MDT Focus group transcription

Participants

1 = Community nurse

2= OT

3= HCA Trainee associate practitioner

4= Physio (Specialist in complex muiltipathology)

5= Community mental health nurse

6= HCA/trainee associate practitioner (physical and MH)

7= Community matron mental health

8= Postural advisor

9= Community nurse

7:13

LS: Do you encounter many pressure ulcers in your day to day job?

1,2,3,4,6,8,9: Yes

LS: Do you work as a multidisciplinary team in these pressure ulcers or do the nurses work separately from the OTs and the physios?

All: we try and work together

LS: Can you describe?

1: We try to hand over most days if we can erm and erm, you’re involved with that anyway aren’t you (looking at p2)

2: I was always on the, because sometimes you can’t physically see someone cause again we’re all out and about, to leave the office, so we’ve got, I think it’s a mobile phones isn’t it most of the time and someone will ring me and I normally pick up and we have a therapy coordinated phone as well so that call will go through and then we’ll triage it and, but normally it’s nice now we’ve only recently moved to area

1: maybe six months ago

2: so now we’re all under one roof so that’s been a big difference as we’re all together whereas before we were in x, the nurses were all spread around the different surgeries so that’s been quite a big thing for our team. I think we’ve all come together integrated so we’re all under one roof here which that makes a massive difference in terms of seeing people and handing things over and…

3: I think as well if we do discover pressure ulcers, we do discuss with you (p2) the appropriate equipment and stuff like that as well and like you say having everyone being all together now makes it that much easier in terms of the MDT, that’s what the focus group is, we are more working along that side.

4: I think that the practice does vary because in the north I work across 5 ICTs just monitoring clinical practice and in one or two of the teams they’ve had no therapy input for years so they tend to just get on and do their own thing and the other three teams have had really close relationships with therapists so they tend to work a lot more integrated so we’ll often get referrals for patients slipping out of bed because they've had an overlay mattress put on, who are getting stuck in the bed because they’ve had a pressure mattress put on so we often get those, whereas with the other three teams we don't because they know, you know, there’s a bit more to it that just putting on pressure care, erm, patients sliding off riser recliners cause the team weren’t aware that you shouldn't put that cushion onto the patients.. So yeah I think, it does point that there’s still this gap in the experience. If you’ve been lucky enough to work with some really good teams where they work closely together it’s really good and you see the differences, an outside observer the difference is huge so the quality of care does differ across the trust.

LS: And are you talking about quality of treatment of pressure ulcers or is it also prevention?

4: Prevention as well because often they’ll call us and say, and the good teams will call you and say, we’ve put a overlay mattress on or we’re worried about the patient slipping out and moving in the bed. Other teams will get a call from the nursing homes saying somebody’s been out there and put an overlay mattress on and the patient’s still got a pressure sore because now they can't roll at night so they’re just flat on their back the whole night so it’s not just the quality of integration and care, it’s also the prevention side. We also get fewer referrals from patients that have had long sits on the floor because what often happens if they’re in their own homes, they try and get out at night and they slip and they're on the floor all night until next morning so we often, we avoid those as well, so yeah it’s both prevention and treatment. And we do lots of complex stuff with vac pumps, so can the patient walk with a vac pump on, what do they need in terms of aids and equipment, that’s just a quality of life when you actually have them. So the integrated teams work much better, the patients get a much better outcome, even if it’s intractable, because we have patients that have sores that will not get better, but if there’s a multidisciplinary team they can have a much fuller life.

5: As a mental health nurse I don't see anywhere near as many people with pressure ulcers as you guys, but being part of the ICT at least being able to, I know everyone’s face now and can put a name to it and I attend the virtual wards erm pretty much every way I can and so if I, it’s kind of helped my knowledge as well listening to other people talking about it and if I pick up things that’s not, that I’m just not certain about there’s people I know that I can talk to quite easily because I know people now from across different disciplines, erm, that it’s made it a lot easier and I suppose it makes me more confidence think about any problems because it’s just a quick catch up or something rather than a oh I’ve got to phone some team that I don't know anything about so that’s probably made my practice a bit erm more aware.

LS: So one of the success factors here is that you’re all under one roof?

12:39

All: Yeah

2: That’s the biggest thing, I think communication, that's how…physically seeing a nurse or you’re seeing me, I mean, we’ve always got our phones, each of us got mobile phones that’s something, we’ve always make sure we’ve got a mobile phone each, erm obviously signal can be quite difficult out in the xxxx , rural xxxxx, but again we come back at lunchtime and discuss if you’ve, you know, you’ve had a patient and you’ve been absolutely concerned about. We’ve all been given cameras as well so that’s, I’ve been doing a lot more, that’s improved my practice, so I’m actually able to see as far as the patient is concerned and take a picture, then I’ll bring it back and I can see straight away I can gauge what kind of classification the wound is, bring it back to the, back to the team and I’ll show the nurse here and that will reinforce it, yeah that is a grade 2, right Ulysses it or whatever we need to do, order the equipment in. So we’ve been given the tools to do our job and it’s improved things hasn't it with the cameras.

1: Yeah, and having the erm, having the TVN erm, the erm…

6: phone numbers, yeah

1: …phone numbers, what phone number is it that they do

6: I can’t remember, the live line

1: Yes, so you can take a photograph and upload it onto rio which is our system that we document everything on and they, they've got access to that system as well, they can look at a photograph and tell us what we, what we should be putting on it if we’re not sure or perhaps erm, that's really useful, really helpful isn’t is so.

2: So we’ve got that, obviously you can upload the photo straight away which the nurses can upload straight onto a patient’s notes, so yeah that’s good isn’t it.

LS: So, who does what in the multidisciplinary team cause I hear you talking about dressings, about prevention, about equipment, if you as a nurse want to get equipment can you get that yourself?

1: Yeah I’ve got access to erm the equipment stores. We have to do a course first to be able to get that access, erm, but I’ve had it for quite a while so I can do that erm, and the team. Newer members of the team are gradually doing their training to enable them to, erm, get access. If they’re not sure about what they’re ordering then they can ask OT or. I mean sometimes we do order things that might not be the right thing and that’s a learning curve you know, erm, so you know we do order the wrong things, but then equipment stores will ring us and say, you know, why have you ordered this because you know this is a priority whatever so do have quite good communication to assist us so.

2: And there’s a clinical team at equipment store as well, there’s an OT, there’s a clinical nurse specialist so we can talk things through with them as well, which is helpful so we’ve got names and contacts there so.

LS: So when do you get called in then? Maybe I should ask who’s the caseholder?

2: Well, we don't really have a caseholder do we I think it’s just, we just…

3: We’ve just started erm a new thing within the team that erm, because we’re, our team covers a huge area erm, xxxx rural xxxxx is a very large area so we’ve put all the different areas into zones and then erm different trained nurses are err linked to certain zones and then to certain surgeries so erm so the trained nurses, the band 5s are holding their own sort of caseload. This is a new thing that’s just starting really so not quite up and running yet, erm so I’m not sure, are the band 4s and 3s being linked to them as well or is that going to be or is that going to be spoken about

1: I think the idea is to get them trained first

3: Trained, yeah

1: So they can get all of the care plans up together and so it’s a work in progress at the moment

LS: The reason I’m asking is when you received these sheets that we tried to make a map of how we think it works

PC: Yeah so based on the previous focus groups really and these were with differing areas with differing professionals erm, there is going to be some variability based on area, but I wonder really, looking at these, does this look familiar

All: Yeah

PC: Can you see any deviation in how it works currently for you?

2: …we do a lot even though obviously we’re therapists we do initial, we do all braden risk, intentional rounding, so we actually do, we have to do it on every visit you know the intentional rounding, but on the initial we do you know, we follow this kind of pattern.

PC: So with the AHP one which is on the other page erm obviously we have erm, would an AHP typically be risk assessing?

2: I think we do yeah, we would be risk assessing but we do initial assessments as well, we’d actually do skin assessments now so. I suppose here we are doing more of a nurse visit patient [referring to nursing visit sheet]. I would say we’re more on this page to be honest, we do skin, we talk with the carers, I’ve been to a care agency this morning making sure they’re you know, checking the skin and identified something. There’s a lot more to it and I’m with, we’ve been given these labels that we stick on, into care agency folders if they’re vulnerable, at risk of pressure sores so there’s a lot more of that. We’re taking on more of that side of things, but looking at this I think we’re more or less, and we’re doing care plans as well, pressure ulcer prevention so we’re reducing the risk so

4: In the northeast to give you an idea, there’s five ICTs covering about 300 square miles so you’ve got xxxx that’s divided into central east and west, then you've got rural east and west erm and they have physio, ot, mental health, social worker in the whole team so it’s like a big team. It’s much bigger than, they have white board meetings everyday. It’s now standard practice that skin assessments are done by everybody. The older peoples mental health team now are starting do the braden and must, they’re starting to look at skin integrity, they’re starting to spot triggers so before Mrs Jones would have a bit of dementia and take to her bed, now the minute she takes to her bed they call in the OT to say can you risk assess this because you don't have to a braden to know someone in bed all day is at high risk so the whole situation has changed, the boundaries have blurred so the risk assessment are, even if the formal risk assessment, the braden’s not done or must isn’t done there’s still that identification of pressure risk has been brought right to the top. And another thing you’re seeing a lot more of now is that the AHPs up at the mass sector are being called into SIRIs and to pre panels to explain their interventions and why they didn't carry out a risk assessment which is very different. In the old days it was just the nurses, now if a therapist is involved they’re called in and have to give their presentation, which is excellent, it’s how it should have been from the start. There’s a lot of support for that.

7: I’m going to speak for myself because I’m in-reach and I’m in nursing homes where they call us usually for challenging behaviour, education or somebody can’t be handled and when you’re going there they don't tell us about these things. They tell us when we ask because we do ask if they’re eating, the normal things, because we do the whole holistic way, but we don't check people because we’re not going into strip them so we just so we just take their word, whatever they give us, whether they’ve lied or not we don't know. So they, actually before I came out I was talking to the manager and I was thinking, I said we just have to take their word because you are not working in there. It’s okay for district nurses because when they go in there they can do the dressing, they know how long the thing is going to heal, but for mental health like in-reach actually the nursing home is actually quite complicated. We think, because I saw somebody a while ago somewhere in a nursing home. I put on my rio notes actually I write it is like it is important so there what they have told me but then somebody had been there with and seen someone with a redish pressure sore, I didn't see it, but I must have been quiet and they told me oh they are fine, no problems so that’s why it becomes a little bit contradictory.

LS: That has to do with your role, or?

4: Well the trust have actually acknowledged that theres, if you look at the proportions, therapies and community mental health are the same, they’re a tiny proportion of the overall staffing. So in our ICTs, we’ve got five ICTs and there’s six times more nurses than there is mental health and allied health professionals so they've said that in case of nursing and residential homes when you go in there as mental health team, you’re in to respond to a crisis and yes you can have awareness but you are not the primary care giver and I think that’s a really important, almost like a relief for the mental health guys, you’re not the primary care giver, if it’s a nursing home they’ve got nurses there to do that job. The district nurses will argue because obviously with the things we find in those places, but in terms of mental health I think they’re so pressured, for them to start doing bradens musts and all the rest is just, maybe a step too far.

LS: Can I just follow up on two things you said, you said lines were blurred between professions, what we heard in our previous groups is that AHPs often said it’s a nursing job and nurses really were quite adamant that it was their job, their responsibility and erm so they would get an OT in but just for equipment, not for anything else because it was their responsibility and when we were talking about physio they were not even seeing a role for physios to come into an MDT. Listening to you I don't think you recognise that, do you?

6: There’s barriers then isn’t there and we haven’t got that

2: For me it’s really important that we’re getting someone up and walking and that's what we’re doing. I mean we’ve been doing some therapy training as a team as well to make sure that everyone’s got an idea of how to assess someone for a walking aid or why are they not walking. It’s a broad assessment it doesn't have to be done by an OT or physio, a nurse can do it. I mean we’re doing bradens, we’re doing musts, we’re doing, you know, so there’s, it sounds like we’re obviously doing much more than basic.

LS: So you don't encounter that

2: I don't think there’s barriers

4: There are definitely some therapy teams who are very poor and I’ve got documented evidence of wheres, for example even a physio has phoned an occupational therapist and said this patient’s struggling to move in bed. I’ve ordered the equipment, but please could you come and assess and give, and because they eat in bed they need positioning, they need everything and the OTs said no that’s your responsibility, now I’m sorry but complex positioning has always been occupational therapy, but they've become a triaging service because they've got one OT handling 7 or 800 referrals a month. So again you might find that where those barriers exist, the root cause might just be staffing and traditionally they've always had to pass back that along and it would be really interesting to see if, because I definitely know there’s some teams who, who aggravate that boundary and make sure it’s there very hard and I must say the majority of it is on the AHP side, erm but there are like I said, there’s two nursing teams in particular we’re struggling to break down that barrier in, but it is a definite, it’s definitely there. In good teams there’s virtually no barrier, people cross work, in not so good teams there’s a lot of barriers.

LS: One of the barriers AHPs mentioned was that they were, and this is our interpretation of what they said, that they were erm scared of losing their own identity when they get involved in pressure ulcer care too much. Is that something you hear from colleagues or is that..?

2: There is, I mean there’s a lot we have to do that it’s just in community they’re more complex patients we’re seeing, you can’t just go out there and do you know a therapy assessment. You’ve got to do everything because a lot of the patients we’re seeing now are living longer and are more complex that are coming home and skin concerns, you know, sort of nutritional intake, they need, they’re more dependent so you, you can’t and also we’ve been involved like the gentleman was saying over there about SIRI panels , we've been, you know we’ve been asked to attend SIRI panels so we’re knowing there’s a lot more about things go wrong so as a team we have learnt. I think we have come a long way in the last two and a bit years, you know in terms of we’ve got the tools to do our job and…

27:00

8: It’s numbers really in terms of staff and people are much more precious about these boundaries if they are overloaded and haven’t got, even the mind space to take on these new skills. I think OTs generally are are holistic and actually like learning new skills. It’s just if they learn that new skills it sadly becomes their job and they haven’t got enough time to do the other parts of their jobs so that’s what I’ve observed working across xxxx. Those teams which have got, you know, good numbers covering, you know, proportionately the right numbers in the population seem to be receptive to take on this work and others which have got one headless chicken just there’s no, no [laughter]

2: This is what it’s like when we get to do holistic assessments because you can’t just think right I’m going to look at this aim, get it right, you’ve got to look at the way they’re sitting, their positioning, how long can they tolerate sitting out in the chair, think about their skin, you’ve got to look at the wider picture really, if you’re sitting someone out of bed, they’ve been in bed for so many months, which we, you know, we’re looking at. So putting in complex equipment in there so, and who’s going to be doing the caring, so things have changed…

LS: So you actually, you do the same as the nurses when they would be the ones who come in first

2: I mean, the initial we do yeah so and obviously if it gets into a wound or a dressing then I would involve a nurse who knows more, but obviously we’re going out to see patients that aren’t seeing nurses, nurses aren’t going in so we have to do the whole holistic because you know it’s something the patient could be sitting on a pressure sore and…

4: Cause when you think this is not just housebound patients that get them. I recently investigated a patient who was going out on his scooter transferring, walking in and out of the newsagent, he had a grade 4. How do you get a grade 4 when you’ve got carers washing you and you’re independently mobile, how do you get one, so I think just getting back on what you've just said. What you've just described is what I would consider basic OT skills – that they look at the whole person, it’s not just about the pressure it’s about the eating, drinking, their social integration, getting out the house and OTs have always been very holistic and I think that that skill is often overlooked and actually that there’s a completely different set of que acquisitions that they have. It’s not about what can we do for you, it’s about what can you do for yourself, how do we maximise your potential whereas in my experience a lot of nurses come in and look at what care should we be providing, which is almost the flip side of the same coin, one is how will you get out and do that, one is how can we help you to do this, they’re very different.

2: I think the nurses are quite new at trying to dig up, sort of if they can get out to the practice nurse

4: Yeah

2: and they also have these leg ulcer clinics so it’s about engaging them so they’re going out and accessing community services, I mean, we’re doing a lot, you know we’re doing referring people on to, we’ve got balance, exercise classes in the area erm, we’ve got sort of different classes, so getting people not to think we’re just treating them as a housebound, actually we could progress a bit more, you know, get them to access community resources. There are teams out there, we’ve got community independence teams, xxxx county council, they can work on someone’s outdoor mobility, get them to you know attend class, exercise classes. We’ve got falls groups at xxxx hospital, erm, so there’s lots of things out there it’s just having the time to encourage and see as many people, we’re really quite short in terms of therapy numbers out here, but things are, have improved erm.

LS: Do you recognise that, what 4 said that nurses are more focused on what care can we give you and AHPs are focused on what can you do yourself. Do you recognise that nurses?

1: I think we do recognise what 2 is saying, you know, we obviously, even though we’re nurses, we’re not therapists but we erm have been, have had some training to actually recognise that you know they might need falls assessment, they’re in bed for long periods of time so we know, obviously like you were saying that there’s a high risk so we are very much aware of all these things as well erm, it’s just that obviously we don't have the expertise that the therapists have so that’s when we would come back and say well we’ve found this person in bed erm what, what can you recommend, what do you suggest so yeah we do recognise very much what 2 is saying.

7: So that's the thing with the mental health, because for us it’s more empowering people so I can understand this and encouraging probably to try and get involved, so it’s a more err therapy.

2: Cause I try and find out what do they want to achieve, what’s their long term aim, so we’ve got a gentleman that he want to, he wants to go back down to the shops and get around as he was saying a month ago he had a fall, lost his confidence, he’s now progressing really well, he’s got a four-wheeled walker and he’s now aiming onto that goal, by the end of May he’s going to be going out to those shops. That’s the kind of, so, it is trying to give more of a meaningful what do they want to do, what’s their goal rather than just putting them as a housebound patient, you need to look out of that box really.

32:33

3: We’ve got, now that we’re having these zones and we’re also putting out the wellbeing care plans erm so we’re going, so each patient on our own caseloads we’re going out to see them we’re going to put it all down on paper of what their goals are, what their aims are just so then we’ve got it on you know one bit of paper and then we’re going to transfer it back onto rio so everyone can see it and then work with that, that’s a new thing we’re putting into place isn’t it.

1: It will be quite good, a change in wound care, the more you do things…

LS: That’s really focused on MDT and the whole what the patient needs. Do you have any specific questions PC you want to ask about the schedules?

PC: Err, only really if anyone sees any deviation to this so the areas that we’ve sort of highlighted in red on there are just areas where, just again from the previous groups, is this where an AHP might come into it and obviously you’ve been saying that AHPs are being involved from the start with this team, but if it was a nurse going into assess somebody that wasn't a therapy input with that patient erm, would they sort of red areas be where you would expect a physio or an OT or somebody else to come in to that or are there different places?

2: I think we do drop in sometimes at the start when maybe like a nurse has been in an done this braden and it sort of jumps between the two I think. I wouldn't say it specifically is always going to be about points I think its variable isn’t it? It’s also about skill mix of the team members, we’ve had new starters coming into the team from all different backgrounds so that, that makes a difference just in terms of the skill mix of the nurse of the care support worker, we’ve had a few new new support workers and they could have been the first one to go in there and we’ve obviously jumped in and taken over, supported.

1: I think its regard, if it’s somebody that’s at risk of pressure sores or they have got a pressure sore and they've got no equipment whatsoever then it might be worth, you know, getting 2 or other OT to come in straight away rather than just ordering the mattress and the cushion and then letting them fend for themselves if you know what I mean, or for example I, I, I, I ask 2 to come in, assess them a multiple in-depth point of view to see what else they can do for them really, erm, so I think we do. I don't think we leave it so long do we really.

LS: So this is a very long route?

1 / 2: Yeah

4: The thing is, even though the route looks long my interpretation is that's not really a time thing. It might be that you come in and on day one you've already had it second graded by somebody else, you've already started the care plan, you've already called the physio and OT so I’m not looking is that a timescale cause I think some of the teams now are brilliant it’s literally I’m at a patient’s house what do you think I should do so even though they pathway might be the decision making process or process, actually some of this is just instantaneous within minutes of each other so I think you can take the timeline out.

2: I think it also comes down to the fact that we’re all under one roof so we’re seeing each other more on a daily basis, ringing each other so there’s in terms of communication that’s improved things so that's making sure that we’re acting, doing things that are needed for the patient, yeah

4: I think there will also be a new driver coming in that if a patient’s housebound then you’re obliged to go and see them even if it’s for a relatively simple procedure so over the north there’s a big drive now to get people out their houses which again has changed the whole way the referral pathway works, before it was oh Mrs Jones has been housebound for 5 years, well she’s walking around indoors independently, OT/Physio get out there, get her up, why’s she, why are we having to do BM monitoring on her when she could be going to the practice nurse for her reviews and all the rest of it so I think that’s also changing the whole, as the nursing staffing levels drop and drop and drop there’s new drivers and it’s nice to see because I think it just brings you closer together and people are starting to say well actually this isn’t right, this person’s independently mobile, why are they stuck at home and it sort of escalates and that also goes for the mental health team as well, they’re calling the nurses now and saying look this patient’s having their legs dressed by you guys, we think they can get out and then there’s that conversation going. I think that’s really positive, but unfortunately it’s being driven by a drop in staffing numbers and the necessity to shunt patients back into the GP practices.

LS: So the driver isn’t good but the outcome is

4: Yeah, the outcomes are excellent and also I think what’s really happening that again what the good driver for that is the role of the band 3s and band 4s is starting to be really appreciated because what used to bug me was people who said oh the band, you’re unqualified staff, I said that my OT assistant, my rehab assistant is more qualified than you are because they got a two year competency programme, they've got a competency list that’s 76 pages long that they've signed off erm, therefore if you spoke to a good matron she’d be saying that they’re not unqualified, they’re qualified and they’re my support team, they’re the backbone of the team, they’re putting in catheters and taking bloods, they’re doing all these things and if you've got a good band 3, they can take the place of 5 new band 5s because they know the job, they can get in and do the the stuff that, the raw, the backbone of what you’re out there trying to do and leave you to manage the really complex cases and even then I’ll say that but to be honest with you half our rehab assistants are actively involved in case managing complex patients because they see them for far longer than me. I go and assess, give them a treatment plan, review them four months later, they do all the work so I think that that’s another good driver that’s happened is with the increase in pressure ulcers and all the rest of it, people start to say well actually this person’s perfectly intelligent, give them the training, they’ll manage to support you. Yeah, I think that’s really good and I think they need to start changing the language as well from unqualified staff and start saying support staff because they have lots of qualifications.

LS: It’s like the discussion that we had last time, right [laughter all]. There’s one issue that I would like to mention from our previous interviews and we have labelled that as fear. I heard you say that you are doing SIRIs, all of you are, what we’ve heard in the other focus groups is that people are actually very scared of getting into SIRIs and we had a whole discussion around avoidable/unavoidable, non-compliance and these terms haven’t come up in this discussion yet. Do you recognise these terms, do you use the terms, how do you look at these SIRIs, do they help you or, can you tell us a little bit about that?

1: I think xxxxx’s been, she normally deals with it doesn't she, more so than…

6: Yeah

1: The band 7, we haven’t got anybody..

6: She has said that she would like us all to go to a SIRI panel or pre-panel

1: Or a pre-panel or a SIRI panel, that’s our point because you can, certainly learn from it and I know people who’ve been to it have said that it makes you think differently about how you’re documenting erm practice erm and a lot of the erm avoidable err cases, you know could’ve been, it could different if we’d have documented differently so erm so I have haven’t been to one in a long time so erm I think we could all learn from it really.

8: They’re changing the way that they’re recording and. I’ve opted to attend a, because when I first came to post I opted to, well it was part of my induction to go to the SIRIs and I found it quite illuminating actually, and what it did was it informed my practice and also what I need to include in my training erm and so since they’re doing this new recording process erm I’ve opted, I’ve put my name down to attend one. It might be next week actually just to get my head around it again and make sure that I’m not missing anything, you know, I don't take prime responsibility for all documentation. I want to kind of make sure that I help with the people I get involved with.

3: From our point of view when we’re dealing with patients who have primary care givers as the care agency. This good education from them, for them and making sure they’ve got written advice, the advice leaflets, the grade 1 erm pressure damage err advice leaflets and we’ve now got these red stickers that we put on the carers notes saying that this patient is prone to, more at risk of pressure ulcers and making sure that you’ve documented that’s all in place especially for for patients who are non-compliant. We do have lots of them that will just keep declining erm everything that you offer them, but unless you’ve put in all of that advice, given all of those advice leaflets and you’ve documented it and you’ve documented that you’ve told the work people it still comes back as avoidable, yeah so, it’s just making sure that you do all those things and communicating with the rest of the team that you’ve done it as well.

7: When you go and see someone and advise them, you don't put it on your notes?

3: Well you do yeah, you do, but some, where we’re just so busy sometimes we forget to write in what we’ve, fully document what we’ve done and a lot of our, then the thing with SIRI panels is is is that it’s a learning thing really, it’s how we can change our practice for the better and learning from our mistakes and a lot of it is that we need to document it properly, you know, often it will be that you know, that you think you’ve documented it but sometimes you think you've done it so much that you you think you have done it when you haven’t.

4: Just to add to that because that’s exactly right what happens is that you go into a SIRI panel, it’s supposed to be learning. If the facilitator’s good you’ll come out positive, motivated, brilliant, but it’s also a vehicle whereby staff can be absolutely hammered. They’ll come out in tears, come out shaking, that’s the fear. If you were to split your cohort and say how many of you are under this person when you did your SIRI that group would be fairly, extremely fearful and not want to do SIRIs and then if you said some other good person would be, if you talk about SIRIs there’s this lady called xxxxxx who up in the xxxxx . Every single SIRI that we’ve come out of and I said that took place at 8 o’clock in the morning and the notes were written half past eleven at night do you consider that’s not a risk factor, she documents that whereas the other individual says that’s no excuse. So you get that really big variation in people who are leading the SIRIs and I think any trust should look at the SIRI experience and then start to identify people who tease learning out and are positive and separate the dross, the rubbish, the people that are just going to be hyper critical and just demotivating.

3: I have to say that I’ve been to one and exactly that happened, the whole team came out so demoralised absolutely it was awful it was really bad it had a very bad effect on the team

2: And I think we had one as well and that was again it was really an effect, it was actually you know it was AHPs I think there was notice that had just came out, it was pretty harsh wasn't it. It wasn't really a learn… well it was a learning curve, but it was…

4:It’s the wrong kind of learning

2: Yeah it was, it was a very negative experience

6: It’s supposed to be a non-blame culture isn’t it

2: It wasn't on that occasion at all

7: In mental health it doesn't matter what you've done you know I would advise anybody, anyone even the patient to come back and put it back because otherwise if you miss it especially on notes that needs to be signed by other people you can find them there and it comes back to you so really the first time I think xxx is still right because of these things, because we are doing it in a way with mental health with the state which is wellbeing so we write all the detail out even if display them which we don't do but we see and take a note how might they xxxxxxxxx but we still write the same way, every detail

1: This is why we do our intentional rounding now, we have our nine point intentional rounding so we look at erm skin, mobility, eating and drinking, elimination, socialising activities

2: Capacity, best interest

1: Best interest, yeah, so and so we do that in all of our documentation now and it and it prompts you to write all of the things that you need to because before we were doing that you would just write all of your speel about what you’ve done and then you’d forget to write in those key points and that’s where a lot of the time we were falling down before, but since we’ve brought in this intentional rounding which we’ve been doing for a couple of years it’s made a big difference, but you still need to remember to write in that you’ve given out the information and you’ve done this, you know.

4: Cause I think there are different models of intentional rounding across the trust so one of the teams uses a 24hr talk through so they talk about sleep, but they don't say do you sleep well at night, it’s how many times do you get up to go to the toilet, can you get out the bed okay, if you do go to the toilet do you feel dizzy, which is very different to are you sleeping, most patients will say yes, if they wake up eight or nine, ten times a night because of prostate problems they might not say that to you there and then, but if you say how many times do you get up to use the toilet they say oh I use a bottle and then you say well nine times at night, you’re sleep deprived, you’re not going to be at your full level, therefore your falls risk is high, your pressure risk is high, everything’s high. And that often doesn't come out unless you actually ask functional questions. These patients don't, the number of patients I go to see as a physio, they say to me oh my bowels are fine and then two days later I get a call from a nurse saying I went to the patient an hour after you, they've been constipated for five days…it’s like you’re a physio, I’m not going to tell you about my bowels.

1: It could also be the role, you’re a physio

4: Exactly you’re a physio

1: A nurse going in and they’re going to respond differently to the nurse

4: Very differently, but the trust need to acknowledge that. If I’m a patient and I’ve got a problem with my ankle and it’s really painful I don't want you to talk about my bowels, I want you to sort my walking out and so I wait until a nurse comes to sort out the other stuff out and that’s why you cannot ever have one profession going in and doing the whole assessment reliably, you can do some of it yeah, but you’ve just got to acknowledge that patients sometimes just don't want to tell you about the other bits.

7: And that can also apply to the nursing team can’t it

4: Absolutely

7: And I remember going to this lady every day and we talk about all the questions, yeah I’ve done my daily dozen, that’s what she used to say and then I happened to go in one day and her neighbour was there and she said now what was it I need to buy, was it super figs, I said super figs, she’s constipated and every day she says she’s going, you know, but it does apply in that case

4: Damn patients, they just won’t…they’re useless

3: And they tell you what they think you want to hear as well. I went to see a lady the other day who who and she seemed completely with it. I would say she had capacity, but she, when I spoke to her daughter afterwards in turned out that she’d told me a complete load of bull, you know so

4: That’s it

3:Yeah so, erm, you know you have to sort of yeah

LS: Paul is there anything else that you would like to ask given the time?

PC: I suppose I had two things, one related to erm you mentioned about locality and obviously here having the therapists and the nurses and other roles all together allows that erm daily conflab if you like, not at a set time, just to chat across the desk kind of thing erm. Obviously that’s not the same everywhere, having that ability to do that so what I’m wondering is locality everything? You know, if you put everybody in the same office in each area are you going to get the same benefits, are you going to get an MDT approach?

4: No, it’s not, again it will be down to individuals because again in the xxxxx there’s one therapies team who are in the same office as the nursing team and they don't talk. There’s another therapy team in the same building but on opposite sides and they talk constantly. The nurses actually come through the therapy department and say we’ve been to see these patients today, please can you go and see Mrs so and so. So I think its, it will always be down to, you can put, if you go into any team, even nursing teams there will be people who just don't quite click and if that’s across a professional boundary it will raise one. So I think being in the same office will limit the damage but it won’t stop the damage, erm just audited a multidisciplinary team where the nurses were not referring to the physiotherapist at all cause they said we’ve done all the physiotherapy so I said right okay describe the gait analysis, this patient’s got parkinsons, what advice have you given them. Oh why do we need to give them advice, he’s got parkinsons, so well he’s falling in doorways, so even when they’re sitting in the same office as part of the same team if there’s no understanding of the professional roles and again it’s not that the nurses were being vindictive, it was just purely that they didn't have the insight. So I sent them all to do the parkinsons group, they've all come back and said oh my god, OTs and physios…wow, for parkinsons, all my patients are going to get referred onto them and that again is just, it’s not vindictive, it’s not a criticism, it’s just unconscious incompetence. You don't know what the other person can do until you've seen them do it so I think that there’s a simple answer yes it does damage limitation, but no it won’t solve all the problems. That’s my role I have to go across all these teams.

PC: Anybody else got a comment on that front? The only other one, the other point that I had really was if and this is perhaps one for the therapists but everyone feel free to chip in. If a therapist is seeing a patient, they assess them err and they act on their assessment and they provide whatever intervention that they’re going to provide how routinely do you think that skin is considered as an impact of their own interventions i.e. an outcome of that intervention or to prevent or actually their own intervention potentially actually even causing something?

8: For me it’s my job so it’s par for the course

2: I think it’s looking at obviously the outcome I think, it’s always sort of thinking about that, particularly we’ve been involved in SIRI panels and I know what the outcome and how to reduce that risk so again I’m always thinking about the worst case situation.

8: You’re always aware

2: …and what can happen. And I think intentional rounding like 1 was saying, intentional rounding, that’s made us more aware of sort of going through all of the sort of skin assessments, trying to build a rapport with patients the first time you go out and..

4: I think again what you’re describing is at the school when you do your MSc in advanced clinical decision making one of the things they talk about is your cue acquisition and that’s when you bring in a skeleton for people to hang their stuff on, so if you go out with some of my colleagues, they’re still very musculoskeletal, because they've never had that intentional rounding assessment, they've never been educated and again they just well I don't see the importance, when you sit down with somebody in the same team and they go oh my god everytime, oh god yes I have to look at it and I’m not just looking at skin, I’m looking at falls, I’m looking at socialisation, I’m looking at mental health, I’m looking at all these different things and you talk them through and actually they are either formally or informally coming to the intentional rounding system that suits them so I think that if you look at it the answer will simply be if they've had that skeleton to hang it on then they will start to intentionally round unconsciously and eventually get good at it, but there are lots of therapists out there who’ve never had that, that exposure, they work in isolation so again compliments to your teams because trust me I’ve been in other teams where there’s been none of this integration, you’d have completely different reports now, the OT will sit there going oh no, no, no I do this and all, so you guys are just very very good, you’re streets ahead of other teams honestly.

LS: I can agree with that because the groups that we’ve spoken to so far had a very different vibe about multidisciplinary working than what you are telling us here cause we also asked them what would their ideal world look like and they would say that it would like I think like this, but they just weren’t there yet .

2: And even now that we’re more integrated with the mental health team as well it’s you know certainly helping isn’t it.

7: I think it’s like the scenario we had this morning with xx. I’m mental health as well as clinical I was there and was able to help and we’ll be there. It definitely works, quite scary to start with I think erm but I’ve got a clinical background anyway so it wasn't too bad for me, but for quite a few members of staff it was quite scary sort of thing, but no it works

LS: The scary part is in the fact that?

7: I think some sort of mental health side didn't really want to do the clinical side and you know visa versa sort of thing but it works

LS: So how do you get people to do it then? Do you just do it?

7: I’m really, I’m not sure, I don't know erm well yeah I think it’s just the way it’s happening so yeah. It needs, it’s got to be done, that’s the way we’re changing all the time, that’s one of the changes that’s taken place and you know

2: And you still keep your skill set

7: Still keeping that clinical

4: It’s ironic that they've moved the other teams in the xxxx, the mental health nurses used to sit in the same office as the therapies and then they moved them out into a completely different location and referrals dropped, once the joint working stopped, now they’re back the same thing now the referrals have gone up again so proximity definitely helps. I think it’s just like sometimes when you come back and you‘re really busy and you’re trying to think of all the immediate problems, thinking of that other problem, just you see that other person and you go oh my god I need to talk to you and you know at the end of the day it is about acuity first and the other stuff is all about nice tack ons, yeah proximity’s good.

1: I suppose the downside is that we forget to do the proper referrals, we just come and speak to you and you say don't forget you need to make the referral and do it properly.

LS: Administration

1: Yeah

2: It’s admin isn’t is we haven’t got anyone for admin have we

1: No, our admin staff seem to have been flying the nest

2: For referrals we need like a GP summary and things for like medications and things like that, all those kind of things before we go out so we try to get out the GP summaries, that’s down to our help to arrange with the GP surgery to fax and say it’s easy to go through them, that’s our sort of central

4: Does that include if it comes from one of the nurses? There’s this change in practice cause all our nurses do is they come down and we’ve got a verbal referral form and we just fill it in.

2: We do do verbal as well, it just depends really but sometimes we do

4: Because if they’re really being nice to us they print off the front sheet off the rio, that’s got name address and NHS number on, Mrs Jones of smith street, xxxxxx rather than Ivy with the grey hair and glasses [laughter]. Ivy, is that Ivy cottage or Ivy the patient so it is down again to, there is two teams, one of which will only accept a full written referral.

2: I mean if it’s urgent we’ll take a verbal referral and go out that day, like we had one yesterday, it was the frame lady and that was a verbal, went straight out within two hours, that was a verbal so it all depends on when we triage it and that can… and we’ll triage it so it all depends on the urgency of the referral.   
4: The question is if a pressure sore can take as little as two hours to occur how can you say a referral is not urgent and needs a full formal process as opposed to your trusted referrer, you’re in my ICT, I work with you every day, just tell me what you want me to do and I’ll put it on the list. If it’s not urgent we’ll see them in two weeks because that’s our capacity, or 6 weeks and that I think is one of the things that in terms of ICTs and pressure management, the trust needs to break this down, because in order to monitor how many OTs you need, how many physios you need, how many nurses you need, you need to get separate referrals into each team, but that referral should be as simple as a sentence and it’s not fair on the teams without administrators to be trying to manage that volume of referral. I mean our teams, what’s one and a bit OTs, one and a bit physios they get 400 , 350 referrals a month so we’ve got an administrator, we’re lucky. Could you imagine the nursing team who refer probably 120 to us, can you imagine the nursing team having to write 120 referrals, it just overall it doesn't work so I think that maybe that’s something in terms of pressure care that the trust should be looking at. During an ICT you should never have to write a full referral ever amongst yourselves, but you do have to log a referral to that team, that’s business.

2: We don't need a written referral just a verbal handing it over to admin so they can get a GP summary as well so when you’re in the home we go straight on and you've put all your referrers notes on there and the nurse is up so we don't need a, so a nurse verbal.

LS: So in order to make it work you need to be preferably close together, you need to communicate, you need to sort your administration out so to not have any barriers. Is there anything else you would need in place when you think about your team, what makes it work.

4: A willingness to be integrated

8: There’s the approach where we’ve talked about having the cameras. They don't have to be just for the nurses to take pictures of wounds, the OTs can take it and consult and things

2: There’s been a lot of training here about tissue viability, nurses they've been doing all the training on moisture lesions and comparing moisture lesions and pressure ulcers. We’ve had a lot of training that’s coming in here

1: Ulyssesing moisture lesions and pressure ulcers cause we don't grade moisture lesions so..

2: That’s like a learning thing so that's been training, sort of face to face training where we’ve had tissue viability nurse has been out so she’s been doing training to the team.

LS: Anything that you want to mention that we haven’t covered that has been burning, I want to say this or less urgent?

1: I think the good thing with our team is that we’re a very supportive to one another and so when we do find sores we’re helpful to one another and don't blame each other for not doing something or you know. We help each other through it don't we and when there are SIRI panels it is really upsetting you feel absolutely horrendous when a patient, you know goes to SIRI but we do support each other don't we, it’s quite gutting when you’re going to a patient and they’re in your care and all of a sudden you go in and you find a grade 2 and you think oh no, or worse. We do feel it, we do and we try really hard to make sure that it doesn't happen but it does.

2: And that's the case when we have trusted the care agency thinking they are doing, have been doing checks. I think that’s why we’ve got the stickers and actually phoning the care agency, are you checking the skin, handing it over to the primary care giver and I think we put a lot of trust in the carers and actually you've got to be actually thinking well are they actually doing those checks or are they understanding how to identify a pressure sore or are they doing those things and actually including family members, we’re having to teach family members how to check skin, heels on top of the bed and if it’s carers developing non-blanching what do you do, ring us back if there’s changes there so yeah.

4: I have had a few very interesting cases recently where carer who was a family relative and she was being asked to do skin checks because they were outwardly not showing signs of dementia so it was only later on when they were discovered through looking at again rio that this patient has a formal diagnosis because you look at the patients notes, but you don't look at the relative notes so some of these patients present really well and that again is just a hazard that the trust need to understand the we have to take all of these things at face value, we can’t assess all the relatives and some relatives tell you they’re doing everything and they’re not and same with care agencies they’re a constant risk

1: And it’s knowing when you should be discharging patients for example we know patients who we only catheterise once every twelve weeks so we, should we be discharging them after each catheter change and then re-entering them into the caseload for their new appointment, you know, so they’re not in our care, but then it, it doesn't quite seem right either you know, so but you are sort of entrusting their care agencies to be looking after them and informing us if any concerns in the interim between the catheter changes and if they do have a pressure sore if it’s on our caseload it’s then down to, you know it’d down to us, so erm.

LS: So you get the SIRI you get the..

1: Yeah

LS: So do you discharge in between?

1: Well I think what, you know, there was a thought that we might do it but then we decided that we wouldn't

3: We just have to when we’ve finished whatever treatment and they still are down for catheter changes we have word very carefully on rio that we are now no longer going in for nursing because there isn’t a need, but they remain on the caseload

4: That again is a variation because if the patient dies, they've died in our care and so you’re then, what you’re doing is adding on 10 or 11 hours work onto somebody else should they die if they’re open to you on your caseload regardless of what you’ve typed there has to be a formal death in under care process and that was highlighted in the most recent thing where they came and they said thousands of patients had died in our care, yeah they had, but it wasn't anything to do with our care it was just the fact that they’d had a chiropody appointment a week ago and died of old age, yeah I think it, it is something that the trust need to, especially with pressure sores that are ongoing, it’s not just them it’s also the deaths, it’s also falls, anything else, if they’re open to your team then you will be expected to participate in the fall out and it’s very misleading when you keep patients open.

2: A lot of patients have got fluctuating health needs are in and out of hospital so again yeah they could be on a catheter and they could have gone in within those six weeks so it’s something that we really need to

4: I think your band 7 might have a few words to say to you when your first one dies and it’s just for a catheter change. Again and it’s, because another thing to add into the mix is the fact that these guys are under completely different commissioning group. We’re under xxxxx CCG, you guys are under xxxx commissioning group, I don't know which one you’re under so every single team. My team actually sits across two commissioning groups and that just adds to your complications further down the line and practice, our commissioning group now, all SIRIs have to be investigated within 48hrs so there’s one on a Friday, there’s one on a Monday, there’s one on a Wednesday, there’s another one on a Thursday if anything comes in so our band 7 and 8s are constantly every single afternoon, they’re just doing SIRIs, every single afternoon because grade 2 and above and that’s just a red mark. You find it they have to investigate it so yeah it’s a massive problem with the CCGs.

Thank you so much for attending

1:11:34