Interview 3 – OT

PC: What does current practice for pressure ulcer prevention look like in your team?

P3: Err, current practice, so it’s jointly done with all therapies and nursing erm it’s looking at, usually on the initial assessment and any subsequent assessments, it’s following up and checking, so it’s doing a visual check if the patient is happy to erm trying to look at the more common areas, so your heels, sacrum, spine, elbows, erm, and then giving out a pressure ulcer leaflet so even if they don’t have, just so they’re aware, with all our contact details on erm and then if there is erm any skin damage or noticeable then it’s put in there equipment, or then preventative if they are sitting for a long period of time or at risk then its putting it into minimise that risk.

PC: Is it all members of the team that are involved in that process?

P3: Yeah, we all should be [laughter] do we, I think

PC: Okay, so how, within the team, how do you perceive sort of role and responsibility, where one role begins and another ends?

P3: Err, well, what within pressure?

PC: Yes

P3: Well, I think historically it’s been more of a nursing potentially, but I think it’s actually it’s all of us, especially more in some respects can be really linked into OT because of postural management and seating and erm, yeah I think it’s all of us really and that spill out into, like you say, the next sector of care agencies as well.

PC: And so you said it should be, is that reflected do you think actually in in practice?

P3: Erm

PC: Where everybody’s committed to…

P3: I think so, I hope so, my view is [laughter]

PC: Okay, Erm, in your opinion is everybody as aware of pressure ulcer and the risk factors for pressure ulcers?

P3: Err, I would like to think so because erm it’s so common and it’s something that we all need to look, plus we have it in our intentional rounding so it is a bit of a trigger to be done, whether or not visual checks are always being done but even that can be subjective as well because its, if you know a patient declines, they have that choice and then also it’s taking the patient into context as well because if they’ve got capacity and they’re fully aware of what to look for then it’s giving those, the information, if you know they don’t want you to be checking out their bum all the time [laughter].

PC: Okay, erm, and actually within that do you think there’s an awareness within the team, within the different roles within the team of erm each other’s role?

P3: Yes, I think so, yeah, we all know which ones we do.

PC: Okay, so how would you, how would you sort of, it may be a difficult question, but how would you sort of define that, you know, between perhaps a nurse, a physio, a healthcare support worker, an associate practitioner?

P3: What define the role of?

PC: In terms of the role that they would take for pressure ulcer prevention?

P3: Erm, well we all have a role and the more basic equipment anybody can order and put in and then I think if they feel that that then is maybe more complex, then they would bring it, they know then to bring that up erm, I don’t know if that answers your question?

PC: Yeah, so…

P3: Yeah, so they’re all aware of the roles, I mean we are quite erm, we’re not as maybe clear cut on the roles and you would be in an acute setting because we do overlap a lot, but, yeah I think everybody’s aware of their role and how it …what to do to be honest.

PC: So, so a more kind of complex assessment might come to an OT?

P3: Well it could either come to both OT or a physio, but erm probably historically it’s more of an OT, with equipment and alternatives and the next bit can be, or a joint or work jointly if it’s its predominantly physio patient then it might be that we actually work together and then do it with reps as well, something like that, so..

PC: Right, okay, how confident do you think different members of staff are in terms of being able to prevent?

P3: Erm, I would like to say I think they’re all quite confident and able to prevent erm, I don’t, it’s having that mindset isn’t it because if you, if there’s nothing there to, I mean sometimes you’re over cautious and maybe it’s not necessary then to throw relieving, pressure relieving equipment at them, it’s trying to change that lifestyle, doing more, you know, actually you’ll not just sit, get up and move around erm, I’d like to say they’re all confident, but I can’t speak for other people so.

PC: No sure, of course, just your own perception, yeah, and so you mentioned obviously about equipment going in. Would that be the first line of prevention?

P3: I would imagine it’s the first yeah, okay right here have a cushion, not err looking at other bits erm, I know for myself it’s more like okay well we can look to do this but you know actually getting up, going for a walk a bit more even if you’re up and you’re jiggling around for a little bit, erm, its better than just relying on a cushion to do that for you erm so I know I give that out as part of my advice, but if that’s standard I don’t know.

PC: So, just thinking a bit more widely then really, you mentioned kind of complexity, would you think the increasing complexity of patients in the community, which is you know well documented erm is changing practice?

P3: Yeah

PC: In relation to pressure ulcers?

P3: Yes, it’s being more mindful erm and it’s the smaller things, I mean historically, a lot of people, you say pressure ulcers and immediately you think of someone sat in a chair for hours and hours but actually it’s looking at that more complex of manual handling with the shearing and friction and moving, erm, so it’s trying to take all of that into account as well, and especially with more, as populations are changing sizes it’s being aware of that and you’re getting them in more uncommon areas, so its its rising.

PC: And and again that awareness of the kind of complexity is across the team as far as you’re aware?

P3: Erm, I don’t know erm, because if it’s a more complex case then it would be held by the more, the registered professionals if its more err err I don’t want to say simple, what’s the word??

PC: Routine?

P3: Yes, yes so if it’s more of a routine patient who maybe you’re going into do more of a mobility, then that’s the ones that we tend to handover to the non-registered so yeah it’s kind of takes more for the physios and OTs and everything and maybe the APs, we see that complexity slightly more control of the high level caseloads.

11:21

PC: So, with those non-registered err professionals, they’re going in, are they, are you hearing the feedback from them that they’ve seen something and they say well this is quite complex you know, could you help in this regard?

P3: Yeah, I believe they would yeah if they come back, they always come back and talk about whoever they’ve gone out to see to the therapist who’s allocated it to them and then for myself, once I’ve allocated a patient to them I always book in a review a few weeks later anyway which then I’ll hopefully chat with them about ongoing and then go and see the patient again at the end and then if it’s more complex, if they’re doing any more then I think the first visit I would do, I haven’t had it yet, but I would do with them so they knew what I was wanting to achieve erm, so yeah, think about crossover.

PC: Okay, and I understand from previous erm that the team in this area is in two different locations

P3: Yeah

PC: …So if somebody who is not where the therapists are goes out and sees somebody are they then, who’s not necessarily on the therapy caseload, are they then referring over? How does that work?

P3: They refer over if there is a therapy need or if they see there is a therapy need erm, but unfortunately we don’t have, so with the nurses that are based with the therapists we can just pop up or they pop down and we have that quite good crossover, but unfortunately the ones that aren’t, that are not based with them we rarely see them, but they will always, they know we’re always there to ring or refer to or if they know we’re going in then we can have that that that conversation and then also it also can be brought up in the MDTs which are weekly so erm.

PC: Is that with the whole team?

P3: No, there’s two separate for the localities erm, but one of us will always attend and then nursing staff will attend as well as the geriatrician and everything so we can have that proper MDT and if we’ve got anybody we need to feed over to, so the MDT where the other nurses are based erm we can give all the information or attend it as well so you’re catching them there and then to discuss it or they can catch you.

PC: And actually within that is there much sort of joint visits, or are there many joint visits?

P3: I haven’t had any myself yet, but that’s not to say that I couldn’t if the need arose so, and I’d imagine that there has been in the past

PC: I’m just wondering if somebody was identified on paper by a nurse for example erm and you look at this and say well this person’s quite complex on paper, you know, would there then, is that, it’s not routine practice to then kind of call a therapist over and they go out together?

P3: No, no, I’d say if it’s quite complex then they’ve probably already been in I’d imagine and seen the patient to get an idea of the situation, erm, and then we could do the visit afterwards, which is actually quite nice if you do it with them because then they’ve already got that connection with the patient and the family and the way into making any change if needed, so that’s how I see it.

PC: Okay, so you mentioned about a geriatrician. Erm, wider than the integrated team if you like, are there other professionals that you would call on in relation to pressure ulcers?

P3: Erm, we’ve got the, erm, related to pressure ulcers, so if we’re not involved erm and theres, might need for pressure care, you’ve got the AFIT team that can refer into us erm so that’s one way a referral might come in and they can also source some pressure equipment erm, wider team, err, we have our our therapists that run across the forest that we can also link in with if we need to erm and you could bring in any reps I suppose if, again looking at that, I mean looking at that..

PC: Okay, and the connection with the geriatrician for example or even like a GP erm again, that’s within the MDT meeting or is there any kind of joint visit?

16:18

P3: So, erm, I’ve never done one with the geriatrician but I wouldn’t say no to it, erm, GPs, we tend to telephone, but they do run practice wards which erm, I mean there’s been a bit of a lull in it, but we’re starting to get back up to have that other MDT with them as well, so we attend or can attend those to liaise and talk to anybody that needed to about them.

PC: Okay, and what about, erm, just thinking about other professionals I mean just off the top of my head, like a community podiatry service or erm dietician. Is there any access to that sort of services?

P3: There isn’t any dietician service in the [locality] so we don’t have access to that erm. If you see there might be a problem or they score high on like the MUST or something, then we refer back to the GP erm and then hopefully they will look to get it that way, erm, and podiatry is limited to their criteria so mainly most of the podiatry is private based unless it’s like diabetic foot ulcers and then I think it then goes over to the NHS side erm but I don’t think there’s enough people or funding for that.

PC: Okay, so you wouldn’t routinely see them in the community or connect with them or anything?

P3: No, no, no we wouldn’t. You mentioned about doing the MUST assessment and if that was relevant then to refer to the GP and have you had experience of what happens at that point then? In terms of what actions occur.

P3: No, I mean from speaking about a patient of my own I’ve, I was worried about his nutrition intake, but he was already on build up drinks and I referred back to the GP to ask to you know if there was any access to any dietician that he had, which, barriers were slightly put up because of the patient’s prognosis, but then he was like well actually, still if he wants to eat we need to see if there’s any way we can, you know, manage that erm and have the involvement because just giving him build up drinks isn’t going to do much [laughs] so, yeah, but I don’t know the outcome of what has happened.

PC: Erm, just jumping back to overall collaboration generally, what do you think are the barriers to…?

P3: Communication,

PC: Communication, okay

P3: Yes, it’s a barrier to everything [laughs] and it shouldn’t be erm, erm yeah communication, time pressures, although it shouldn’t be again, it’s all the ones, it’s the ones that are easily fixable, but still crop up erm and I think it’s also again trying to find, for us because we’re on two different systems it is trying to chase, chase the system on who’s involved and where they’ve documented bits, so that’s something missed, if we’ve got patients on one system we’re the only people who write on it as part of a trial erm but then if they’re seen by other people they write on the RIO erm so we’re having to constantly look in two places to see if people have done anything or been involved. Erm, barriers erm.

PC: I mean one thing that came up err in some of the focus groups and interviews we did before was erm, some people who worked in separate locations between therapy and nursing suggested that sometimes that can be a barrier.

P3: Mmm, yes

PC: I mean going back to your communication thing…

P3: Yeah, I mean ideally you’d have everybody in the same room that could catch up and everybody knows who everybody is erm, I mean I’ve come over to here and erm I try to pop in a few times if I’m in this base so people know oh look she’s her and she knows who she is but not everybody does and I don’t know half the names of nurses over, I’m just as fault erm, but no it would be nice if you could all be together, at least you have that social contact as well, face to face

PC: Okay, so you mention the system, these two different systems erm and you mentioned that was a trial on one of the systems, erm, can all of the team see both systems?

P3: Only the [locality 1], all of us can see both systems [locality 2] nurses can’t as far as I’m aware cause it’s only locality 1 patients that are using system one as part of the project, because the system that they use is what the GPs use down here, but then not all GPs use that system so it’s yeah.

PC: So, does that mean that the therapists are needing to write in two places in terms of notes?

P3: No, so if it’s a locality 1 person we just write all our stuff on system 1, if it’s a patient that comes under the rio then we would just write everything on rio erm but yeah, and then the nurses are separate, locality 1 nurses will just use system one because they tend to just see locality one patients whereas the xxx will see the patients so it’s only therapy really that crossover.

PC: Right okay, I see erm,

P3: Oh barriers, equipment store [laughs]

PC: How is that a barrier?

P3: It’s just trying to get the equipment and if the equipment is in stock and what equipment you need erm cause for one of my ladies who had a grade 4 on her spine it was trying to look at getting a cushion that would help relieve the pressure cause even if she had a V-shaped cushion behind her, her spine was still touching the chair and the cushion erm so it was trying to, luckily the one I wanted they found a recycled stock that they maintained and got out, but yeah it’s trying to get your hands on the equipment and filling out the forms and waiting for it to be delivered and then going back out to set it to the right weight, so I’m going out to a lady in a minute who err, mattress she’s got a high risk area that could go at any point and the mattress has been put in the garage [laughs] so I’m going out to set it up, so yeah that’s quite a big barrier.

PC: Yeah, so for those slightly more complex patients to get stuff that’s not on the normal list is that particularly or is that for all equipment?

P3: No I mean for all pressure relieving mattresses unless it’s standard, which is only like the propad cushions or the propad mattresses you have to fill in a whole, a special equipment request with a justification of clinical reasoning erm so that tends to fall to probably us more than the assistants erm which is fine, but it’s just like, can you just give me a mattress, I need a mattress [laughs], it’s just the justifying all the time and then it’s the waiting for them to get it out, if they’ve got the stock and if they haven’t got the stock it’s a problem.

PC: Okay, last couple of questions if that alright, so it will probably be another five minutes or so if that’s alright,

P3: Yeah, it’s fine, as long as I’m answering them alright for you

PC: It’s whatever you say is perfect, erm, do you refer or make contact with TVNs or the AHP clinical advisory team?

P3: Have done and I would do if it needed to be. Erm the TVNs I wasn’t aware of a new service they did until a bit of training I went on, which is the, I want to say the action line, but it’s not, what’s the…

PC: Live line

P3: That’s the one, erm, which will be useful, erm, I mean our first port of call usually we take a, if there’s any sort of query, we take a picture of it and speak to our district nurses erm because then they’re closest to us, we can grab them to come out with us if we need to erm so yeah I’d imagine we can, but we would start there first or go straight to clinical advisory if it’s more I think posture management or pressure bits in there as well.

PC: Sure, okay, and just thinking about leadership, erm, within the team and sort of more widely actually within the trust, erm do you think pressure ulcers are a focus for leadership?

P: From our particular lead, yes, she’s very hot on it erm, from the trust, wouldn’t really know at the moment erm, no, I wouldn’t say it’s probably their main focus for the moment, but then I don’t really, but definitely from our line manager it is, she’s very hot on making sure it’s all, and then you’re trying to make sure the wording is right so if people who were reading it or picking it up after you, then they actually know what it was like so you’ve got that comparison, so yeah she’s quite hot on it, reiterates it regularly [laughs]

PC: And, and within that from a leadership perspective again is collaboration encouraged in professional groups?

P3: Yeah, I believe so yeah, I mean you’re always going to get the bits that probably we do that they’d probably like more information off and especially there is bits that we would like more information of, especially when it comes to mobility, in a way that they don’t, but it’s fine, it’s how we think about things differently. We do a, I have noticed there is definite defferent, different thinking with nursing and therapy in everything I think we just think about things differently.

PC: Have you been involved in any of the reporting process around pressure ulcers?

P3: Err, no I haven’t, I would like to do a panel so I can see what it’s like, erm, I don’t think, oh no I have done a…, but that was when I was based in an inpatient OT erm so if I did see anything then I would ulysses it and take good pictures and get people involved erm, but yeah anything above the big panels, I have not seen.

PC: And a final question really and it’s kind of a biggy, what would an ideal world look like for you in terms of pressure ulcer prevention?

P3: None at all. It would be having, just having everything to hand and being able to get, if there is need for equipment, get it quickly but be able to maybe change, it’s changing the mentality isn’t it, it’s looking at the prevention as more of a get up, move about, being normal as it would, rather than let’s just throw equipment and that will do, because I think we need to, we’re very good at saying oh no no you’re a falls risk so don’t move, although we know that the less you move, you knock your proprioception off, your mobility’s going to go and everything happens rather than actually get, the benefits are keep moving, get up and about. I see that as more of a prevention, I mean have the equipment, yes by all means but they need to go hand in hand because one’s not going to just do it, and then checking the equipment because you know, if you’re sat on it 24 hours a day the likelihood that it’s going to wear out within 6 months to a year, so yeah.

PC: Perfect, any other comments or burning things that you wanted to say?

P3: I will think about things probably later on, erm, no

PC: Well there’ll be the second interview won’t there?

P3: Yeah, I think from my point of view I try to talk about it and make sure people are aware of it and if I don’t get to visually look at it then at least give them all the information erm and try and get people up an moving and prevention. I think we’re very good at reacting, being reactive rather than proactive so… I think that’s NHS wide but erm we could be better.

PC: So that’s more of a symptom overall than just pressure ulcers?

P3: yeah, but I think even with pressure ulcers sometimes we can be a bit more reactive than proactive necessarily, but I think the, the focus is on it more here of actually you know let’s get in there and do it erm, but, from this team the focus is, I don’t know about others. I think that’s about it.