Interview 5 – Physio

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

P5: Erm, It’s probably pretty much everything I do and go and talk to with the patients because physiotherapy in my team is about maintaining mobility and and so every part of that is getting up, erm, reducing pressure, keeping moving, get the circulation going erm, it’s about allowing them their independence so they’re not relying on people to to wash, err, it’s about getting up and getting their meals, you know, all that side of things erm and I think it it’s interesting because we work very much alongside our occupational therapy colleagues erm, the nurses are there as well but because we don’t share office space there there’s very much, and so my idea of of prevention is is much more active than, because of my OT colleagues who take on the more long term seated erm, very static lying postures and that’s not necessarily where they use my physiotherapy skills.

PC: Okay, but you see a direct link between your own role and your profession and the prevention of pressure ulcers?

P5: Yes, oh yes, yeah

PC: So, within the team would you say that it is a whole team perspective then when you’re looking at pressure ulcer prevention?

P5: In what way, because the whole team won’t look at the, at an individual patient, it it, I take ownership once the referral comes through so then its, it’s my responsibility to, along with all the other considerations, when I’m looking at treatment regimes and aims and plans and things like that, to look at, you know, the pressure care and then I’ll take a lead in that. If I need to look for other erm, other professions to help I’ll call them in, but I wouldn’t, I’m not quite clear maybe about how a whole team would look at one patient that’s on my caseload.

PC: I suppose within that I meant like err collaborative working, joint working if you like with a different profession?

P5: Yes, I think while it’s preventative it would, I would be the one to take ownership of that. If I discover a pressure ulcer or even something that looks like a pressure ulcer because I’m not the one with the skills within the wider team I would call in my district nursing colleagues, my occupational therapy colleagues, but if nothing’s there I just identify that the patient’s particularly static erm or malnourished or doesn’t attend to their personal care that would be me.

PC: And so identifying some of those risk factors for pressure ulcers and acting on that?

P5: Yes, but I, but I would also see that I’d look at the patient holistically. I wouldn’t say, just because they’ve got weak quadriceps muscles and can’t stand up that I wouldn’t necessarily think about what their sacrum looks like erm and how they’re toileting.

PC Okay, do you think that’s err, that perspective that you have as a physio is shared by other members of the team, other physios, OTs, nurses?

P5: I would suggest to you that it depends, and it’s not on their, on their clinical role, it’s much more about their experience and obviously I’ve spent a lot of time working and have built up a wealth of experience, not necessarily in the community and looking specifically at pressure ulcers, but looking at mobility erm and probably having the confidence erm to identify areas that I, I would think would be a danger, rather than, than maybe negating that because I don’t see it as a threat to my professionalism or anything like that.

PC: Okay, is there that attitude for some do you think?

P5: I don’t think meaningfully erm, but, but we’ve all been junior at some point and and there is a temptation with pressure care erm to, for it to be a little bit of blame if you don’t notice things quickly and I think the team has changed, but when I first started it was, it was very much erm, something to be afraid of erm and that draconian things would happen if you hadn’t picked up a pressure ulcer or a risk of and erm, so the team changes doesn’t it, things very static and I think there’s a much more open attitude nowadays which it it comes from above and also from the team, you know the level that we’re all working at.

PC: Okay, so would it be fair to say then it’s coming from individuals, the team and the organisation as well?

P5: I don’t know how much they were concerned about me arriving into the team erm with my experience and so they, they kind of were maybe making me aware that I should have it at the forefront of my mind and now they’ve seen how my attitude has changed towards pressure care that makes them more relaxed or whether it was a more erm not the team, but but erm the sort of xxxxxxx xxxxxx [the trust] attitude.

PC: Okay, what’s the sort of awareness within the team of erm the different role, roles of different kind of professions in relation to pressure ulcers?

P5: That’s a really good question. I think there’s a reasonable amount of awareness the more senior in any profession, the more sophisticated their, their reasoning is as to when they’re referring through to the different, the different professionals to give their advice and opinions erm or management. It’s, yeah [laughs] it it it’s sometimes because we are all incredibly short of time, the referrals come through and and it’s you can question sometimes what you are being asked to do because it falls back into stereotypes or erm maybe the people you’d question why they’d given you the the role when they were already visiting the patients and could perhaps have taken on that role themselves and maybe have done that in the past, but all of us run hectic lists and we know that we we take our personalities with us in the job.

PC: And your experience

P5: And your experience, so if if they feel the need to ask me to go in as a physiotherapist I may gently question that sometimes with some people, but if they have asked me, they’ve obviously identified a need and I will go in.

PC: Within that, if you’re being called in by different professionals and knowing that there’s an increasing level of complexity in the community, which is fairly well documented (P5: Yeah) , is there sort of a direct correlation with, you’re called into the more complex patients to provide your opinion?

P5: Sometimes yes, yeah definitely and then of course it’s completely appropriate because I am the one with the specialist physiotherapy skills and and likewise I, I would expect my nursing and occupational therapy colleagues to help out, but also when you get extremely complex patients, what can be extremely valuable is doing combined visits so you’re not just taken to the patient and dumped into a situation and so the other day there were, there was a nurse, occupational therapist and a physiotherapist in with the patient. How amazing is that, the patient I’m sure felt a little bombarded, but if one person asks the question there are three sets of ears listening to what the answer is and erm you try and make the decision with the patient there, which is also quite good, rather than it tending to be a a corridor conversation or on the phone, guessing what the other person’s said, so you know there is that option yes.

PC: Now I understand that with this integrated team that you’re in two locations here. How much of that has an impact on collaborative working? The actual kind of structural being in different locations?

P5: Less than you’d think, erm, in as much as I tend to think I’m based at another site, but the, but the incident that happened with all three of us that were in the patients came from, from a referral from here at [the hospital] so they’re obviously confident erm, there aren’t huge numbers of professionals, it’s not like a big huge general hospital, so you get to know each other quite quickly.

PC: Okay, and kind of within that, that I suppose that kind of informal erm I mean you mentioned before the sort of hallway discussion of actually seeing somebody, erm, is that an important factor?

P5: Yes, why is it important? Erm, it’s because you can get across subtleties that don’t come across with a profession to profession referral , so it’s easy enough for them to, or for me to start of a referral to one of my colleagues, but how much better is it to communicate, erm, and to allow them to ask questions so that you can put across the subtleties and and I always feel more confident when I go out to see a patient when I’ve spoken to whoever it was who started that referral and called me in.

PC: Okay, erm, do you think there are other barriers to collaboration?

P5: Apart from time? Yes, in the community, huge, because the area, the geographical area we cover, erm, training, holidays, the logistics of it and and whatever team you work in it’s it’s the curse of the NHS in some respects, is because we do have, right from the get go a a an idea that each one of us is particularly special. We have, well certainly when I trained, it it was very erm we know you trained as a physio and and the occupational therapists and the nurses were trained in a very different area and erm it’s only when you start working together erm and ultimately you work together for the betterment of the patient, but there are always issues behind that, you, you, the NHS constantly tries to get everybody to work generically to get these healthcare assistants work across the boundaries and it just, for whatever reason, it’s still, I have never been in a team where it’s particularly gelled and been efficient.

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PC: Do you ever make any contact, thinking about the wider MDT, so I understand there’s a geriatrician linked to the team, so with the geriatrician, with the GP, with podiatry, dieticians any kind of other service in relation to pressure ulcers?

P5: Yes, they’re, they’re not my first port of call and erm, but yes, more often than not erm I’ll use the internet a lot to communicate so write down erm emails to specific people err I refer to orthotics quite a lot, where else do we go, erm, spend a lot of time on the, on the erm TCES ordering equipment erm, I don’t tend to to go and to the MDTs erm, I’ll write and email the GPs, phone sometimes, phone’s not ideal, because like us, they’re never in the office and there was something else I wanted to say then and I can’t remember what it was now, oh yes, there are some other professionals, because I write my records electronically I would expect them to review my electronic records, so if I know that that err the geriatrician would be able to access my notes then I wouldn’t do anything more than that.

PC: I understand at the moment there’s a two system, system going on?

P5: We’re a part of a trial for a second system but it’s only for some of the team it it’s not a problem for them, they they they either have one or the other, it, it’s for those of us that work across the two patches, for us to struggle with, erm, that’s just what happens.

PC: Do you ever make contact with any of the tissue viability team or the…?

P5: That’s a very good point, no erm, yeah, that’s because tissue viability are are and have been involved with some of the patients on my caseload err and err, well that’s an interesting point, they’ve, they’ve been contacted by the, the district nurses, they haven’t ever with the, the record that I’ve observed err made me want to contact them and it hasn’t influenced my side of the advice for management and things like that, but yeah, I mean it’s yeah.

PC: And what about, because I understand there’s another service, the AHP clinical advisory team as well. Do you have any contact with them?

P5: I haven’t yet, erm, I’m aware they’re out there

PC: And probably, there may be two or three more questions if that’s alright? (P5: Mmm [agreeing]) Just thinking about from a leadership, you know within the team and more widely actually in the trust erm, are pressure ulcers a focus for leadership do you think?

P5: A focus for leadership.

PC: What do leaders focus on?

P5: Yeah, okay, alright, erm, I think they probably do, but that’s a very personal opinion because I, this is my first experience of working for a community team so it’s been quite a shock for me as a, as a very acute based physiotherapist where my role for pressure area care has always been quite mobility focused, posture focused, but I’m now expected to, with my caseload, as I said before, take the lead and, and so I, I do, I do look to my manager quite often to just review whether I’m doing the right things, erm, and she’s always been very positive and has, had identified early that it was, it was a struggle for me to take on that side of, of my job, rather than, than having acute blinkers on erm to to open my eyes and have the privilege of being inside their house to to look at the, the, the impression about what’s happening and whether that, that’s give the the the same sort of whether you get the confidence from what you can see in the environment, what the patient’s actually saying to you.

PC: And within that er, equally for leadership do you think collaboration and joint working is a focus?

P5: Yes

PC: Locally and more widely

P5: I’m now talking about my immediate manager and it is, yes, because they manage combined teams, so, you know, and and when I’m discussing management issues that my manager has been very good about directing me as and when it was required. I’ve not necessarily needed to go the, the higher levels to know whether and, and that hasn’t influenced my day to day caseload management.

PC: Quite a generic question, which I’ve asked, I mean everyone gets these questions basically, but in your opinion what would an ideal world look like in terms of pressure ulcer prevention?

P5: I don’t think there is an ideal world because every, everybody has a different set of challenges. Are we going to say that everybody sits, you know has a low air loss cushion and mattress and as soon as they make contact with the team, no, erm. Would it be led by the patients, what do they think they need, well they don’t have the specialist skills for it. Do we need to throw more money at it? Potentially, yes, but that then gets awfully lost if it’s not focused, erm, so I, I, I’m actually relatively intrigued with pressure ulcers and pressure care, erm, because it’s, I’ve come to it, and it is the novelty value. So a lot of my day to day work is fairly boring and repetitive [laughs] so the pressure care is something that I’m new to and, and, and so I can sort of dip in and out of it erm and and you know that’s why it’s also nice to know that there are other team members that have a vast amount more experience than I do about it.

PC: And for you that wouldn’t have been the case before you came to the community, that focus on pressure ulcers?

P5: Not as, not in the same way, pressure care and movement, but not looking at the seating or the how to access the toileting and the personal care that they need and erm the nutrition, you know, how are they managing with their meals, no, I, that’s not where I was expected to to focus.

PC: Okay, that’s wonderful

P5: Okay, and obviously that, that’s a really personal, erm, input which is I guess why you’re doing a few interviews isn’t it