Occupational therapists and digital care records: exploring health and social care integration through ethnography

**Key findings**

Occupational therapists in a Community NHS Trust and Local Authority use their digital care record (DCR) systems for similar purposes, within the wider contexts and demands of their organisations. They are used for receiving referrals, triage and allocation of caseloads, information gathering, record keeping of interventions, and monitoring/audit of clinical activity.

We found that occupational therapy staff are grappling with three key tensions.

- **Recoding versus recording.** There is a mismatch between the DCRs and the concerns of occupational therapy. Occupational therapists cannot simply record their interventions but need to translate, or recode, information to fit the structure and demands of the system.

- **Data processing versus occupational therapy.** DCRs are not neutral receptacles for information, but influence and shape practice and the nature of the clinical encounter. The records necessitate a focus on comprehensive data collection, risk management and adherence to standard procedure, rather than developing rapport and a therapeutic relationship. It requires expertise to combine the demands of the DCR with the concerns of practice.

- **Information versus communication.** There is a difference between information and communication. In the computational paradigm of DCRs, clinicians facing a decision problem turn to a computer-based system for support, and the information stored there. However, occupational therapists in this setting preferentially turn to people. It is through conversations and discussions – communication – they interpret information and decide on actions. Communication and collaboration are achieved mostly through telephone calls, email, professional relationships, and jointly agreed processes.

**Project aims**

The principal question was: *How do digital care records support or hinder integrated occupational therapy services across health and social care?*

The aims of the project were:

- To understand how occupational therapists use DCRs, and to what purposes.
- To examine the impacts of DCRs on work practices, and cooperation and communication within and between organisations. In particular, the impacts of using multiple DCRs in one health and social care system.
- To generate learning that can be applied in the research setting, and might have wider transferability for the successful development, implementation and use of DCRs.

**Background**

Collaboration between and integration of health and social care is a pressing issue. DCRs have been positioned as essential in promoting quality and standardisation of care, and reducing duplication, inefficiency and fragmentation.

Targets have been set that all patient and care records will be digital, real-time and interoperable by 2020 (National Information Board, 2014). This ambitious vision is matched in occupational therapy in *Managing information: a 10-year strategic vision for occupational therapy informatics* (COT, 2014).

There are indications, however, of a significant gap between policy and practice. Many occupational therapists do not currently use DCRs and staff complain of duplication and inaccessible data within and between organisations.

While there is much research into DCRs in medicine and nursing, mostly focused on acute settings (Greenhalgh *et al.*, 2009), there are no existing studies of the contexts and details of occupational therapists’ use of DCRs. There is a need for detailed investigation of the realities of occupational therapy practice if the profession is to use DCRs successfully for health and social care collaboration and integration.
Methodology

The research project used ethnography, specifically “evaluative ethnography” as outlined by Hughes et al. (1994). A guiding theoretical lens was the academic field of Computer Supported Cooperative Work, in particular the concepts of ‘boundary objects’ and ‘articulation work’ (Schmidt and Bannon, 2013).

The setting was community (physical) health and social care services in a metropolitan borough in the UK. We recruited 14 occupational therapy staff, seven each from a Community Health NHS Trust (primary care, community rehabilitation and rapid response services) and a Local Authority. Participants included occupational therapists, occupational therapy technicians, trusted assessors and clinical leads. Three DCR systems are used: EMIS Web and Rio (Community NHS Trust) and Azeuscare (Local Authority).

Data were collected by observing everyday working practices during use of DCRs, and by talking to and interviewing staff. In an iterative process, data were analysed using the constant comparative method. The NHS Health Research Authority granted approval on 15 September 2017. Ethical approval was gained from the School of Health and Social Care Ethics Panel, London South Bank University on 6 November 2017.

Conclusion and Recommendations

This is a small study, specific to its local context, but it has generated learning that might help bridge the gap between policy vision and practice reality in a positive way. It highlights the skillful and creative human work that promotes collaboration between health and social care. There are three key recommendations.

- **Be realistic about what DCRs are good (and not good) for.** In this setting, to varying degrees, DCRs are useful for receiving referrals, caseload management, information storage, internal communication and audit. They are less effective for communication across organisations, exploring and solving uncertain problems, and capturing the dynamic nature of the occupational therapy process.
- **Value and validate workarounds.** Workarounds (i.e. ways of working around, rather than through, the DCR) are everyday, effective and essential. We need to understand how to facilitate and improve workarounds, and consider what other processes (and technologies) might enable collaboration.
- **Influence organisational implementation of DCRs.** Given that local configuration to develop a better fit with work practices is possible, and the current largescale investment in DCRs via Sustainability and Transformation Plans and Integrated Care Systems, we need a strong occupational therapy (and allied health professional) voice to influence implementation.

Publications


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References


