BRIDGING THE GAP

between current care provision

&

the psychological standards of burn care

Staff perceptions of current psycho-social care provision and their views of the way forward

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Changing Faces

with

the Centre for Appearance Research

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INTRODUCTION

Following the thousands of burn injuries sustained each year in the UK, individuals often undergo complex physical interventions, depending on their degree of burn, during the course of their treatment. The psycho-social impact of burns injuries is complex and is affected by the degree of physical impairment, individual characteristics (1-3) and to a lesser extent, the degree of disfigurement. The process of adjustment is experienced over a lengthy time span and can be a lifetime process in many cases (4, 5). The potential for psycho-social distress spans all age groups, for example in children and adolescents it is reported that some do not develop appropriate coping strategies and require additional help (6) in order to successfully manage the psycho-social aspects. For adults there are indications of a range of emotional problems (7) and distress (8). In addition it is not only the patients who are affected but there can also be considerable impact on the families (9). It is widely accepted that families would benefit from psycho-social support, which would also be beneficial to the patients since the social support from family and friends is positively linked with good adjustment (10, 11).

The implementation of the provision of psycho-social care is a crucial factor in the rehabilitation of patients. The guidance published by the British National Burn Care Group (NBCG) recognized this (12) and in the summer of 2007 indicated the guidance concluded that:

- there is consistent and incontrovertible evidence of psycho-social distress
- the extent and severity of the burn is not a good predictor of psycho-social outcome
- psycho-social factors are very influential for adjustment

Following the consensus achieved at a meeting in July 2007 concerning the Psycho-social Standards of care achieved during and after, the next task was to map the way forward from the status quo to an adoption of these standards within each burns unit in England and Wales. In addition and reflecting the view of experts in the field (13, 14) an important priority in implementing the tiered approach to psycho-social care was to achieve 'buy in' and ownership from the staff from all levels of the burn teams.

An additional aim was to give voice to care providers' views concerning the perceived quality of current psycho-social care. This has been seen as a crucial part of the by-in process by commentators such as Moss et al. (15). Studies have indicated that line staff such as nurses often find themselves inadvertently addressing psycho-social aspects of care, for example, appearance and body image issues. Some staff have reported feeling hampered in these situations as they do not feel sufficiently skilled or educated in providing psychosocial care (16, 17). Alternatively, they experience time constraints or do not have access to an environment conducive to conversations of a sensitive or personal nature (17). These difficulties can occur in both in and out patient settings. The research team considered it was essential that staff felt involved in the process of moving towards a more comprehensive model of care and that they had the opportunity to actively participate in this process (18, 19). The most appropriate way to elicit individual views on the current levels of psycho-social care, to maximize a sense of involvement with the process by the whole team and to document opinions on the best way to achieve these standards of care, was deemed to be a semi structured interview approach.

METHOD

Design and Procedures

A qualitative research approach was adopted in order to generate an understanding based on participants' views. The choice of one-to-one interviews places the perspective and experiences of the interviewee (20) firmly on the research agenda and is a valuable tool for examining the subjective experience and meanings of the participating individuals (21). In order to facilitate the subsequent analysis and the comparison of responses of all the participants a semi-structured interview approach using a SWOT (Strengths, Weaknesses, Opportunities, Threats) methodology was used. Using this structure, participants were asked for their views concerning the implementation of a tiered approach to psychosocial care.

All participants were informed that their contributions would be kept confidential and that individual responses would not be identified from the data. Outputs from the research would represent the combined views of staff from the burn centres/units in England and Wales.

At each participating hospital, the researcher established initial contact with a key staff member, who arranged the details of the visit. The researcher then sent out an explanatory e-mail to the contact person together with a paper version of the SWOT analysis and the documents "A Tiered Approach to Psycho-social Burn Care" and "Proposed Revised Standards re Psycho-social Rehabilitation" (see appendix I.). These were circulated to participants so that interviewees could familiarize themselves with the topic and have time to reflect upon the issues before they filled out the SWOT analysis, and prior to the interview being conducted. In order to generate as full a picture as possible, the researcher also asked if the contact person could distribute the material to other staff members who were unable to participate in an interview so they could return the information by e-mail or post to the researcher.

The interviews were conducted individually, or at times in small groups of two to three people drawn from the same profession (nurses, physiotherapists, occupational therapists or psychologists). The choice of an individual or group interview was made on the basis of time constraints and/or the interviewees' wishes. The individual interview lasted from twenty minutes to an hour depending on the level of engagement of participants with the topic of psychosocial care and their level of involvement with patients. The small group interviews lasted from thirty minutes to an hour. At the end of the interview, the researcher summarised the interview and asked the interviewee or interviewees if they felt that the content had been accurately captured. The researcher had no prior relationship with the participants or any affiliation with the hospitals visited. The data were collected between December 2007 and August 2008 (see Appendix II for list of hospitals visited).

Participants

The interviewees were from burn centres/units in England and Wales and the material were collected by either individual interview, group interview or the respondent completed their SWOT analysis and sent it back to the researcher for analysis, overall 76 respondents participated in the analysis. The respondents had from 5 months to 35 years of experience in burn care, with a mean of 12.6 years. In accordance to their level for the "A tiered approach to psycho-social burn care" displayed the following distribution, see table I.

Data Analysis

Incorporation of a phenomenological approach to facilitate the participants sharing their subjective perception upon on how the psycho-social aspects functions for both in- and outpatients at their work place was used. The participants responded in the themes of a

SWOT analysis, under the headings Strengths, Weaknesses, Opportunities and Threats. Guided by grounded theory, the content under each heading was analysed by using an inductive process (22, 23). As the material collected individually, in small groups, by e-mail or regular post did not vary systematically, all the data were analysed together. Constant comparison of the collected material during the coding process with the incorporation of field notes and memos generated commonality and divergence and certain themes emerged. Verification of the themes was achieved by re-examining the initial data and by incorporating data from new interviewees as the project progressed.

Level	People and professionals	Respondents
1	The whole burn care team (clinical and non-clinical staff)	11
2	Professionals with additional expertise such as nurses, physiotherapists, occupational therapists, social workers, chaplains, counsellors, play specialists	36
3	Trained and accredited psycho-social burn specialist/professionals' such as assistant psychologists, trained burn specialist counsellors, social workers, community psychiatric nurses	9
4	Mental health specialists such as clinical psychologists, psychotherapists and psychiatrists	10
5	Psycho-social Care Co-ordinators such as consultant clinical psychologists or consultant psychotherapists	10

Table I. Number of respondents in accordance to their level.

RESULTS

The following nine themes relating to participant perceptions of how the standards of psychosocial rehabilitation should be achieved emerged from the analysis.

- The need to integrate psycho-social aspects into overall burn care
- The need for liaison with other relevant services
- The levels of experience amongst existing staff
- Training needs

- Social issues
- Offering an environment conducive to psychosocial care
- Outpatient care
- Care of children and teenagers
- Psycho-social specialists

These themes are outlined below in relation to the strengths/weaknesses and the opportunities/threats perceived by the participants. In cases where views differed, detail relating to the tiers of participants (level I – III and level IV – V) are articulated.

Strengths/Weaknesses

The need to integrate psycho-social aspects into overall burn care

The majority of the staff at the burn centres/units focussed on the positive aspects of implementing a multi-disciplinary approach and how it is of paramount importance that the contribution of all team members are equally respected and prioritized in the course of the treatment of the patient. Participants expressed the view that psycho-social care should be fully integrated with other aspects of care and that each member of the team should be aware of the function of all other members in order to genuinely embed this care within the multi-disciplinary approach. The number of staff involved in the care teams was perceived to influence the functioning of this approach to psycho-social care. There was a tendency for staff working in smaller units to perceive these teams as functioning very well, however, staff from larger centres/units were less positive about the functioning of their teams. Although participants felt that all burn centres/units strive to incorporate psycho-social care within a multidisciplinary approach, many participants felt that psycho-social issues were overlooked due to heavy workloads or as the result of a lack of necessary knowledge. This was considered by many to be a significant weakness in current care provision.

The need for liaison with other services

Due to the complexity of caring for patients with burns, especially in relation to the psycho-social aspects of care, many participants emphasised the importance of liaison with services such as psychiatry, social services and psychology. It was felt that specialist

knowledge can contribute crucially to the psycho-social care of burns patients and where this liaison did take place, staff rated the contribution of specialists highly, viewing this as an important and crucial resource. However many participants felt that opportunities for liaison were limited due to time constraints and the lack of financial resources for specialists to contribute to burn care. There was a clear consensus amongst participants that these aspects of care should be considered and strengthened, particularly post discharge and, in relation to the resources, patients might need in order to successfully integrate back into their communities.

Levels of experience in existing staff

A major strength of existing care was perceived to be the experience of the staff currently working in the burn centres/units. Many of the interviewees had considerable experience, ranging from 10 – 40 years of service in burn care. Individuals with this level of experience, and who express an interest in psycho-social issues maintained that they had acquired some expertise as the result of working with their patients and realizing the importance of the psycho-social aspects in their rehabilitation. These participants felt that they currently provide a relatively good psycho-social service, but it would be helpful to have their knowledge and experience validated by specialists, as they lacked confidence in whether they were handling the full range of the psycho-social issues appropriately. For participants who were less experienced or who did not consider the psycho-social aspects care agenda to be particularly important, there was a tendency to focus on the physical aspects of the burn and not to address psycho-social issues. Staff stated that this was a deliberate omission on their behalf, as they lacked the necessary training to deal with these issues competently.

Training

Participants reported that in several burn centres/units, informal training in different aspects of psycho-social issues did sometimes take place. If teams included a psychologist (level IV – V) it was often this person offering the training. Since the training is informal, participants reported that it is quite common for staff to fail to attend, either due to staff shortages or to an emergency taking precedence over the training. Furthermore, it was noted that it is usually the staff who are interested in the psycho-social aspects of care who were most likely to attend while others tended to opt out. In all the hospitals visited, staff offered the view that a major weakness is that there is no formal or continuous professional

development (CPD) training in psycho-social care, especially for staff at levels I – III. Since this formal training does not exist, some of the participants felt this gives a signal to the wider team that the psycho-social aspects of care are not considered important by management or alternatively, that this is something individual staff should pursue on a personal level if they have a particular interest in the area.

Social issues

Many participants expressed the view that the social aspects of the psycho-social standards, are given too little emphasis. Several staff indicated how important it is to include a social worker in the team. The contribution of the social worker would be to provide and guide the patients with burns in relation to the help and assistance they can expect to receive from their community and social services. Those centres/units that do have a social worker consider this to be a particular strength, while those that do not have this resource consider this to be a significant weakness. Although some staff reported trying to help the patients address these social issues, often this is time consuming. In addition, specialist knowledge about the social system is required in order to facilitate the best help. Nevertheless, a genuine commitment from staff was apparent. Participants felt that if patients are preoccupied with issues such as how to pay their rent or feed their family following their injury this would be more pressing concern for the patient than how to adhere to a physical and/or psychosocial treatment plan.

Offering an environment appropriate to psychosocial care

It is very apparent that the provision of appropriate space to conduct psycho-social assessments and dialogue is highly valued by staff and patients at centres/units with this facility. Participants from centres/units that do not have these resources highlight this as a major weakness since at times they have to discuss psycho-social issues and attempt interventions on the ward or in other treatment facilities. The lack of a suitable allocated room is particularly a issue for specialists in psychosocial care (level IV - V) as an appropriate environment for therapeutic interventions is an essential requirement.

For those centres/units that have a psychosocial specialist (level IV - V) as an integral member of the in-patient team, this is considered a strength since accessibility to psychosocial care both patients and staff is easier. This level of service cannot be achieved

when the specialist has only a limited amount of hours allocated to burn care, and s/he is located outside the burn ward.

Outpatient care

A current strength of burn care was considered to be when the inpatient and the outpatient wards are integrated, as this means that the patients' transition from in patient to outpatient will remain within a familiar environment. Several examples were given of patients choosing to travel some distance in order to see the staff they knew and because the patients felt more comfortable and secure in a familiar setting. Not all participants from centres/units that do not have this potential felt that this was necessarily a weakness in current care, but all expressed the view that this facility would be an easier environment for patients to negotiate, and would offer greater opportunities for staff to establish a relationship that could endure during the treatment process. At some centres/units staff worked in both inpatient and outpatient settings. Even when these were geographically disparate, participants offered this as a strength of their service. The priority for all participants was seen to be a well established and enduring communication channel between staff and patients, and this was felt to be especially important in relation to the psycho-social aspects of care.

The majority of participants felt that the time allocated to consultations in the outpatient setting is often too limited, and that frequently there is insufficient time to address any psycho-social concerns. In the few outpatient centres/units in which staff have more time to address psycho-social issues during the outpatient visit, this was considered to be particularly valuable.

The provision of an outreach team designed to link hospital and community care was considered by participants to be a particular strength and resource. Staff felt that this allows them to see/experience the extent to which the patient has rehabilitated into the community and also to observe them functioning in their current home environment. This is also a setting in which patients may more easily be able to express concern over how their burn injury affects them in their day to day lives and in which psychosocial aspects can be addressed. Participants felt that a current weakness in provision is that there are very limited resources for this kind of outreach intervention. This was highlighted by staff across all tiers.

Care of children and teenagers

Staff working in the burn centres/units which specialise in the care of children and teenagers concur with the themes already outlined, but in addition expressed special concerns for their target group. Firstly, the majority felt that they do manage to address the psycho-social concerns of the children and teenagers and their families, especially during the inpatient phase of care. Many have resources to address presenting concerns, including the ability, in most instances, to allocate sufficient time to these concerns.

Another important priority was felt to be the capacity to help young patients to deal with pain and anxiety. The majority of participants felt that they were able to address this need, and play specialists are perceived to be particularly important in this regard. For teams without a psychosocial and/or play specialist, the provision of this resource was seen as a priority. Participants felt that being able to provide an effective service to help young patients deal with painful procedures and other psycho-social concerns was a source of immense satisfaction.

Being able to have an age-appropriate environment that incorporates and addresses the different requirements that children and teenagers have was perceived by participants to be an important strength. This included the opportunity for children to play indoors or outdoors, a family room and appropriate age related informational and play materials for children and teenagers. Having a room where the parents/family members can retreat from the ward and talk to the staff or other parents was deemed to be particularly important. Additionally, if there are overnight rooms/apartments available for parents/families who have a long commute to the hospital this was thought to be advantageous.

Despite some optimism about current care provision participants felt that they did, on occasion, miss psycho-social issues due to lack of time, insufficient staffing or lack of training. All of these were perceived to be significant weaknesses.

Psychosocial specialists

It is recognised as a strength to have psychosocial specialists (level IV – V) involved in the inpatient teams, especially when the specialist is located on the ward and is easily accessible by both patients and staff. The opportunity for patients and staff to have informal conversations with these psycho-social specialists is seen as a very valuable resource and an important mechanism in the integration of psycho-social aspects into burn care. Many staff expressed how much they value the informal training they receive from the psycho-social specialists and wish they had more time to devote to both informal and more formal training.

It is perceived as a weakness within a team when a psycho-social specialist has only limited hours allocated to the burn ward, as this results in only formal and scheduled conversations taking place with very limited opportunity for informal consultation. Thus, staff from all tiers believe that the psycho-social specialists are an important part of the team and have a crucial function for both patients and staff.

The psycho-social specialists themselves believe that they are an integral part of the team, and that they have an important role to play for the patients, their families, relatives and friends. Furthermore, psychosocial specialists are viewed as an important resource and support for staff as well. The participants thought that the psycho-social standards were a good tool to emphasise the much needed presence and importance of psycho-social specialists on the wards.

When addressing the broader picture of psycho-social care, many articulated the benefits of raising the profile of this aspect of care in all teams. Many felt the appointment of psycho-social specialists at all centres would facilitate collaboration between teams. Common protocols for audit and agreement concerning process and outcome measures would be facilitated. Many acknowledged the need for research to increase understanding of psychosocial adjustment to burn injury. Many highlighted that this was a particular priority for the outpatient group since there is inadequate information on how patients adjust in the long term.

Opportunities/Threats

The integration of psycho-social aspects in burn care

There is a clear consensus amongst the staff who participated in the study that efforts to integrate psycho-social aspects of burn care in the future will continue and the momentum is likely to increase, as more professionals and policy makers acknowledge the importance of psycho-social factors in adjustment following burn injury. Participants stressed that they felt it to be crucial that all staff members buy into the psycho-social guidelines. There is a threat that staff who feel alienated from the process will be inclined to leave psycho-social aspects of care to the specialists. This would undermine the ethos of a whole team approach to the psycho-social standards and provision of care.

The need for liaison with other services

With an increased awareness of the importance of psycho-social care, participants felt that the need to liaise with other specialist services had increased, and that this was an opportunity to increase the expertise available to patients. They felt that this kind of specialist support would increase the chances of providing an optimal burn care service. The major threat articulated by the participants is that the specialists from other services do not have time allocated to offer and maintain an appropriate service to burn care.

Training

Participants from all tiers expressed the view that the provision of training in psycho-social aspects of care is crucial in a tiered approach to care delivery. The possibility of establishing training opportunities is seen as an exciting prospect. The main need is perceived to be training for staff occupying levels I – III since they are the ones that interact most with the patients with burns. Staff operating at level IV – V feel they rely on staff with less expertise to identify and report psycho-social distress. Those in roles in the lower tiers could also conduct straightforward audits, and perhaps some routine psychological assessments if they receive appropriate training. The majority of staff in levels IV – V were of the opinion that the psychological training they have received in the past has equipped them to deal with some generic aspects of care, however, to have additional CPD focussing on specific aspects of psycho-social care was perceived as desirable. Furthermore, the prospect of establishing a

network of specialists and of holding regular collaborative meetings was also viewed very positively. This could possibly occur in conjunction with CPD training. Participants felt that this training should be timetabled formally and delivered in a location away from the burn ward, as there is always a threat that if staff are on site they might be called to cover staff shortages on the ward . The main threat articulated by participants was that signs of psycho-social distress might be missed, if (as currently), the majority of staff lack the necessary knowledge, training, experience and skills. Participants also expressed the view that in the current care provision, there is an insufficient allocation of resources and time to deliver psychosocial care effectively.

Social issues

The main opportunity for the future was described as a greater emphasis on the social aspects of care. Participants favoured the inclusion of a social worker in the burn team, preferably full time. This prospect was seen to offer considerable potential benefits for patients and families both during hospital stays and to an even greater extent, in the period following discharge. Once again the major obstacle was perceived to be a lack of sufficient funding and time.

Offering an environment conducive to psychosocial care

Staff expressed the hope that the greater emphasis on psychosocial care would lead to the opportunity to move to newly fitted wards which would include the provision of an environment more conducive to discussions of a sensitive or personal nature. Several participants felt that the possibility of raising the consciousness of management about the need to improve current facilities was an important opportunity. However, others were more pessimistic, expressing the view that there was little or no chance that the current environments would be improved. They saw this scenario as a significant threat to the provision of good quality psycho-social care.

Outpatient care

Many participants expressed the hope that outreach services could be established or increased in order to provide psycho-social help in a more effective and appropriate way

during the post-discharge and longer term rehabilitation phases, especially if effective liaisons with community services could be established. Staff are particularly concerned to address the needs of those who have never been inpatients, as they feel the psychosocial agenda of care can be ignored for these patients. Improvement in this area is perceived as being important and a variety of suggestions were made to this end, such as the provision of a psycho-social specialist in the outpatient setting. Once again, participants saw time constraints, the lack of staff and insufficient funding as the greatest threats to implementation in the future.

Care of children and teenagers with burns

Although many issues outlined above are also relevant to the care of young people with burns and their families, participants were excited about the opportunity of being able to support this group more effectively, especially in relation to outpatient care. Ideas included the provision of support for the reintegration of children back to school. Moreover, with an increased focus on achieving the psycho-social standards there could be an opportunity to increase the number of places available at burn camps as well as providing specialist camps for various age groups. Another suggestion was that staff should be paid for their work at the camps. Currently many staff volunteer for this activity. Relying on volunteers in the long-run was felt to be a threat to the sustainability both of burn camps and other community activities such as support groups.

Psycho-social specialists

Participants rating themselves at level I – III felt that an important opportunity was the appointment of more psycho-social specialists as full time members of the burn teams. Patients are felt to be in urgent need of this resource. The staff at these levels also stated that they want to be involved and included in the process of psycho-social care, and felt that if this does not happen, there is a threat that there could be an unhelpful segregation between staff at levels I – III and levels IV – V. The likely result of this would be that staff at levels I – III would be required to focus solely upon the physical aspects of care, leaving the psycho-social aspects to the staff at levels IV – V.

The psycho-social specialists expressed the view that the process of implementing the psycho-social standards presents several opportunities, and believed that the greater

investment in staffing will enhance the psycho-social care of patients and their families. The opportunities they perceived as potentially beneficial included the following;

- staff at levels I – III receiving formal training in psychosocial care.
- more time being made available for all staff to focus on psychosocial issues with patients.
- the prioritising of the needs of outpatients.
- the possibility of networking with other burn teams in order to share experiences and ideas on a regular basis.
- the implementation of common audit process and outcome measures across teams as this will maximise the chances of advancing knowledge and understanding of psychosocial issues in care.
- the possibility of collaborative research across teams, especially in relation to increasing understanding the needs of the outpatient group.

The key perceived threat in this category was the familiar refrain of insufficient funding being made available to fully implement the psycho-social standards.

RECOMMENDATIONS

The following recommendations are based upon the participants' views of the best way to achieve the standards of care.

R1 → Encourage an ethos within the burns team that everyone 'owns' and is responsible for the psycho-social care of the patient and their family.

R2 → Capitalise on the expertise and experience of existing members of staff within the tiered approach.

R3 → Provide appropriate training and continuous professional development (CPD) opportunities for all members of the burn team in accordance with their level and require that all staff participate in training activities and access appropriate resources.

R4 → Integrate and liase with other relevant disciplines to achieve psychosocial care, including psychiatry, social services, etc and establish networks with other burn treatment facilities in the geographical vicinity.

R5 → Provide easily accessible and appropriate supervision for all members of staff.

R6 → Apply psycho-social standards throughout the patient journey, including conducting an assessment of patients' needs in relation to community reintegration and long-term rehabilitation.

R7 → Acknowledge the importance of social services and consequently consider social workers as key members of the burns team, and incorporate social aspects into the standards of care.

R8 → Provide appropriate facilities to support the effective provision of psycho-social care (eg private rooms for discussions, assessments etc); opportunities for staff to meet with the consultant psychosocial specialist both informally and by appointment.

R9 → Ensure the staff at higher levels of the tier are full members of the team (i.e. a full time presence for psycho-social specialists is required and they should be located on the burn wards) ensuring ease of access by staff and patients.

R10 → Maximise the commonality and continuity of staff between in- and outpatient settings and/or design a functional hand over system for inpatients who will become outpatients.

R11 → Longer outpatient appointments should be available in order that psycho-social issues can be addressed as necessary.

R12 → The provision of outreach teams should be considered, in order to enable to them to visit clinics in the community and/or visits patients in their homes.

R13 → Implement audit and research to increase understanding of the factors contributing to adjustment and positive outcomes and in order to develop an appropriate psychosocial service based on evidence.

R14 → Ensure sufficient specialist input to cope with the particular needs of children and adolescents.

R15 → Provide appropriate environments for children and teenagers, especially ones conducive to private discussion.

R16 → Management should allocate sufficient resources (in the form of funds for staffing, training, networking etc) in order to progress the implementation of standards of care.

LIMITATIONS

There are certain limitations in the methodology of this study that should be acknowledged in order to consider the results in an appropriate context. This study was supported by the NBCG in order to assess how different burn centres/units perceive and plan to move forward to the implementation of the psycho-social standards. Participants at each hospital understood this, however, some may have believed they were under pressure to produce evidence and to over-state how well they were currently meeting and already adhering to the psycho-social standards. The contact person at each hospital selected the various members of staff who would be interviewed by the researcher. There is a possibility that those members of staff were chosen as they were more favourably disposed to the implementation of the psycho-social standards and to psycho-social issues in general. This could have influenced the interview process. In some instances, staff did not have sufficient time to familiarize themselves with the proposed psycho-social standards and to reflect on them prior to the interview.

In order to address these issues, each interviewee was informed that all their responses would be confidential and that the results would be presented in a manner in which it was not possible to for them or for the hospital they work for to be identified. Furthermore, participants were informed from the beginning their subjective perceptions of how they viewed their psycho-social work/skills at the burn ward were of interest.

DISCUSSION

The majority of previous research in this area has focused on the psycho-social needs experienced by patients and their families. The data collected from staff in this study offers an important insight into the perspective of those involved in the delivery of care. The analysis of the interview data clearly identified several themes constructed around the SWOT framework. These were the issues that staff considered paramount to the successful

integration of the psycho-social standards into burn care. Participants expressed appreciation that they had been able to express their views concerning potential improvement to their work place and healthcare service.

To successfully implement improvements in any organizational setting requires consensus on all levels, together with appropriate funding and resources in combination with dedication. The interviewees displayed a tremendous dedication to their work and stated that the majority of their colleagues have the same dedication. All were committed to improving psycho-social care for those affected by burns whatever their perceived roles and responsibilities in this process [R1].

The need for training was highlighted by participants as a crucial component in achieving the standards for several reasons. Training for all staff at levels I – III would ensure that all members of the burn team have the same foundation of knowledge and would enable them to build an understanding of what their roles and responsibilities are in regards to facilitating psycho-social support [R3, R5]. In addition to this, staff with considerable experience in burn care who perceive themselves as offering good levels of psycho-social support, would also like to have their knowledge validated and extended by a programme of continuous professional development [R2]. This would increase their confidence in the care they are providing [R3, R5]. Psycho-social specialists (level IV – V) identified the need of staff at levels I – III to have a working knowledge of psycho-social issues, since the specialists rely on others to identify the individuals that could benefit from seeing a psycho-social specialist. This is especially so as not all psychologists are located on the burn wards and/or have limited presence [R9], while staff at levels I – III such as nurses, physiotherapists, play specialists and occupational therapists have a more continuous presence and more treatment interactions with the patients and their families.

There was a consensus from all participants that staff at levels I – III should become more integrated in facilitating basic psycho-social care than is currently the case [R6]. This would enable staff at levels IV – V to then address the more complex clinical issues and focus on other important components such as establishing and/or maintaining liaison with other services and establishing collaborative networks between hospitals[R4]. These efforts will facilitate opportunities for research and enable psychosocial specialists to establish common approaches across burn centres/units [R13]. Staffs at all levels believe that an integrated, tiered approach would be beneficial for in- and outpatient care for patients of all age levels. It will optimise the chances that psycho-social support is fully accessible, appropriate, proactive

and preventive as well as reactive, and also that psychosocial advice and support is available to staff as well as to patients and their families [R6]. Recent research by Wisely et al. (24) and by Phillips (25) have also strongly articulated these points.

Another essential component of a comprehensive service is the provision of appropriate facilities that are conducive for psychological intervention [R8]. These facilities should also incorporate the specific needs of children and adolescents [R15]. Specialized psychosocial support and intervention should be available for children and adolescents based upon their specific needs [R14]. Participants suggested that interventions should involve social skills training programmes and the opportunity to participate in burn camps, these views are supported by Blakeney et al (26)) and Cox et al. (27).

Participants felt another key component of psycho-social care is the incorporation of a social worker [R7]. The potential of having a knowledgeable person who knows how to access support and aid from social services, community services and other institutions, and how to support patients through the process of securing benefits was thought to be invaluable. Participants felt this would improve the chances of those with complex problems to focus on their physical and psychological rehabilitation.

As participants indicated, based upon their experience and understanding, it is crucial to provide high quality psycho-social care at all facilities that deliver burn care [R6, R11, R12]. This is especially so since research indicates that the physical characteristics of the burn (e.g. TBSA, depth, location) are not related to the degree of psycho-social distress (12, 28) and as and as several researchers have highlighted (9, 25, 29-32) that psycho-social problems can persist for many years post burn. It is particularly important that a smooth transition from the in- to the outpatient settings is facilitated [R10]. The chances of achieving a positive outcome in the longer term could be increased through the provision of an outreach team that worked from outpatient clinics and/or through visits to patients homes [R12].

CONCLUSION

This study confirms the commitment and enthusiasm of participants to improve the provision of psychosocial care for patients and their families. Many practical recommendations were generated for how progress might be made from the status quo to full implementation of a tiered approach to care.

The recommendations arising from this study are broadly in line with other studies discussing the provision of psycho-social care in the United Kingdom (24, 25, 33). The most significant barrier to progress is thought by participants in this study to be the lack of sufficient resources, in particular, investment in specialist staff and in appropriate training for all members of the burn team [16].

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APPENDIX I

Proposed Revised Standards re Psycho–Social Rehabilitation

From discussions at and after the NBCG Consensus Seminar in Bristol 09.07.07 regarding the best long-term care arrangements for patients with burn injuries and their families:

The following Standards for psycho-social care and rehabilitation of burn-injured patients and their families should apply – for which evidence would need to be available:

1. Appropriate psycho-social staffing is provided in the Burn Centre/Unit as recommended using the tiered approach.
2. Specific standardised protocols (including for referral and follow-up) for children, young people and adults are used to guide the delivery of a tailored psycho-social rehabilitation programme to meet the normal, non-pathological psychological and social needs of patients and families including access to self-help information, available support groups etc.
3. Psycho-social Assessment protocols are in place and properly carried out on in and out patients warranting admission.
4. After assessment, an individual plan of care is drawn up for each patient, if one is needed, of the interventions and actions to be taken by the burn care team.
5. Psycho-social outcomes are audited.
6. Regular follow-up and ongoing access to support services is available for adults and children, and their families (eg: via a phone line for patients and families to contact the burn care team).
7. Specific protocols are in place for the management of patients with psychiatric problems (eg: self harm, substance misuse), which broadly comply with NICE guidelines.
8. Access is available to a Liaison Psychiatry Service or on-call psychiatry, including arrangements that allow patients to be referred if they live outside the local Psychiatric Unit's catchment area.
9. Training on psychosocial issues is provided regularly to the wider burn care team, co-ordinated by the Psycho-social Co-ordinator.
10. A range of support systems for all burn team members are routinely available and accessed.
11. Appropriate regulation and clinical supervision is in place for all psychosocial staff.
12. Patients, families, groups of burns survivors and other related organisations collaborate and are involved in the planning and execution of patient-centred services including their psycho-social care.

Each Standard will need to be tested by seeking evidence from burn care teams.

October 2007

Proposal for the National Burn Care Group: A TIERED APPROACH TO PSYCHO-SOCIAL BURN CARE

Psycho-social care and rehabilitation should be an integral part of burn care services using a multi-disciplinary approach within a Managed Clinical Network of Burn Centres, Units and Facilities. The following principles recommended by the Psycho-social Working Party should guide all practice:

- Routine care: the integration of psychological screening and support for patient and family should be routine from the start of a patient's journey.
- Patient/family-centred: given the complexity and individuality of psycho-social needs, a whole-patient/family approach should be adopted.
- Psychologically-trained staff fully-integrated into burn care: psycho-social care should be "positioned" to be collaborative, routine and empowering.
- Psycho-social care (from the whole burn care team) and psychological interventions (by trained psychological therapy staff) should be distinct.
- Psychological advice/support and training for all members of the burns team should be routine.
- Tiered care: future psycho-social burn care and interventions should have a 'tiered care' structure as per NICE guidelines.
- Peer support: the value and importance of lay/survivor/peer support should be recognised in delivering psycho-social care.

Level	People and professionals	Activities	Competencies and intervention
1.	The whole burn care team (clinical and non-clinical staff)	➢ Recognition of psychological needs (including privacy and boundaries) ➢ Co-ordinated by level 5 specialist	➢ Communication skills to engage routinely with patient and family ➢ Awareness of signs of psychological distress ➢ Giving support, reassurance and information within an 'agenda of care' agreed for each patient taking advice and suggestions from the Psycho-social Care Coordinator
2.	Professionals with additional expertise such as nurses, physiotherapists, occupational therapists, social workers, chaplains, counsellors, play specialists	➢ Basic screening and identification of psychological distress in all patients/families, flagging up issues to level 3 specialists if appropriate ➢ Co-ordinated by level 5 specialist	➢ Relationship-building with patient/family, supporting expression of feelings and normalising common signs of distress ➢ Psycho-education to normalise and thereby contain anxiety ➢ Simple problem-solving; basic counselling skills (agreed framework) ➢ Identifying symptoms of psychological distress and understanding of when referral/input is needed from tiers 3+
3.	Trained and accredited 'psycho-social burn specialist/professionals' such as assistant psychologists, trained burn specialist counsellors, social workers, community psychiatric nurses	➢ Assessment of all patients/families for psychological distress ➢ Treatment of basic psycho-pathology (under supervision) including of risk, capacity, mental health issues, substance abuse ➢ Supervised by level 4/5 specialists	➢ Basic psychological assessment using interviewing and standard assessment tools ➢ Psycho-education to normalise and thereby contain anxiety ➢ Counselling and specific psychological interventions such as anxiety management and cognitive behavioural therapy (CBT)
4.	Mental health specialists such as clinical psychologists, psychotherapists and psychiatrists	➢ Diagnosis and treatment of traumatic stress (typical/atypical) and possible psychopathology ➢ Clinical autonomy	➢ Sophisticated psychological assessment of complex cases ➢ Specialist psychological and psychiatric interventions such as psychotherapy and CBT
5.	Psycho-social Care Co-ordinators such as consultant clinical psychologists or consultant psychotherapists	➢ Leadership of the psycho-social rehabilitation process for the whole burn care team including co-ordination with Network as a whole ➢ Managing a team of psychologists, psychotherapists, counsellors, etc.	➢ Oversight, support and clinical supervision of all staff involved in psycho-social care in the burn care team ➢ Co-ordinating teaching/training provision for the burn care team ➢ Clinical governance and quality assurance (including outcomes; child protection, referral pathways) ➢ Research and service evaluation including review/revision of clinical processes, clinical effectiveness and user satisfaction

APPENDIX II

VISITED HOSPITALS

Unit	Department	Hospital
Manchester	The Department of Burns and Plastic Surgery	Wythenshawe Hospital
Aylesbury	Department of Plastic Surgery	Stoke Mandeville Hospital
Birmingham	Department of Plastic Surgery	University Hospital Birmingham - Selly Oak
Birmingham Children's	Department of Plastic Surgery	Birmingham Children's Hospital
Bristol	Department of Plastic Surgery	Frenchay Hospital
Broomfield	St Andrew's Centre for Plastic Surgery & Burns	Broomfield Hospital
Chelsea & Westminster		Chelsea & Westminster Hospital
East Grinstead	The Department of Plastic Surgery	Queen Victoria Hospital
Liverpool	The Department of Plastic Surgery	Whiston Hospital
Liverpool Children's*	Department of Plastic Surgery	Alder Hey Children's Hospital
Manchester Children's		Booth Hall Children's Hospital
Newcastle	The Department of Plastic Surgery	Royal Victoria Infirmary
Salisbury*	The Department of Plastic Surgery	Odstock Hospital
Sheffield	The Department of Plastic Surgery	Northern General Hospital
Swansea	Welsh Regional Plastic Surgery and Burns Unit	Morriston Hospital
Wakefield	Plastic Surgery and Burns Unit	Pinderfields Hospital
Nottingham	The Department of Plastic Surgery	The City Hospital
Preston	The Department of Plastic Surgery	Royal Preston Hospital

*Interviewed on member/members of staff from Alder Hey Children's Hospital at another Hospital
*Phone Interview/interviews