check the haematoma and all the rest of it whereas Mrs Wise has got a pressure sore, it needs dressing, but actually it was because she had a long lie on the floor, but now she’s up and moving so what happens at allocation is there it becomes very difficult, you, the model that they were using again which we’re looking at again is meant that people didn't want to take responsibility for any of the patients at the beginning of the handover because by the end of the handover you might end up with too much work.

1: Mmm [agreeing]

3: So it’s looking in these multi-disciplinary teams like that is how do you get that team leader, if they’re a therapist to acknowledge the nursing workload and if they’re a nurse to the physio and OT workloadand also I’m sorry to say but get some of the old fashioned physios to acknowledge that actually the OTs work is very different to the physios. Physios even on a complex assessment don't have as much follow up to do. I find that the OTs find their follow up stuff and their, the stuff they have to do in the office is often far more in excess of what the physios have to doSo it’s like how do we get these team leaders to understand the differences to work with those and respect those differences when it comes to actually you've got sixteen urgent patients on the board, you know how do you, we make sure that that sort of leadership is there because that’s what’s lacking in the trust. You've got about seven thousand nurses versus all the other healthcare professions including podiatry and dentistry and all the others and how do you stop us getting lost in that delivery at the front, at the coalface so it might be that we need to do something around how do we look at all the teams have a consistent measuring card, because if you’re looking at pressure sores maybe that is a good measuring card to see how good the leadership is in the team in respect to respecting people’s roles and making sure they get the development, making sure they get the professional support, I don't know…

2: Mmm, I mean I [exhale of breath] I think it’s sort of a challenge on a day by day basis sort of thing hearing nurses will or nursing/healthcare support workers will say oh therapy have only got four visits or five visits, but I’ve got ten visits so I’m working harder erm

3: Yeah

2: And and I say to them it’s not about the number of visits it’s about the complexity and I think some people are able to take that on board and others find it more of a challengeI was just interested in 1, you know you work with 3s, grade 3s and 4s now predominantly. Is there things that you can see that have gone wrong or if they've been done earlier on what are the key things that you think would have made a difference earlier?

1: Erm, I think the problem that I get is that I tend to get brought in quite late in the day, which is something that we’re trying to change so the patient has developed a pressure ulcer of some form, a nurse has gone in and tried a number of different dressings over a number of weeks or months and then perhaps they've referred to community therapy because they've gone well actually the dressings aren’t really working so we need another opinion, then the physio or the OTs gone in and the wound is now very, erm, large, complex, whatever and then that therapist might refer to our team so by the time I get out there… I mean I’ve actually got one person who they've been trying to close his wound for 13 years and now with looking at his 24 hour routine like you were saying earlier 3. We identified a huge amount of things that no one had ever thought of and the main issue that I see around pressure ulcers is moving and handling everybody’s missing, I say everybody [laughter] a lot of people are missing how much moving and handling and equipment is contributing towards skin damage and preventing pressure sores pressure ulcers from healing, so I think that's probably my biggest frustration and we are doing a lot of promotion work to try and encourage people to seek appropriate advice earlier and hopefully before that wound even occurs.

2: I mean I think, I think, you know, it is a frustration time wise, our our rationale is that anybody who has a grade 2 within our teams, we start a pressure ulcer tracker tool to make sure we’re doing everything and within that that includes the therapy referral, now it may be the therapy referral may be a discussion about you know, have you looked at x,y and z, but actually we are then trying to make sure all those patients have a therapy assessment and the challenge is having capacity to do that,erm, and it may be, may be a one off visit and actually you realise it’s because of shearing because somebody’s chair’s too low and that’s why and you can kind of, so sometimes you can sort something out quite quickly erm, but that’s what we’re striving towards, but it’s the capacity, it’s okay when you’re fully staffed with people who are, who’ve got the competencies, but the moment you get vacancies and sickness and you've got new starters who are not, you know need that training, but that’s where you sort of struggle with that, but I’ve certainly seen the benefit when we see a, you know a nurse will come back and say Mrs so and so has got a tiny pressure ulcer, right okay, let’s make sure we’ve looked at everything, let’s get therapy out there, let’s look at the posture and mobility and actually then the next week you hear the grade 2’s healing. It’s not become one of those, you know, horrendous sores, so, we’re certainly sort of just seeing that low key evidence of that, but it’s actually being able to sustain that.

1: And know that that’s happening across the whole of the trust which I suspect it’s not because you’re saying even with all of that in place it can still be a challenge to implement so the teams that haven’t got anything in place, they haven’t really got a hope

2: Mmm [agreeing]

3: Yeah, even the teams which use the tracker are, the last three I looked were the, a chap that was walking to answer the door and letting people in and out and going into town, got a grade 3, erm, you know they had the tracking tool but somebody had ticked it on the first visit, but nobody had followed it up.

2: Mmm [agreeing]

3: and no one had referred onto therapies and it’s almost like, I know why they hadn’t because the team they were referring onto is very, how should we say, very pressure sore resistant in terms of their treatment. They don't see it as a whole multi-disciplinary thing, they think well there’s a sore there stick a dressing on and we’ll you know, it’s got nothing to do with us and you know, yet when you looked at a like for like case where the teams have been really working well with the therapists you've had an OT go out that day, not a physio because actually the guys walking around, he’s moving he’s, he’s he’s, how do you, you know what the physio going to add to that whereas yes they can go out and they can screen for the 24 hours, but actually what I find is missing, I don't know if maybe I’ve had the luxury of working with some top level OTs that just the way they get the question, the way they think, the way they interact with the patient and also the patient’s expectations means that they come out with solutions that other people haven’t thought of because pressure sores are complex, they are very seldom a unilateral factor, you know it’s very seldom because they’re sitting, it’s because of other things so things like remembering to go and open the fridge, open the cupboards, look in the dustbin and then you find a dustbin full of unused ready meals you know the person’s malnourished, you know, and that's the sort of things I think the OTs bring to it so where you've got teams where they have the time to actually go in and do the assessment, the nurse is engaged in it and everybody engages, fine, but again coming back to the thing is where you've got teams there’s no consistency you’re not going to find that all the teams using the tracker will refer to the therapist.

2/1: Mmm [agreeing]

3: Then the therapist will not always accept the referral so it’s almost like a whole pathway that needs looking at and then a whole process that needs to be put into place, which is as mandatory as it can be within our resources and I don't know about you guys but I’m finding more and more that the the eyes on approach is better so rather than spending 30 minutes doing a big handover that we started to just send somebody out and the nurses are really good at saying I think it’s more of a OT issue than a physio issue or vice versa and we just send the person that they think is most appropriate out and quite often they come back and there are things that they need to, in fact 99% of the time they come back and there’s stuff that they needed to do so we’ve yet to say okay we’re wasting time with it and then with some of the SIRIs that have come back where we’ve sent an OT out the feedback from the panel has been, well the nurse said we need an OT, within 3 hours and OT went out did a quick assessment, came back and said there is nothing we can do about these points, carry on with those points and that gave us positive marks whereas other teams haven’t included any other professions. Does that make sense?

1: Yes, and having sort of a birds eye view of the, across the whole trust because I support case holding clinicians across all of [the trust], erm, I do still get the, the emails saying 1 can you pick this up because it’s not really my job, it’s a mattress and a sleep system, it’s not really my job so that should easier if you just did it and maybe contact a nurse for a little bit of help so I still that there is that culture within different teams of not really my responsibility, I know I touched on it earlier, just sort of adding into what you were saying.

3: Yes

2: And I wonder what, you know, that culture is that because, you know people are so busy, people haven’t thought about it, erm, you know what’s influencing that, erm.

1: And is it the leadership and the set-up of their team or is their own personal interest or confidence or just generally don't think it’s their role…

2: …or their knowledge, I mean historically pressure ulcers had been nursing

1 nursing

2: and what’s interesting is when we get new therapists and therapists coming out of the hospitals, erm, and we go through well this is what we require you to do, we need you to do a must and a braden and skin assessment and they go well that's what nurses do and so staff coming out from the hospital with well the nurses do the pressure care bit, the OTs do the kind of ADL, equipment and complex discharge planning and then the physios do the chests and the mobility and they see it as being separateerm, and you know why have I got to do obs, why have I, why have I got to do, the nurses used to do that so it’s that understanding that in the community you've got one person going and you need that baseline, but then you've got to have your special, well that’s my opinion, you know that everybody can do a baseline and then you need your specialisms, you need your physio expertise, or your OT or your nursing expertise for certain patients, erm, but it’s even that, you know saying to a new band 5 did you look at that person’s heels or bottom, well no that’s not, I’m an OT I don't do that so is it from a training, you know what is, what is the culture within the, in the universities going right back to that. What what are they taught, you know, is it very separately taught or or not I don't know, you know I don't know quite how that is taught now, does it need to start before they even come to the trust, you've got to go right back to the core training.

3: I think the core training is something that that doesn't really need to be addressed because it is core training and if they decide to go into… I think what happens is when they come out of university they’re a blank sheet and your development of them is very, going to be dependent on two things. One is having a leader who can engage with them and inspire them to go along the path and the other thing is an interest to become engaged and go along the path and I think what happens is you get a conflict of interest in that on one hand we’re demanding high standards of occupational therapy and on the other hand we’re asking them to fill out a lot of tick boxes and do a lot of things as well as their day job, so what’s happening is that they’re getting confused and they’re getting frustrated because you know you've gone out there and you’ve got somebody with very complex needs and they're asymptomatic, they’re walking around, there, there’s somebody, you know you don't need to do the observations because pale, sweaty, clammy or anything else you’re looking at maybe somebody in a wheelchair, but you have to now do obs and it’s like well actually where’s, I can see both sides of the coin, but for somebody coming into the trust that might be really confusing. It would be far better if you had some kind of, erm, leadership that engages with people and respects their clinical opinionI don't do obs on every single patient I see because a, I see people in car parks, I see people in sainsburys, you know I’m there to deal with complex issues with people so pulling their pants down to look at their bum or their heels, they might have a grade four I don't know, but I’m not there to see them in their house. It’s almost like we have to, it can’t be a black and white you have to do a braden on every single patient, but at the same time it should be you must think of doing these things otherwise what happens is when the time pressure starts, and working with nurses, let me tell you something, about 40% of patients don't have an up to date braden, they don't have an up to date must, they don't have half the things they should have because the nurses are too busy doing the dressings, doing the catheter change, doing the stuff that they have to do and then that brings a conflict in my teams which are working with the nurses that nobody wants to do those things that aren’t really necessary at that point in time so they’re all trying to dump it off on the other person and that’s where it gets so complicated so yeah, no matter what you teach them at university the minute they come out the influence will be their first manager or when they come out of the acute hospitals with such a change you’re going to have to look at doing that so I think leadership and pathway for their learning would be better.

56.30

2: Yeah, well no, I mean, it’s just putting thoughts out there isn’t it, and I think the issues around what are staff required to do whether it’s must, braden, obs, you know, that there are certain criteria that people are told they have to do be it whether it is clinically indicated or not and my concern is that sometimes yes people have got an up to date must or braden but that’s what it is, it's a tick box and actually there isn’t a care plan or action planwhatever you want to call it that actually you might have somebody with a high must and high braden, but it’s kind of like I’ve done it and they've got a mattress, well that's fine, err, and I’ve told the GP their must is high, erm, but actually is that really making a difference to the clinical outcomes of that patient, I don't, you know, sometimes I think it is a tick box and therefore it is, what is it that we……. where do you use clinical judgement and where are you guided by or instructed by what, you know, the trust expects you to do…

3: Yeah

2: And for an individual patient what is clinically appropriate may be different and like you say the obs yes, you know, if somebody looks well then you know why do you do obs? A lot of people don't and they but, you know, if you an holistic assessment according to [the trust] it’s supposed to be done yearly, erm, but actually, and if you have a baseline and they are unwell then have you got, you know, is there something then that you've got, actually normally, this is normal for them and now they are unwell, I don't know, I mean it it…..yeah, plusses and minuses aren’t there.

1: I’m afraid I was always the rebel as well. I refused to do a set of obs for someone who needed a grab rail at their front door and used to get hauled over the coals, but I think if you’ve got confidence to use your clinical judgement and ultimately can justify why you have or haven’t done something.

2: Yeah

1: If you’re somebody who, erm, you know, the perhaps newly qualified members of staff who are just being put under so much pressure to do all sorts of paperwork that they don't really know whether it’s needed or notand so won’t necessarily say well actually I don't need to do that so I’m going to focus my attention on the fact that this lady can’t get up easily from her chair and perhaps not do some of the other bits that aren’t quite so relevant at that moment in time. I used to have my own blood sugars machine and everything. I had everything, but actually I didn't use most of it most of the time I was just able to…, but then I’d get the telling off when someone found out [laughter].

3: Yeah

2: And that's the whole thing. Why, why is somebody being told off, what, when does clinical judgement come into it. If you’re new you don't have so much of that clinical judgement

1: Absolutely

2: But then it’s what’s the point in doing, I mean, sometimes I’ll see a falls assessment and I’m thinking actually that’s not really, that doesn't tell me anything, it’s been done as a tick box, erm, the braden, yeah, actually erm is that really influencing having a braden, it’s a score, but actually what, what is that telling you about that person err.

1: And it takes away peoples actual clinical judgement and just gives them a list of numbers and high, medium and low risk, but actually somebody can present with, see a lot of people who present really, really high, high risk in terms of their braden score, but when you look at their actual presentation they don't need the highest all singing, all dancing mattress, they just need to be repositioned a bit more often, erm, but that the braden score would indicate that their skin is going to break down imminently, but they actually; I see a few people like that, but it, yeah I do sometimes wonder whether facts, figures, assessments, formalised assessments take away from an actual, erm, your your clinical perception of a person, because it’s almost overridden by, but the bit of paper says.

2: Mmm [agreeing]

3: What you've got is, what the trust has lost sight of is that fact that those are risk assessments, they’re not clinical judgement tools

2: Mmm [agreeing]

3: They are simply a risk assessment, like TILE, you’re gonna, you go out there, task, individual, load, environment and you do those and actually your actions are more important than the score. See what happens with braden and that somebody comes to me and says I’ve done a falls assessment and they need physio and I say why, oh because they scored 28 out of 30 and I say why and they can’t tell me why they think the person needs physio or what they want me to bring to party, they've ticked the box which says have they scored above this, refer to physio and it’s like you go out there, they've had a stroke, they’re always going to be at a high risk of falls and yes I check to see if there are any changes and everything, but what worries me is that person’s clinical reasoning isn’t there, but on the plus side of that, it told that this person is at high risk of this, get this person’s opinion and I think what should happen with the braden is, and I know I’m going to get shot down in flames for saying this, is that for every single person who has a pressure mattress issued should have an OT assessment within five days, every single patient, because the number of incidents we’ve had where we’ve gone into nursing homes to go and see a patient who’s falling who’s sliding off overlay mattresses because the person has done a braden, says they’re at high risk, they can’t have a full-on air mattress, so they stick on an overlay on, the patient 3 foot nothing in their bare feet and all of a sudden they’re five foot tall and they’re sliding off every night, you know. I that that’s the difference between the risk score and then having a definitive intervention, so with regard to pressure sores, not everybody, like you say needs a pressure mattress. If you speak to [the] equipment stores they’re telling you that since they changed their policy to allow nurses to order the pressure things a lot more easily they've been inundated, it’s like they gave out three thousand cushions in a couple of months whereas the year before in the same period they’d given out two hundred and it’s almost you need, you need almost like a bridge between this is what you do to do the risk assessment, if they score this, these are the people that you bring in for a second opinion.

2: Mmm [agreeing]

3: Now if the person who scored that, so let’s say that it’s an OT that scores that pressure thing as such and such and they, they are trained in the complex moving and handling and positioning stuff then they don't need to go elsewhere….

2/1: Mmm [agreeing]

3: …they can order the pressure mattress. If it’s a band 5 nurse who’s three weeks into her post and it’s a high score she doesn't go and call them, she calls an OT to come in, do you see the difference

2/1: Mmm [agreeing]

2: And I think I often see that with the nurses. The decision making is oh they've got a pressure ulcer they need a cushion and a mattress and then…

3: Yeah

2: …the next, then they go and get, put that in and the next minute we’ve got an ambulance referral because they've fallen off the edge of the bed and I said well did you look at the height of the bed and they say well no, erm, did you think about how they might get on and off it, err no, so they haven’t actually thought about the function or, you put the pressure cushion in and then their chair’s too high and then the person can’t reach that and then they get, yeah, then they’re slipping and sliding, erm, so I think the nurses, nurses partly, you know, they tend to focus I’ve got to put the equipment in, rather than actually is that going to impact on somebodies function. Is it actually better that I don't put the equipment in , but we get them more mobile, erm, and I think that’s one of the constant things, erm.

3: And I think that this is the key issue that that’s not the nurses’ job…

2: Mmm

3: That’s our job, you know they’re trying to do our job for us, yeah put the equipment into and think that the patient might be safe, but we should be going in and saying right you’ve done your bit, you've made the patient as safe as you think you can. We’re going to go in and we’re just going to dot the i’s and cross the t’s, so we’re going to look at can they get in and out of bed. If you put an overlay on they struggle to get in and out of bed and they used to go and lie down for 2 hours in the afternoon, two days later they've got massive swollen ankles and a pressure sore on the heel, why because you put in an overlay and they struggled to get on and off the bed so they stopped going to bed in the afternoon, now you’ve got more problems and that's what we should be doing, that is our job, that's where we come into our own, but that sort of decision making is being watered down and the respect for the complete fitting around that because it all sounds so simple, but actually when you go there and you’re actually doing the assessments and you’re looking at the reasoning, erm around the whole person’s belief and day and that's why I’m such a nerd that I keep going on about this, that's why I’m a strong advocate for OT. It’s just the missing link in all this is that functional assessment is, is not being thought about.

2/1: Mmm [agreeing]

3: Sorry I keep saying that… [laughter]

2: The challenge though is capacity isn’t it, it’s you know recruitment, recruitment and capacity to be able to do that

1: Yeah

3: Well no one’s going to work in the trust because they know for a fact that OT is under, undervalued

2/1: [laughter]

1: Very true

3: Speaking to those as a person that’s got connections in all the world, the word’s gone out. Look at the job descriptions in [the trust]. They’re for generic workers, if you want to be a professional don't go there

2/1: Mmm

2: Interesting

3: You know if you look at them you can’t tell who’s a physio and whose and OT in the job descriptions they’re so generic. You’re so generic, you’re just a physio generic and even the title now is, erm, band 5 clinician, band 6 clinical…snr level or something, then a band 7 is team leader or something. Even if you look at the new job description the trust are rolling out, they don't mention your profession in them at all anymore. No one’s going to sign up to a trust that’s proud of their profession.

PC: Okay, so we’re kind of coming to an end, but I’ve got one final thing to pose if that’s okay with you, just to get your kind of opinions on, erm, so, in an ideal world what would pressure ulcer prevention look like?

2: Right

3: I’ll go last

2: You’ll go last

All: [laughter]

3: Or I can go first I don't mind

2: No I was just thinking for a moment that was…[laughter]

1: I don't mind, I can put my little bit in, erm, I think training, training, training and not rocking up for an hour to watch a video and look at a powerpoint slide, but actually training of everybody from band 2 to band 8, erm appropriate to their level around not just dressings, but around the basics of how to advise somebody in repositioning, erm the basic equipment that’s out there beyond what we can get from stores, erm, and I think we need to empower our band 2s, 3s and 4s to a little bit more of that, It’s something that we’re looking into as a team to try and provide more training, erm so that everybody feels empowered to go in, know what they’re looking for and know how to do something about it across the whole trust.

2: I mean I, I think it, in terms of what does it look like you can go for the big wide picture right from early on, do you have information in GP surgeries, do you have general public information so that somebody goes to pick something up and thinks ooh maybe I need to go and ask somebody about that, so is it, what about the general public education, erm, then within [the trust], you know, I think everybody, you know should be looking for the risks and actually in an ideal world yes people would have, well there’d be more therapists, more therapy input, erm there would be, you know, the more collaboration with nursing teams and the MDT working and, you know, much more focus on prevention so we don't end up with the people who need the specialist, you know they've got the grade 3s and 4s and need specialist input, erm, it just feels that we don't do enough right from the beginning , erm, to try and prevent those and you know, and also we haven’t , we’ve talked about community, but in a sense that does that include residential homes and nursing homes as well, err what about their training and kind of involving them as well, erm…yeah, erm I think that’s probably the key things. Yeah, over to you then 3

3: Okay, well what I did was I run a pathway, so I look at pre-referral, referral, all the way through to discharge. So pre-referral, how do you stop the referral coming in, so you look at training carers, training relatives, friends, anybody who’s involved, giving out information pre stage which is all you said, then when the referral s come in its recognising the urgency and the bigger picture around it so when the referral comes in how’s it triaged, how do we spot a potential grade, pressure sore before it happens at referral , so if somebody comes in with decreased mobility, how do you know that’s not a pressure sore waiting to happen in the next two to three days. They look routine, are you going to wait six weeks, are you going to see them tomorrow, now just a minute, so how do we make those decisions. Once you've done all that then it’s the initial assessment, I think we need to persuade the trust to allow, erm two models of assessment recording, so with the recording side of things is to have iso barders and emergency response because it’s precise and it’s evidenced and it works and then the MDT assessment for a later response so that you can speed your thought processes and speed your communication, erm, it’s concise, consistent, everybody’s got the memory prompts and as part of that assessment you do use the risk tools, but they have very firm onward referral criteria to assist your decision making and then as you go through the treatment options you’re not just looking at equipment, erm, and you can draw some grey areas, so you can say right, if you go out to see a patient as a nurse and find a pressure sore, you must ask an OT to review it as your second assessor, because what’s happening at the moment is that a first assessor goes out and assesses the patient, finds something, you get a second assessor to come in and confirm that it is a grade 2 and not a grade 3, or a grade 3, not a grade 4, but what we don't do is that we don't have a second assessor to come in and look at the whole picture, you’re so busy trying to get through the assessment and type up your MDT assessment, nobody comes to do that second overview and ideally it should be an OT or a more holistic physio, not an MSK based physio, but a more holistic physio, so some kind of therapist coming out and then once you look at your follow up treatment it’s about continuing that pathway, so you don't try and do everything on your first visit, you go through it with the patient at a patient’s level so they can understand it while you’re doing everything around them and then at discharge you’re looking at long activity of discharge, it’s no use discharging Mrs Jones today and two weeks later she’s referred back with the same problem, it’s about long activity of discharge, do they need ongoing assessments or episodes. So each of those points give you natural work streams, but to me it would like a, we never get referrals with pressure care mentioned on them and no patients coming in have pressure sores because we’ve done our work as [the trust] so well in the community, no one gets them anymore. The reality is patients will come in and so we triage them quickly, within an hour or two we know whether we need to see them, erm but in three hours they’re seen, they’re assessed, they’re made safe, within 24 hours they are treated in some description, within a week or five working days the patients have been thoroughly screened for the whole psychosocial and physical aspect as well as their mental health aspect and then a discharge is a smooth process wherever they’re going, whatever they’re doing so they don't come back with the same problem, you know, unnecessarily, some patients will, but the majority of them shouldn't, does that make sense?

2/1: Yeah, yeah, no it does

PC: Okay perfect, thank you very much all three. I just want to kind of, err, some of the bits that you've mentioned over the hour really, erm just kind of voice back to you really, erm , and just see if you had any other brief, you know if you agree or disagree, just with what I’ve got on here, so there was something about:

* Management over prevention, a focus on that within the trust
* Nursing and that care is very focused on equipment provision or prevention is focused on equipment provision, not necessarily a more holistic approach
* Professional identity for certain therapists, for different roles, may be a loss of identity by being stretched in all sorts of different directions
* What are the limits, what can we actually achieve in practice, there are only a finite amount of hours to do the core physio, OT, podiatry, nursing, whatever role it may be, but being asked to do lots of other intentional rounding based things as well
* Management, the criteria from management – is it treatment or is it preventative care and is preventative going to then longer term influence the emergency stuff that comes in as a sort of rapid response
* Moving and handling, therapists focus on understanding about friction and shearing and pressure related to sort of moving and handling techniques
* Differences between teams, so how some teams can be very focused on this, others aren’t and that can be related to training, but it can also be related to the leadership in the team and the interest of those members of that team
* Risk assessment and the braden and how braden isn’t really there to, it shouldn't be there to replace clinical judgement because it doesn't give enough information
* The role of OT with nursing staff and collaborative working
* Ideal world solutions – training and empowering staff at all bands, but appropriate training for different types of staff, public education, further therapy input in this area, collaboration with nursing staff, focus on prevention rather than management wounds focus
* What else happens in the community with residential and nursing homes
* Pathway mapping , prevention, are things coming up in referrals, why is the referral coming in, MDT assessment and emergency response differences between assessment
* Treatment not just equipment
* Therapy input more generally

Does that kind of, I know that’s a lot of points, but that does not broadly…?

1: Yeah

2: Yeah I think that's the key points

PC: Is there anything else that you feel we haven’t discussed that you feel is important in this area

3: I think one of the points that was mentioned, I was listening, but I was just listening generally and I didn't think whether you did it or not was the mental health side of things and I think again the overlap between physical nursing and mental health nursing isn’t as big as it is between occupational therapy and mental health nursing. The mental health nurses we’ve got now are very holistic and they tend to refer to OT very quickly so we need to do a piece of work around mental health in general and how get, are we hitting the right targets because they’re still very very different, erm, in most areas of the trust they’re quite separate. We’re lucky in some of our areas that they’re integrated but in other areas they aren’t so need to just remember that mental health side of things as well and maybe do a pathway for mental health patients with pressure risk or, cause I know patients who’ve got dementia who are not part of the mental health team and the primary cause of their pressure sore is dementia related behaviour or mental health related behaviour, but they’re not referred onto older peoples mental health team at all and that’s always a bit shocking when you think well actually it shouldn't be so I think that something that we need to keep in focus as well.

PC: Thank you for your time, it’s been incredibly invaluable.

1:18:53