**Other professionals focus group transcription**

LS: What are your experiences with pressure ulcers in the community, how do you experience it in your work and how do you come in contact with pressure ulcer prevention/management?

1: Certainly I do on a pretty much daily basis as a posture management specialist and tissue viability AHAP is in my title so I have the luxury of working with colleagues within tissue viability as well and patients that I’m looking at we do a lot of posture and positioning and also equipment when it comes to helping healing and also prevention as well so, future proofing, so certainly my little team we deal with them on a daily basis.

2: So, as a nurse having spent the last however long it is, 30, 35 years as a registered nurse that’s mostly working with frail older people, but also 20 years in stroke care as well pressure ulcer prevention but also management has always been very key and the nurses role in that. Also working wider with multidisciplinary teams, certainly with stroke patients who can be very complex in terms of their positioning, posture management and linking that naturally with continence and nutrition though in a very broad sense. Now in my role as programme director for rehab working more out in the community, but also in community hospitals making sure that people remain skilled and knowledgeable, up to date as advances are made around equipment, but also really keen that nurses still absolutely see this as key and understand the impact that pressure ulcers can have on an individual patient and their family as well

1:07:28

LS: So is equipment, would that be around prevention or around management?

2: Both, really, both yeah, certainly equipment that can be provided, but also help patients and their families to make choices for themselves as well and within the provision of equipment we can really medicalise somebodies home environment which for some patients and their families I think can be very difficult, you know that many people are very house proud and all of a sudden we’re chucking their lovely three piece suite out and bringing in a profiling bed, you know, I’ve had relatives say to me, you know, how careless some of the carers are and they chip the wallpaper and knock the paint and all sorts of things and that can have a real impact on people as well so I think it’s helping staff to understand the wider impact of what we do as well

LS: And do you recognise that? [to 1]

1: Erm, absolutely and also a concern is with regard to equipment, erm, the language that we sometimes use like pressure relieving. I remember a story about an elderly lady was given a pressure relieving cushion from a nurse so she was making sure she was sat for longer on it because it was relieving her pressure rather than actually standing so I think it’s, you know, information about the equipment, but also then how it’s used appropriately is, err, fundamental for the best results.

LS: So you talked a bit about knowledge development, so can you tell me a bit more about that?

2: I think certainly from a nursing point of view it’s become so high profile that you know it’s really seen as very bad if someone in your care develops a pressure and almost that fear detracts from the person centred care you might be able to give and there may be other things that actually are contributing to that, continence, nutrition, erm, environmental factors – heat all sorts of things, how people are moved and handled but the fear for the community staff of actually then the cascade of risk eventing that, you know, possibly having to do an investigation around that can really detract I think from actually looking holistically at that individual and stopping to think about their wider care. So I think there is work to do and I think in [the trust] acknowledging, we were talking earlier about the fact that some of the specialist services are being aligned so the falls team, continence, 1's team thinking more about how they might work in that multi-professional team so that all the knowledge and skills in a much broader sense are blended.

1: Certainly from the occupational therapy world our assessments are always very holistic so all those questions are asked about continence, nutrition, positioning, lifestyle, people’s wants and wishes, making sure that you’re taking the patient’s wishes and needs into consideration rather than going off in our own direction thinking oh yes, they've got to have this when actually when something arrives like a profiling bed they won’t be using it cause that’s not actually what they want, they want to remain in the same bed as their partner and those kind of things and I don't think we’re always very flexible where it comes to that and we are obviously a bit limited with the selection of equipment that we can choose and also where I think personally we should be doing more of is reviewing, so where we have got, erm, something that is prescribed as a medical device how do we actually know that it’s working unless we’re going back and having a look at it and actually capturing that really valuable information that for this person this worked really well, healing occurred in this sort of timescale, how can we then share that nugget of information with, you know, other people in similar types of situation. I think there’s so much valuable information you can get from case studies. You know we can learn from our patients much more than we have the ability to do in our roles so I think, you know, we’re missing a whole wealth of learning from not doing reviews, not having a system set up, a mandatory system set up really.

2: I mean we mustn’t forget of course that the majority of care will be provided by, erm, care staff that are non-health based, so the agencies, social services provided and their knowledge and skills can be very limited. I’m sure we’ve all seen carers going into quite complex patients at home who do not have the knowledge or skill to work with those complex patients, so I think there’s a real skill gap in the community from that point of view.

1: And for patients themselves, I was out visiting somebody with MS just last week and she’d developed a grade 4 because she was sitting in her wheelchair all day long and she said I completely admit that was what I was doing, but nobody had ever suggested that I did something differently. I didn't know what a pressure ulcer was until it was here, erm, which again is a shame because you would have that thought that several people would have been involved with this lady, she was a wheelchair user at this point so how did that information get lost. I know you've got the cognitive side of things you know with some people with MS but she seemed very on board now so I’m sure that she would have learnt if somebody had highlighted those risks much earlier for her. So I think it’s patients, it’s carers and clinicians where education, but also you know media, society, it doesn't seem to be, I know it’s not a very sexy subject for the media to have on the telly, but I think it would be quite useful have…

2: DVT caught people’s attention didn't it…

1: It did yes, absolutely, so I think if it’s much more in people’s awareness I think we could be doing a lot more preventative work, and also you know the positioning side of thing, I’m, I’m actually changing my job description a little bit, posture and positioning, 24 hour posture and positioning because we’re getting people posturally aligned, we’ve got the equipment in place, but then people are just relying on that and they’re forgetting the care element still needs to follow in so many cases so you know it is the positioning and repositioning frequently enough.

2: And that brings err a lot of issues with the amount of care people get at home

1: Yes

2: Erm and the reliance on family carers…

1: Yes

2: …who may or may not have any kind of understanding or would need a lot of training to support those people too so, we talk about large packages of care, but often they add up to a couple of hours a day don't they and that’s it.

1: Yes

2: And very little overnight of course

LS: Do you have any education for family and for the patients themselves? Do you have that in place do you have material for that?

2: Erm, I think there’s a lot of err condition specific information, so somebody with MS or parkinsons disease there’s…

1: If they tap into those

2: Yeah to the nurse services, but I think for frail older people there’s nothing in particular and there’s a sense of oh, it’s inevitable cause they’re getting old and frail, but err. So I think there’s less.

1: Certainly I always allow enough time at my visits if there’s an opportunity to work with families and carers. They’re usually very committed at caring for somebody and actually want to know what to do so I will give them information without overloading and then an open door to ask for more information, if they later need a bit more help and advice.

2: Because otherwise people will try and seek it for themselves and the internet is the best and the worst…

1: Google

2: …isn’t it [all: laughter]. So I think it’s that individual advice of how you apply that to that particular person is key as well

1: And you can do it in somebody’s own home, you can do a very personal advice…

2: Yes, it’s also linking it of course to pain services etc as well I think too yeah

LS: So do you think that you are called in time?

1: Erm, I think increasingly so actually, erm, certainly my number of referrals have gone up and at a much earlier stage and also with the training that I’m doing, erm certainly what I’ve seen, I haven’t just heard about it, what I’ve seen is clinicians acting in a much more preventative way earlier, they’ll pick up the phone and say I’ve got this situation, it feels like it might be getting a little concerning, you know what should I be doing so you kind of can give information, advice, information on the phone. I have photographs sent to me as well saying is this, is this okay, erm, when it comes to posture and positioning and things I think, you know, our devices, our ipads and picture and bits and pieces are very valuable in terms of saving time because you know when you’ve got lots and lots of visits to fit in you've got to find any means to quickly get that information so I think that could be used probably, you know, more if we had the opportunity to do that, yeah.

2: Yeah, I think the use of technology is really key in this too isn’t it definitely for training and education, but also telemedicine err consultations is a fabulous way forward.

1: Yeah, one of my colleagues was saying the other day, if I had, I wish I had an ipad and I could have just done a call to you then we could have talked it through. You know I think, not in every case.

2: No, it’s about appropriateness isn’t it

1: Yeah, but certainly you can say well actually I do need to come and see this person from that initial screening as well so I think we need to get cleverer and use technology better.

2: Cause the complexity of patients in the community is increasing all the time isn’t it…

1: Yes

2: So I think that's the other thing to really acknowledge that and as we develop services. I do, I do less clinical hands-on, my role is more service development and redesign, but I think as we are doing that we need to be very mindful of ensuring that the services are developed with the individual patients in mind, but also that their needs and their, the ongoing training etc requirements of the staff, often it’s the educational bits that are, they’re an easy target aren’t they if you’re reducing costs, I think we need to be very mindful of that.

1: Are we just talking about people in the community or are we looking, covering nursing/care homes as well in this remit?

LS: Yes

1: Oh okay, erm I think we’re doing a lot in the community, what I feel we could still do more of is erm in our nursing homes, residential homes, staff there, even though it’s like their client group, they don't seem to have the knowledge certainly when I’ve been called in which is usually in nursing homes when they've gone wrong, not at the preventative stage really in nursing homes. It seems that a lot of what I’m saying is complete news to people, just about moving and handling techniques, repositioning, offloading, you know very, very basic information which I would have thought people in that that set up would be, erm, skilled in really, I think even as a non-professional common sense perhaps would have told you that, but it doesn't seem to be happening and also what we are concentrating a lot on is beds, profiling beds and mattresses, where you’re putting somebody to bed, but actually what happens about their daytime, their life when they’re awake. I’m not quite sure why seating hasn't got a higher profile than it has really because the risks are higher, it’s what most people would like to do, to be sat out and interacting erm, but the physics bit the surface area in terms of contact surface areas and times, seating seems to be not seen when somebody’s going into a nursing home they get their profiling bed and their mattress, but what about their seating so they can still continue to actually live their lives and it’s usually when they’ve been sat out in inappropriate armchairs, so the nice queen ann high-back chairs, nothing else going on them, erm, it seems to be in those sort of circumstances that I get called in and that person is sent to bed for often the rest of their lives it feels like, but again all these chairs, even the quite basic ones with rise-recline, tilt, built in pressure relief, which are modular and quite easy to set up, why these aren’t seen as the standard in those type of facilities, erm, is beyond my understanding really.

LS: Is it a matter of lack of equipment or too, that there’s not enough equipment available?

1: I think it’s because erm, the nursing homes. I remember certainly when I first started working as an OT it was hard enough to get profiling beds and mattresses. We’ve done that now, but seating has not followed on.

2: It’s always been arguments about who should pay for it

1: Yes, but I kind of feel that, you know, for a 24 hours in that person’s life, is it just about the bed or is it about the…

2: It should be a fundamental, it should be a given…

1: It should be a given, yeah, I did contact CQC about this, erm and they apologised for their very woolly reply. They couldn't actually say well actually in terms of looking after that person it should be seen as a standard bit of a, oh well equipment, depends on what you want…

2: Yes

1: Probably for those people who have got complex needs they probably could be called a bit of equipment really, but for those people where, they are still mobilising and things, you know, sticking a cushion on the top of a chair which I often seen when I scan around rooms, that means that they’re leaning to one side…

2: Doesn't fit

1/2: The cushion slips

1: So it often makes the situation worse rather than better, they often exceed the weight limit that the cushion is on so I kind of feel that, you know, nurses seem to be called into nursing and residential care all too frequently for things that, you know, again could be prevented…without too much money I would say, I think the cost effectiveness of having a £1000 chair that would cover all of that spec that I just said, you know grade 1, 2, we’re sorted aren’t we really in terms of finance. I do wonder if nursing homes, if they were fined, whether that would be a financial incentive to buy the right bit of equipment. I don't know if that does, they do that in America or other countries.

2: Yeah I don't know

1: I don't know, I think I, when I was reading one time, I think this was America and they said that it was actually the nursing or residential home itself that said if your per, relative develops a pressure ulcer in our, our care then you won’t need to pay us.

2: Oh right

1: There was something like that. Financial penalties often do focus people’s energies

2: I think staffing in the care homes are also a real issue too aren’t there with a lot of

1: …yes, kills and retaining

2: Turnover of staff and oversees staff

1: Language

2: Language barriers, I know when I’ve been in it’s quite difficult and also you have different cultural standards and backgrounds and things to acknowledge and accommodate so I think it's a real, a real issue.

1: Yeah

LS: So I hear, heard you say something about nurses are scared?

2: I think so because the high, the high profile of pressure ulcer development, they all have to be recorded erm, and some depending on the severity investigated so it’s one of the performance indicators that the community teams, the community hospital wards will have to report so I think it is, it is an issue for staff, erm, sometimes, you know it’s all, there’s a lot of debate or through the investigations about whether it was avoidable or unavoidable, and err who did what and you know you’re reliant on good documentation which isn’t always there either so I think, yeah, it’s, for staff it’s about making sure you assess that patient early on as soon as they come onto the ward, before you've even said hello, you know, the poor patient will be checked over to see if they've arrived with a pressure sore developing so that can be noted and then it’s all that oh, phew it wasn't us, they came with it, so I think, whilst it’s right that there is a lot of focus on pressure ulcer prevention and management I think it is one element and I think if you talk to the falls nurse specialist sometimes the falls assessment may not be done as early as it might, you know there are other bits, there’s only so much somebody can do so rather than actually being able to focus on what that individual person needs at that particular time because of the political, organisational pressure about certain aspects it cannot always be as person centred as it might be.

LS: But do you feel that it invites to more multi-disciplinary working or to more holistic working the fact that they are so, that they are scared to be held accountable for developing?

2: I still, I still get the feeling that the nurses feel really accountable for that and I think some of the community teams are more, have more of a integrated feel about them, there are some that are co-located, that they have physiotherapy and occupational therapy in the same building, but whether they’re truly multi-professional and err really working in an integrated and interdisciplinary team, I think the teams are at very different levels as you go round so there are some that are much more advanced that would see that pressure ulcers prevention and management is everybody’s business, but my experience of others have been that that’s kind of the domain of the nurses, I don't know what you think 1?

1: Yes, I mean I’ve got a home email from one of my colleagues the other day and they were saying that, erm, what the nurses are now tending to do is where they see that somebody’s at risk they are doing referrals directly to OTs rather than, you know, getting on and perhaps doing a prescription and education about standing more regularly and things, so I think it feels like there is a bit more joined up working, but it’s a little bit erm, almost, are they, my colleague was saying it feels like they’re passing the buck now because equipment is seen as OT and wounds are seen as nurses

2 Yes

1: …and standing regularly is seen as physio, which to me shows that it should be multi-disciplinary and don't pass this person around, work together, do a joint visit together, you know, if the nurse is not familiar with equipment and wants advice from the OT then fine still look after your patient, but actually work together.

**3 enters focus group**

1: I feel rather than passing things around, pass the parcel, it actually does need to be okay pull it in

2: Yes because actually for that poor patient that could be three new people visiting them, asking similar questions, going through the same stuff again, which for patients is exhausting, frustrating and…

1: So that’s the sharing of skills so if you got a, got a nurse, erm, that wants some advice from the OT about the equipment then do that, if you get the OT that wants some advice about the wound then still hold onto that person but just pull in the nurse, rather than pass it, you know it’s like ooh…

2: I absolutely agree, it’s like phew, somebody else’s problem

1: Somebody else’s responsibility now, I can finish my RIO notes and off I go

2: Yeah, definitely

1: So I think that, you know, we need to hold on

2: yes

1: …to our people

LS: So it’s more passing tasks than working together

1: Yes, together

2: Mmm [agreeing]

1: Yeah and that is a little bit because of the nervousness about responsibility and things, but people need to, you know, know that passing it on is probably worse than dealing with it yourself and pulling in the right people.

LS: Feel free to chip in.. [to 3]

3: I agree totally, that happens too much

1: Yes

3: Whether it’s professional snobbery from the person who’s being asked who then takes it over, it’s a two way thing…

1: Yes

3: …quite often I find

1: Yeah

LS: One point I wanted to get back to that you said is some teams do work together, others don't. If you look at those teams as an outsider what makes them different? So what encourages one team to work multi-disciplinary and the other team to…

2: I think that some of that is personality driven; some teams have had a lot of change. I think they've changed boundaries and areas slightly too, err, you need to have professional trust don't you and that relationship so that you, you say it’s okay I’ll do that or I’ll ask somebody else to go in and you know they’ll be okay. So I think a lot of the organisational change that’s happened has caused some of that as well I would say.

1: Change fatigue don't they

2: Yes you do and then there’s a lot of err focus at the moment on the MCP work as well, so the multi-speciality community provider and the new way of working alongside primary care, so again more shuffling going on, there are new managers coming in, MCP general managers err, working more closely with GPs and GPs beginning to understand that they’re going to have to work differently as well so, again whereas some of the teams had expanded and were getting bigger with the multi-speciality community providers it’s actually going to be shrinking again and they will be working more around a natural community of carers it’s been referred to so I see that as a great opportunity to actually then really develop smaller teams that work closely together.

1: With the right disciplines, proportionately, so…

2: Absolutely, with everybody that needs to be there, so I’ve been doing some work around, and you’re going to tell me off, the buurtzorg model, so I have, several people have told me how to pronounce it properly, so I’m really interested. So this is the, I’m sure LS can tell us more about it, but, a much smaller team focus nursing model of care in the Netherlands that focuses on a small population and actually are really responsible for that that group of patients for everything so far fewer people go in, so we’re looking at perhaps trialling, erm, there’s a lot of interest through the royal college of nursing actually at the moment and err several areas have been out and there are some buurtzorg nurses coming over so next week we’ve got a visit in xxxx so we’re looking at in some particular areas where there’s high need of how we might do things differently focusing on the individual patient what they need, but also tapping into the community around them so they’re not just, you know, a complex patient stuck behind their front door with hundreds of people going in and out, but actually there’s more of a community feel and support for the individual and their families. I’m really interested in that model and looking how that might translate to here and whilst that model is very much nursing I think for a, to translate it to the UK would need to be much more multi-disciplinary so I would like to see OT, physio, mental health nurses within that small team rather than purely nursing focus, but absolutely see the advantage of that small, so you know GPs for a long time have mourned the loss of their district nurse, they always talk about oh when my district nurse was just down the corridor and I kind of get that, that actually you could have those corridor conversations about a particular patient, it’s so important just to say how’s Fred today, how was he or you can say oh I’m a bit worried he wasn't quite so good, rather than having to do a formal referral or trying to get through to a GP so erm I’m sure there’s opportunity coming to work in a smaller locality focus way which will really help the teams to develop, to be responsible for their training and education, identifying their knowledge and skill gaps themselves so I think rather than having a very top down approach having much more of a team ethos about okay this is what we need and this is how we’re going to develop will really help.

LS: And do you feel the multi-disciplinary team is up to that because we have done interviews with physios and OTs and nurses and particularly the AHPs said well nurses think it’s just their role and they don't share enough, nurses say well physios actually don't think it’s their role at all so they don't feel responsible pressure ulcer prevention then particularly, so they don't take up their responsibilities, so how do you think…?

2: But I think this small team because it will be very visible then who, who will be doing what and who isn’t doing, so I think actually then it will be much easier to have that shared responsibility and erm also, you know, perhaps one person more case managing an individual patient so that the relatives and the patient know who to go to, so it is again rather than being a much bigger team with lots of different people, that it will be much more personal.

00:36:17

3: The old fashioned district nurse model about bringing other disciplines into it

2: Yes, I think district…

1: Yes, instead of district nurse, district health care

3: Exactly, exactly, and I think in xxxxx I know in the community, because I was a district nurse before I joined the equipment stores and the teams are very much, there’s your allocated therapists, but it’s almost only in name only the might just take the referrals, there’s no togetherness with it

1: No

3: apart from the odd time when you might go to GP surgeries for their, for their monthly meetings, erm, but that, and there’s too much that, that’s my office, that’s your office

1: Yeah

3…never the two shall meet kinda feeling and even when I’ve noticed since being with the stores just around the whole of xxxxx different people work in different ways

1: Different teams

3: …I think in some particular area the nurses will not order mattresses, that’s all down to the OT, we’re obviously trying to work on that, that’s definitely a no no, erm, because

1: Because that’s equipment

3: …because it’s equipment it’s got to be an OT

1: [laughter] I rest my case

3: Yeah, however when I was in my team, okay it was rapid response I wasn't actually a caseload holder before I joined, but I actually couldn’t access to get a hoist for example because that was done for the OTs next door. I wasn't allowed, I couldn't physically access it on the system. It’s a lot of historics, a lot of pathways that are blocked for whatever area so you know there’s a lot, there will be a lot of work, but actually some say, good old, is it xxxxxx neighbourhood nursing kind of ethics that I was, when I did my district nurse training that’s what we were taught so yeah, sounds very…it’s about ownership

2: Yeah

1: Yeah, I think in terms of the teams and having teams in place for long enough to build up those relationships and trust because what what seems to happen is that you know the nurses, OTs and physios they have their defined, what they see their job role to be, but actually I think that all of those job roles have changed now because of the patients that we’re seeing, erm and those very tight boundaries that people put around themselves in their comfort zone. People are often nervous about, erm, learning something new perhaps because then it might become their job and they’re already overloaded…

2: Mmm [agreeing]

3: There’s that to it as well

1: I mean I’ve, I’ve with the link trainings that I, that I do around xxxxx I have OTs are always very, erm, keen. I have some, some physios and the people that are interested are committed to it and they have said that it’s actually enhanced their job role, it’s not made it more difficult, it hasn't given them more cases it’s actually just made their day job much more satisfying and I did have a a wonderful nurse attend on one occasion and she’s making a huge difference in nursing homes because, erm you know, she’s got what we laughingly say her OT stripe [laughter].

2: Yes

1: …but the OT that she’s working with has also got her nursing stripe and actually it’s not about additional work, it’s actually about that patient

3: Holistic

1: Yes, seeing the whole picture about working together.

2: People get very anxious don't they about their professional identity as well and, you know, being err down-skilled or undervalued, but I think you know where those blurs can happen, the blended approach I think actually it makes then much more apparent about what the specialist bits you absolutely do need

1: Yes

2: …so what do I really need an OT to do, do I really need an OT to say this person needs…

1: A toilet seat

2: A toilet seat, exactly, you know I don't, I really don't think I do, actually sometimes I might really need an OT to do a more in depth cognitive assessment

1: Yeah

2: Cause it isn’t just about equipment is it

1: No

3: It’s about knowing your boundaries and your knowledge

2: Yeah, so actually I think, you know, just letting some of that go and I think from what I can gather the organisations approach to some of the core competencies were trying to have a bit of an impact, err, through developing those. I know that they caused quite a lot of anxiety didn't they about therapists all thinking that they were going to have to do nursing, learn about nursing tasks and nurses having to learn about therapy, I think, I don't know about communication of err the core competencies didn't go very well, but hopefully it’s calming down now, but it did cause, a couple of years ago when I came in, it caused a lot of

3: Knee jerking

2: …upset

1: And I think it’s a little bit about methods of communication, I mean, I believe like the AHAPs are quite a minority in the [the trust] and we don't really have, you know, therapists saying we don't have a voice at a very high level so we’ll, you know people are saying that erm it’s led by nurses for nurses and this seems to be a little bit of a jungle drum that's being played at the moment and I kind of feel to change the culture we actually do need to have recognition, or a felt recognition of the value of what the other professions can do, erm, you know everything starts with GP, nurses and others, even in the directors, execs roadshow, I noticed erm, it was GP, nurses, and others.

3: Oh nice

1: And I kind of thought well, okay…

2: Yeah, thanks for that, yes…

1: and that, the way that that then makes that staff member feel is not very good

2: Mmm

3: No, on the other hand I’ve also identified that the user group that come to the…

1: Yes, all OTs

DL: …I was the only nurse ever, years and years and years ago who always had an interest in equipment and I was the one nurse that went who’s going to, cascaded it all down. So, as a matter of fact we’re going to try and start to sort of invite and send the minutes to the matrons to maybe get some interest because people don't know.

1: And if people want to change something, well actually you need to put your foot forward and say okay I will attend this because actually I need this to change for my nursing team

3: Yes

1: …you can’t just sit and mither about it you actually do need to say there’s this opportunity to influence the the equipment service

3: Yes

1: …you’re not going to do it from your office you actually do need to attend the opportunity

3: Moan about it and what have you, yeah I know yeah

LS: We also heard that the use of equipment has gone up a lot over the last few years, is that something you recognise?

3: Yeah, think that xxxxx, he would have known and he did send his apologies. He would have known the statistics off the top of his head, but yes they’ll, there were, there is an increase of demand but not of budget.

LS: Okay

3: Erm, ad infinitum I think that’s just maybe society as a whole the way we are getting more complex

1: And people prescribe quite quickly don't they

3: They do

1: Rather than looking at that person’s lifestyle

3: An example of that is the Liverpool care pathway where it’s stated that you have to put a hospital bed in. I don't want to die in a hospital bed in my own home or anywhere else thank you very much and that was just one of the things that was never questioned and you’ve got the young family that now aren’t a young family on that bed as he passes away, but he’s in a bed though, very sad and very, well, yeah. Erm, so I lot of those kind of trends didn't help that and there is a lot of history, a lot of habit.

1: And I think going back to sort of the fear factor, you know people have to record that they’ve done something and often the…

3: Datexing has got a lot to answer for with pressure relief in particular

1: …yeah, the done thing is to put in a propad

3: You've got to do something

1: regardless of whether actually it’s the right thing to do

3: Yeah, exactly, the better, the bigger the mattress the more intense the mattress

1: the more expensive, the more money they can spend

3: then you've covered yourself

1: Yeah

3: You haven’t got that datex on your conscience

1: Rather than sitting back, doing a holistic assessment, saying are you able to stand for five minutes every hour, every half hour

3: Absolutely, yep, yep

1: you know those type of things

3: Or just looking at the bed and not the wheelchair they’re sitting and that’s why they’ve got sore heels

1: Yeah, and explaining why, I think, certainly the patients that I’ve worked with they say well I had that information, but I didn't know why, erm so I think it’s, you know you can have a conversation, do this…they won’t do it unless they know the why, unless it’s actually meaningful to them so I think it’s a, the in depth of information that we can give as MDTs which is, you know, fundamental.

3: And there is, certainly in xxxx, which I can only speak for, huge change in staff

1: Yeah

3: …so a lot of the old ones have gone, some new ones, not a lot have replaced, there is a lot of shortages and undervaluedness going on and therefore not stepping outside that boundary, you said earlier on, is totally reinforced by that…

1: People get very oh I can only see this number of people so I can only do this, this type of work, yes

3: Ideally, one mornings of really good holistic, but you need the staff to be able to do that too, per population, problems within that population as well

2: Yes

3: …there’s no point if it’s within that hunky-dory thank you very much, well, I nearly said effluent then…Freudian slip, affluent sort of areas as opposed to maybe a little bit more of a…

2: Yes, I think that’s the bit that the MCP work should do, is actually reflect the needs of that local community more as well, so, you know, what inner city xxxx needs is quite different to around xxxxx.

3: Yes, yes

1: Or the xxxxxxx

2: Yes and all of those, yeah the demographics, but also the geography of area

1: It’s been very interesting because I feel a little bit like, you know, I’m floating above xxxxx, erm, you get a very good bird-eye view of what’s going, what’s going on, you know I’ve had to adapt in terms of how I respond to things, erm, depending on locality and teams and lack of teams really

2: Yeah, morality

1: Travel time

2: Oh [agreeing]

1: Yeah, all those things

LS: So if people order equipment, do you ask questions?

3: Yes

1: For some

3: For some, the screened, screened equipment, erm well and others if they’re ordering three toilets because they’ve got a three storey house they might be questioning that from the front office, for standard equipment, but yeah in particular especially if I, I’m making a bit of stand if somebody hasn't written a braden score down for example and I will phone and ask them how can you just, you haven’t justified to me really, justification is questioned on nearly every bed, unless it’s really well written and they've looked at the guidelines and they've either worded it well, not mentioned carers, for only provision of a bed etc, etc, you know, that old chestnut. Erm , but I definitely erm, and I actually phoned an OT team, therapy team, erm yesterday and said, you've not put a braden score on and that girl was out but the OTA was there so I said, she said I know the patient and I went through the braden with her and she was able to tell me, you know, they knew he was at risk, but actually we didn't have a score so I suggested she went and got herself a copy from the team next door or downloaded something, or at least have some awareness so I feel we should be going that way, purely by the fact that I did that yesterday, that we should be more, all more aware of it.

1: Do you think that that would also be a good idea for anything that is prescribed for, err, pressure care prevention, including like the propads?

3: Well, yeah possibly yeah

1: I do, I’ll put my hands up and say well yes because actually if they’re just being given out like smarties because it’s been seen to be done, it’s an opportunity to educate that prescriber at that time isn’t it

3: It is, absolutely and that is what we do a lot erm and I have done it with propad, propads in particular, actually they should be stepping them up

1: Yeah, the dynatech or something

3: And things like that and they think they can get it quick because they’ll have a two section bed and propad, they’ll get it through quickly

1: Yes

3: That’s not actually what the patient’s needs are

1: Yes

3: And they can have the, this other equipment after discussion just as quickly, but yeah

1: Or as I say it might be a lifestyle, bit of education

3: Sure absolutely, I don't know how many times I’ve said look at the environment

1: Yes

2: Mmm [agreeing]

3: which is really hard when you’re speaking to an OT from the hospital and if they’re not going to go out like you used to in the old days and do the whole home assessment and what have you they may well be reliant on the professional out in the community or they may be going and saying this is complex I am going to go out and see this one.

2: But often the patient is known to the community already

1: Yeah

3: There’s always that old chestnut too

2: And actually what’s already in the house and..

3: Absolutely

2: …the ability to share notes and look at each other’s documentation will really help that won’t it, because otherwise…

3/1: Yeah

2: And I do wonder because rather than prescribing, I always felt that was rehab as well, it would be better to refer the patient in and identify their needs and issues and then you do the prescribing, so they phone in and say somebody’s got their braden of whatever and they've had a stroke in the past or they‘ve got dementia or, and these are the issues and you talk them through rather than them phone up and say I need a bed and a propad.

3: Quite often there is a lot of people who phone up and ask advice, there is and actually I’ve got a paediatric OT I’ve got to phone this afternoon about, that with a child that I’m thinking no I can do that skin is skin, you know, but I’m thinking ahh children, but you know we all have to incorporate and encompass these sort of changes I think, but erm, but yeah a lot of people do phone and I actually have been really pleasantly surprised at how people don't mind the fact that you've challenged their professional judgement

1: Yeah, you get some that are a little bit…

3: There’ll be the odd ones, yes indeed

1: …but I think erm, yeah

2: You don't know what you don't know

1: No absolutely

2: You don't know what equipment’s there or what the opportunities or what the possibilities are

3: Yeah, yeah

1: Yeah, and actually it’s within our professional code of conduct that if we’re not sure we should be asking

2: Absolutely we all should know our limitations

1: absolutely

3: And the person who thinks they know it all is the most dangerous practitioner ever, the person who thinks they know it all and what have you

1: Yes

3: Yeah, there’s a lot of discussion and I’m trying to encourage it my way because obviously there’s been a gap for a while and the other assistants are trying to answer the questions and I’m saying that to you are there any queries about that can I at least, so they can hear what I’m saying for next time otherwise again that can be.

1: Some of the advisers up there don't see patients or haven’t seen patients ever

3: And we’re doing that too, we’re getting them out, one of them’s been out with a therapist team for the day which is great because then they can actually see what they dealing with and talk to the patient they’re dealing with, if you lose that touch

1: Yeah, it becomes very scripted then…

2: Yes

1: …you can only get this for this scenario, rather than actually person centred, that has to mean something

2: Every situation is slightly different isn’t it

3: Yeah

1: Yeah, so they’re seeing patients, so when clinician’s phone in they don't want to feel like they’re being given a hard time, particularly by someone who hasn't seen a patient in their life

3: Yes

1: …kind of gives them a little bit more comeback to say well actually, yeah

3: Yeah, definitely

LS: Well I think we have covered a lot of the topics we wanted to talk about, but is there anything in particular that you would like to raise about pressure ulcer prevention or management that hasn't been?

1: Hospitals, I think actually in hospitals when I’ve had people set up very nicely at home with a positioning routine and equipment at home go into hospitals go into hospital for something unrelated, erm and come home with a pressure ulcer because that hasn't been translated, erm in the ward so that’s a, that’s a concern.

3: Exacerbated by that fact they’re probably unwell and therefore those five things that they would be..

1: More at risk

3: Yeah, yeah

1: than it would have been

3: It’s actually more important actually to maintain that in hospital when you’re unwell

1: Yeah

LS: So how do you communicate that once they’re at home?

1: Well, when I’m involved with complex case management I don't casehold. I get the caseholder to do, to take photographs, err to have erm their 24 hour routine written down so it becomes part of a care plan, erm and then that can then go with them. I have got somebody in xxxxx where they take their care agency staff with them and the nurses in the hospital don't actually look after them because they are too complex, erm this particular person is too complex, but we know that if she went in hospital and got left to the nurses there, with all due respect, she would not come out because her level of need is that, is that high so I think again sometimes we kind of, oh well goes into that door, erm, but nothing that goes on in this set up follows that person, erm and I don't know how much in terms of knowledge, erm staff have in in, on wards where it comes to positioning in particular and people that are contracted, you know they’re getting them to lay on a very flat surface and you can just count down the hours before the wound can start again it’s about raising the profile for our, for our more complex people in particular, I think that’s where we need to …

2: I think in acute hospitals it’ll depend which specialty you find yourself in, medicine for older people should be better

1: Yeah

2: the problem is you could be on a trolley in ED for too many hours before you even get onto a proper bed

1: Yes and there you have it

2: the damage often be done very early on

1: I do get quite a lot of call from, erm, xxxxx therapists in particular actually, but xxxxx General and xxxxxx as well, but probably mostly from xxxx, particularly like from the stroke ward, neurology and Parkinson things where they run a scenario by me and I’ve actually been in and set up positioning cushions which then can then go to residential home in a lot of cases and things, but I’ve done a bit of training with those staff and they’ve been brilliant actually, so yeah.

PC: I just wondered, I had one kind of quick one really, although it may extend, erm, you talked a bit about GPs, nursing, physio, OT, what about any other professionals? Do you see any other professionals getting involved in this area?

2: Podiatry I would say

3: It’s possible

2: …is quite important in terms of heels and

1: Yes

2: …feet and obviously in terms of poor circulation

1: I mean the healthcare assistants we have, whatever they are called these days, I cannot keep up with their name, often they are very , they seem very invested in, on a very personal level with the patients that they see, certainly when it comes to assisting with, erm, positioning and err helping somebody have a bit of quality of life so they can actually do their knitting and you know some of the more humane/humanistic type things. I think that they’re very committed to that and are very keen to learn, erm

3: Are you talking agency staff or talking…

1: No, no no

3: or are you talking people who are linked to actual…?

1: Techs, Techs, rehab assistants, often they go

2: Associate practitioners

1: Associate yeah

3: That’s if they’ve got put up a grade

1 Yeah, where it comes to sort of doing the posture management assessment often you need two people and I know certain teams are now, erm utilising a second person as you know their band 4s and that person can then do like a little bit of follow up, they can probably do the reviews so you’re not getting the band 6s and 7s having to go out all the time.

3: Yes absolutely

1: That person can then report back so they’re kind of there, they’re there at the set up so they understand what’s you know being asked of that person’s care routine, the equipment use, erm and all those type of things, they’re very, a resource that could be utilised more.

3: Definitely, however one little spanner in the works there again back to rapid response days is that our guys maybe one of our healthcare assistants would, you know we were healthcare assistants day by day erm, would identify a discolouration of the skin and I brought this up at the TVN day, and dare I say the qualified community staff that went on twilight as a follow up because it was like five o’clock at night and therefore they followed on, erm, said oh no no no it’s okay, the next day it was worse and I think that talking about prevention was about I’ve got to do all them bloody forms and I can’t go out to the patients, erm, you know so to speak, and that is highly dangerous, very contentious, but I think I’ve, think I’ve witnessed that on a couple of occasions and I think that’s happening.

1: Whatever grade somebody’s in they’ve got a duty to report that

3: They’ve reported it and the person’s gone on and gone no no no it’s okay

1: Yeah

3: And I have a feeling as first level nurses that they, and I know they should, but that is what I have felt has happened a couple of times and that skin has gone on and deteriorated and the healthcare assistant was accurate, was spot on, but it wasn't followed up because of time. The other thing is yesterday we had a big meeting at, because I’m only really used to the health side of things and when you talk about other staff and there’s this clustering of OT visual impairment and CRT and we were putting together some, thinking about what sort of training they would need for and it’s very much the same line as this, for them all to be doing the same kind of assessments if you like. Okay that’s only to do maybe with equipment and and installation of of, but that’s definitely going that much more that way and more multi-skilled with that one team, but again that’s another thing that they will need to know about is pressure relief, so that is another facet if you like coming from adult services as well as health that should be, hopefully that that venn diagram and is all juxta-, it all working together should be, should be better, cause always one of my questions always was is you know when CRT is finished after 6 weeks who follows up the equipment.

1: Yeah, yeah

3: You know and it’s a huge, a huge, huge job

1: Certainly because my background was, you know, 22 years in xxxxx county council before, err, [the trust] and things and certainly the staff that I work with, well I offer training even though I’m employed by [the trust], to xxxxx county council staff, because if they don't have the skills to deal with that patient they’ll be passing the referral onto [the trust] anyway

3: Absolutely

1: …so in terms of the training side of things and the link supports it’s basically, my remit is anyone with a xxxx GP, so

3: Yes, which again is good because it’s the patient…

1: It’s the patient

3: It’s the patient and whatever affects that patient, yeah

1: Yeah

3: That’s how it should be

2: So your question xxxx, and I think obviously social workers as well, often they’re, when there’s nobody else involved if there’s a what used to be a simple care package, a social worker overseeing that, then if things begin to deteriorate then they need to be able to pick up quickly

1: Yeah

3: Yeah, you say overseeing that, but once they've got an established care package and everything’s all hunky-dory no one’s assigned to that person are they, I also find that quite frustrating apparently

1: They close it

3: They close it, which I think

2: But the care agency would

3: But it’s the care agency, then it’s the care agency that would be important so then bring that person back in should they need it

1: But I thin, care managers, certainly I was in an office with social workers and care managers, you know back in my original OT days, erm and because we were all in an office together, erm we used to have very good communication lines, erm and certainly when people were going into erm care homes and things they were saying, you know, what else do I need to consider here and in terms of the care package, and often it was more than just the bed, the profiling bed that we’re actually well, you know is this person out and about. Is it a wheelchair that they need, is it a armchair that they need because that is part of their basic.

3/2: Yes

1: ...needs you know, so yeah when people are setting up care packages then that’s a great opportunity for them to specify to the care home so they don't get a surprise that this person is asymmetric and needs some type of chair that accommodates, erm, that at the point of entry.

2: There that’s a good point

PC: And just briefly, I mean obviously in the trust it’s not just health, there’s mental health, there’s learning disabilities, how do you find that as a sort of, are they getting involved in this sort of overall picture as well in mental health and learning disability?

2: There’s definitely a move with the MCP work to align err. I think older person’s mental health is much more aligned anyway because many of those patients have health and older person’s mental health needs so I think that is but adult mental health less so but I think that will, that will come so for example in xxxx err there are huge mental health issues associated with drug and alcohol substance misuse and so there’s a pilot where a mental health CPN is being put into the GP practice and meeting patients and screening and seeing patients so they, the GP have a lot of time freed up so proving very beneficial so I think again there will be much more of a locality focus with the specialties, sub-specialties within that locality so I think that will come as well.

1: And with my little advisory team we have got a member of staff whose specialty is learning disability and mental health, I obviously cover mental health as well the posture side of things and another member of staff who does the plus size as well

2: Yes

1: Erm and we’re thinking with this new member of staff might well get involved in the transition stages because that seems a little bit of a gap that needs sorting out as well so we kind of respond to where the demand is.

2/3: Mmm

1: Erm and err yeah

LS: Thank you for attending

PC: A very brief summary of what’s sort of been said

* Reporting, fear anxiety with some clinicians mainly within nursing, avoidable/unavoidable criteria, how this can detract from prevention sometimes
* Role, nursing feeling more accountable for pressure than some other clinicians
* MDT approach personality, locality driven, teams need a trust relationship between professional groups and if in different localities difficult to do
* MDT offering a depth of working, a more holistic approach
* Those who don't think it’s their job see it as an overloading of extra work, rather than adaptation of role, not seen as enhancing their own practice
* Education for patient, carers, clinicians and more widely for the family, if we don't do this where do they get information from, currently quite condition specific
* Telemedicine, use of tech in this area to promote a greater MDT approach without always having to be in the same room all the time to be doing a joint assessment
* New ways and models of working allowing a smaller locality focus, hoped to bring an easier shared responsibility
* Mental health learning disability
* Other professions in HCAs, RAs, Aps

1: I think it’s really important that the language that’s used there is not others, not GP, nurses and others, if you’re an other

3: You’re undervalued straight away

1: You think yeah okay it’s not my…

3: You have no ownership of it whatsoever

1: I know it’s being pernickety, it happens in the teaching world as well with teachers and classroom assistants and admin and it’s like the teachers, teachers, teachers and then they don't get invited to things, you know it’s all kind of like if you want to embrace and use all these people’s skills then do it properly, you know do it right at the top and the bottom and then bring it together

Thank you for your time