Date: 20/03/2021

Time: 1500

Location: Dorset county hospital, private office.

Participant Role: healthcare assistant

START

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| Interviewer | Right, its recording. So, [participant’s name] you know me, I’m [interviewer’s name] we work together. What we’re doing is something a bit different today because I’m collecting information about you from umm… from hospital at home basically. What you think about it, how it works and so on. And you’ve read the information sheet? |
| Healthcare professional | Yeah |
| interviewer | And signed the consent form |
| Healthcare professional | Yeah, gladly consent to take part |
| Interviewer | Lovely job. And you know its recording? |
| Healthcare professional | Yes |
| Interviewer | And I’ll write it all up word for word. Cool? |
| Healthcare professional | Yeah that’s good for me |
| Interviewer | Let’s make a start then. Umm…tell me about the hospital at home service and what you do within it. Let’s start with that. |
| Healthcare professional | Yeah. So my…my job role as a healthcare assistant on the acute side is to support the nurses within the department and that’ll be in the patients home. So, that will be…so let’s say, from an environment aspect, it’s to make sure the patient has got everything they need. Umm…in that respect, that’s when we’re in there helping them its making sure they’re eating and drinking correctly and that they’ve got some food that sort of thing. Make sure their environment is safe whilst we’re in there…umm…umm…make sure that just…check that they’re washed and dressed that sort of thing, see if they need any support there. But the main, I guess, the main important duty is to support the nurse, the acute nurse with doing the observations, help with any dressings if that’s needed. And sort of just like, sort of morale support as well. |
| Interviewer | For the nurse? Or..? |
| Healthcare professional | For the nurse and the patient |
| Interviewer | Oh nice, I like that. |
| Healthcare professional | Yeah ‘cus I think sometimes the patient isn’t fully aware of what’s going on or how their treatment is developing. So it’s, it’s just a bit of encouragement really to just get a bit of feedback really |
| interviewer | Right so what sort of thing takes…so you’re there with the nurse, what sort of thing takes the nurse there? What are you there for? |
| Healthcare professional | Well, obviously we’re there to treat the patient with IV antibiotics |
| Interviewer | Right |
| Healthcare professional | As the patient is still under the duty of the trust, of the hospital; we’re there to follow up the treatment in the community. To support their medical needs |
| Interviewer | Right, ok. So it was interesting what you said about checking they’re safe by checking their environment and that they’re eating and stuff. |
| Healthcare professional | Mmm |
| Interviewer | That’s something that I haven’t heard in the other interviews. So is that something you think is more *your* role as a healthcare assistant? |
| Healthcare professional | Yeah that plays a vital role. It’s all well the clinical aspect but we don’t really look at what the environment is really like because we’re only in there a short period of time, so it’s to make sure that they’re maintaining their needs when we’re not there. I mean, is there environment safe? What sort of thing are they… I mean, they might be living on their own; they might not have any interaction, they might not have any close friends or relatives or family. So it’s just, like, trying to make sure they’re maintaining their daily life needs. And if there’s anything we can do to add to that if they’re not getting, say, correct nutrition. We can get a nutritionalist or give them some suppliments things like that. Looking at their, are they managing their domestic needs you know…in that aspect how safe is the environment? Umm… |
| Interviewer | So you use the time you are there to assess those things? |
| Healthcare professional | I think you do that…I think you do that anyway as a professional I think you’d do that. You’d look at the peripheral things around what you’re offering as a service, not just from a clinical side. Well I do, I do from a professional aspect I always look at things just to make sure everything’s going on. Just asking the question; “what did you have for breakfast this morning?” “are you taking on enough fluids?”, “are you drinking properly?” all these little things you know? But, umm…it’s all things, you know, you should be asking… |
| Interviewer | Mhmm |
| Healthcare professional | …and enquiring about to make sure they’re being cared for holistically which is quite important. |
| Interviewer | Yeah. So you’ve got that information. What do you do with it? |
| Healthcare professional | Well I feed that back. So, you work with the acute nurse, that’ll get fed back when we’re supporting the patient as a team. |
| Interviewer | Mhmm |
| Healthcare professional | Then that will get fed back. If anything flags up that will get documented |
| Interviewer | Yeah |
| Healthcare professional | And that will be fed back then to the line manager or the sister |
| Interviewer | Okay |
| Healthcare professional | Or the manager of our department. So, we’re covering all the angles and not missing anything. If we have got any cause, or think the patient might not be getting enough nutrition then…then..they…if they’re low energy then they probably haven’t had a sufficient meal that day or umm…just kind of things like that. Just to have a bit of support. |
| Interviewer | Do you ever, support with those things? So if you went in and you found someone was not preparing their meals or something. When you’re on the hospital at home team would you..do you ever support with those things or do you just report? |
| Healthcare professional | I would, yeah. I would ask them if, you know, I would make them a cup of tea, I would offer them a simple meal if they needed it. Some toast. Because while we’re there and they’re having an IV…an IV infusion you’ve generally got, you know, you could have a good 45 minutes of time or an hour. |
| Interviewer | Right… |
| Healthcare professional | Depends if you’ve got dressings or other things. So, I think maybe as the HCA role it’s something else to be considering, you know. It’s…how long does it take to make a cup of tea and some toast. As long as you’ve got their consent and they’re quite happy to receive the support. I think it’s quite…it’s not, it’s not difficult tasks to, to perform to the patient. |
| Interviewer | Yeah. So sometimes you…no scrap that! So we’ve talked about nutrition, what other sort of things do you find? |
| Healthcare professional | Umm…obviously make sure that they’re managing their…umm…if they’re, if they’re incontinent, if they’re having problems passing urine all these sorts of things. Catheterised. We’re looking at all these things from a HCA aspect. Especially where they’re still an inpatient within the trust you’ve still got to provide the same sort of service from a HCA perspective. That they would be receiving if they were still on the ward because we’re supposed to be a virtual ward and that’s what you’d want to be looking at…umm… |
| Interviewer | Yeah |
| Healthcare professional | I think that’s quite important that we manage all these. We’re dong observations and checking their vital signs and we’re checking that they’ve been to the toilet, have they urinated, have they had their bowels open, all these things. So you’ve got to follow this process up. ‘oh no they haven’t, so let’s do something about that’ |
| Interviewer | Yeah |
| Healthcare professional | I think all these things are quite vital to provide the same service you do when you’re on the ward. And I think that’s quite important. |
| Interviewer | So do you measure yourself against the ward? Not ‘measure’, maybe that’s not the right word but do you consider that that’s what you’re trying to do? That you’re trying to match the standards |
| Healthcare professional | Yeah. I use my skill set that I’ve learnt within a ward part, within the ward structure and then brought it out into the community. Because they are still part of that system aren’t they? Patients. And the clinical systems of the department so the patient gets discharged out of the hospital… |
| Interviewer | Right… |
| Healthcare professional | On the proviso that they’re now, they’re in their own home but they’re still under the charge…under the clinical care and charge of the, of this department; Acute hospital at home. So you need to provide hospital service |
| interviewer | So it’s part of the hospital? |
| Healthcare professional | Yeah part of the hospital |
| Interviewer | So they’re discharged to the community but they’re still under a trust? A hospital service? |
| Healthcare professional | Yes. They’re still under the clinical support aren’t they. Bacuse they’re not discharged into their community GP service so I just feel that it’s nice to bring that…the skillset that a HCA would know, and have an understanding of, from working on a ward |
| Interviewer | Okay |
| Healthcare professional | Just to make sure you maintain that, because you still have to provide that service as they would been an inpatient otherwise.  It’s a bit of a fine line because they are at home. So you’ve got to treat them as they’re in their own home environment but we’re still providing that clinical service…umm… |
| Interviewer | So they’re supposed to be getting the same clinical support as someone in…as if they were in a hospital ward? |
| Healthcare professional | Mhmm…yeah. Because obviously on a ward they would be receiving their IV antibiotics wouldn’t they? But also receiving all of that nursing support over a 24 hour period. so it’s nice that we’re going in and backing them up; and given that they’re still part of the hospital system it’s nice to make sure we maintaining all the other things that would…because we are controlling their medicines aren’t we? We’re still, we’re still, so we’re still controlling and making sure that they’re taking their medications correctly and we’re giving IVs, we’re making sure they’re managing thir oral antibiotics. And we’re also supplying them with medications from the trust, from the hospital… |
| Interviewer | Mhmm |
| Healthcare professional | So, I think that’s good to follow that up like you would if they were still on the ward until, obviously, they’re well enough and discharged back into the community service. |
| interviewer | Okay. You touched on earlier that you were there for 45 mins to an hour… |
| Healthcare professional | Yeah depending on the treatment |
| Interviewer | And how many times? Just once a day or…? |
| Healthcare professional | I mean, if it’s…I mean it could be TDS, three times daily or it could be…if a patient is on a 24 hour pump then it’s just once a day. |
| Interviewer | Yeah |
| Healthcare professional | So that does tend to vary |
| Interviewer | But then you’re trying to…provide…umm…hospital level clinical stuff within one visit within one hour compared to a 24/7 hospital stay. What do you think that’s like? Do you think that works? |
| Healthcare professional | I think…well I tend to find that are obviously, there are, there are grey areas of support. Especially when you go from the more twilight, evening services. Where probably the level of support tapers off. |
| Interviewer | Right? |
| Healthcare professional | Whereas in regards to the service, it finishes at midnight and then there’s nothing else other than if they’re having a medical emergency it’s 999 or 111. There’s not, there’s no, there’s no, there’s no real support thereafter. |
| Interviewer | Okay. |
| Healthcare professional | Umm…which is something that may need to be looked at…umm… |
| Interviewer | So…they…must…there must be a certain degree of patient or something? Your typical patient…in my experience so people who are in hospital, that sounds like something that wouldn’t work for them, only being seen an hour a day. So you must have a sort of typical patient? |
| Healthcare professional | Well they’re, I mean, they’re, our acute patients are well vetted for suitability for the service. That’s quite an important thing. Umm…theyre, well we have to look at what their infection markers are so that we can effectively support them. |
| Interviewer | Yeah |
| Healthcare professional | So that’s quite, you know…if there infection markers are above a certain value then we wouldn’t be able to manage them for the time frame needed to support them. knowing the statistics we have on the other patients they umm…the success rates of the treatment of a patient with a certain rate of infection, anything that’s above that infection rate…and depending on their health issues, I mean, you know, that does obviously, their particular health issues has a massive impact on what support we can give them. |
| Interviewer | Right…do you mean what you’re treating them for? |
| Healthcare professional | Yeah I guess what their medical need are. If they’re palliative or they’re terminal illness problems that you can…I guess the IV is having an impact but they’re not really curing… |
| Interviewer | Right… |
| Healthcare professional | Then obviously the amount of time you’re going to spend with that patient is going to be excessive and there may be other patients that are more suitable to the service depending on their, on their type of infection or how we treat them. |
| Interviewer | Yeah. So, that’s their suitability based on how unwell they are from infection markers and so on |
| Healthcare professional | Yeah |
| Interviewer | What else would or wouldn’t make someone suitable to be at home and seen once a day instead of being in hospital 24/7? |
| Healthcare Professional | I mean they might not have the environment. I mean, they might not…there might be issues with…they might even be homeless and have nowhere to live, or be in temporary accommodation or living with a relative |
| Interviewer | Are these people that you can’t take that you’re listing here? |
| Healthcare professional | Yeah. They are, whatever the umm…the protocols are for selection |
| Interviewer | Yeah |
| Healthcare professional | Of a patient, that they fit, they fit the right criteria. There must be the right environment. We do an environment risk assessment to make sure it’s safe to go in and support the patient. So there is a lot of protocols in place for that to take an effect to make sure the members of staff are safe going in, the environment is safe…umm…that you, we wouldn’t as…it’s difficult because there’s all these factors that are happening and sometimes…I mean it’s all very well documented on paper but in reality what is happening is that you’re faced with environments that isn’t safe and secure. And getting the support and feedback for the patient and the staff its, it’s sometimes a big gap where you just need to, you need more impetus for something to happen to make that… |
| Interviewer | So where would this ‘unsafe environment’ be picked up? Are you picking it up once you’ve gone in? |
| Healthcare professional | Yeah you pick it up. So, when the patient goes home we do the first visit. Obviously we visit the patient on the ward and check them and try and strike up a rapport and trust that we’re going to provide a service and that they consent to it. Then when you get the first visits when you go to treat them with IVs |
| Interviewer | Yeah |
| Healthcare professional | You don’t really know what their environment is like until you walk in over the threshold and you’re invited in |
| Interviewer | Mmm… |
| Healthcare professional | Then other things start to become aware. What the patient’s needs. What their needs are might be different because of their environment is like. No bit of paper…even if it’s a social service report or something, how it was written sometimes doesn’t have a realistic impact on what it was like when you walk through the door. |
| Interviewer | Yeah |
| Healthcare professional | And the other… the other realistic implications that you might be faced with, that the team might be faced with. And you know, it’s, it’s umm…it’s, it’s it’s it’s it develops within the support you give. As you are supporting the patient things develop |
| Interviewer | What do you mean develop? |
| Healthcare professional | Within the environment and with the patient and the team. Like, umm…obviously a level of trust gets built up and an understanding and sometimes it’s things that can cause little rifts, maybe with trust. |
| Interviewer | You said, as your trust and rapport builds thing develop. What do you mean ‘things develop’? |
| Healthcare professional | I mean things develop with regards to the security of knowing the patient is being provided with. |
| Interviewer | So you find things out? |
| Healthcare professional | Yeah. You learn, you start developing, learn, start developing things more..’oh I didn’t realise the patient is having this type of treatment’ or sometimes they might be having a more, they might have an external support coming in and they’re having a district nurse coming in. There’s things coming in. there’s always things that might have an impact and you’re learning as you’re supporting them. a patient that you’ve never met, they’be never met you, they’re having a service from the part they are being supported from.  Thet get one visitations, or two visitations from the nursing team who goes to see them on the ward before they’re discharged and then we walk into their lives and go ‘right!’ and we identify ourselves by showing our ID. We’re also identified by the uniform we wear but then we have to build on that trust that we’re providing. |
| Interviewer | So in summary, do you think when you get there to see a patient you find things that wouldn’t otherwise been find? |
| Healthcare professional | I tend to find also that sometimes, also the…how the department is umm…portrayed and advertised within some departments with the hospital…our service isn’t delivered well. There’s lots, there’s…how would I say it…sometimes it’s a bit insufficient how some members of staff deliver our service to the ward aspect. So the ward might not understand what the Acute hospital at home service delivers so we then get portrayed as a care team. So sometimes our service isn’t packaged correctly. “You’re going to get this service. This is what the team will provide for you” |
| Interviewer | Yeah |
| Healthcare professional | “this is how it works”. So sometimes I think the teams ethics isn’t portrayed well from the wards that when sometimes when patients go home they don’t really know what to expect. |
| Interviewer | So they go home under the impression that you’re doing other things? |
| Healthcare professional | Yeah! |
| Interviewer | Or that you provide other things? |
| Healthcare professional | Yeah and they don’t identify who we are. Obviously, we’re showing our ID badges and uniforms but sometimes it gets diluted because they’re not sure. They might have two or three care providers coming in. |
| Interviewer | Oh really? |
| Healthcare professional | So sometimes there’s a little bit of confusion where that’s concerned |
| Interviewer | Over what you do and don’t do? |
| Healthcare professional | Yeah. Yeah |
| Interviewer | Okay. So some…umm…yeah okay |
| Healthcare professional | I just think it’s sometimes how our service is delivered via the ward staff that are discharging to our service… |
| Interviewer | Yeah… |
| Healthcare professional | Sometimes that gets, the functionality of what we do isn’t all there |
| Interviewer | Right. |
| Healthcare professional | The package that they’re offered, they don’t fully understand what they’re going to receive. |
| Interviewer | So what happens then? They go home and they’re expecting something else from you but you cant provide it… |
| Healthcare professional | Yeah because thy haven’t got the full information about what the service is about |
| Interviewer | So does that leave a gap in the support they have? |
| Healthcare professional | Yeah it would do because they don’t really realise, not all patient, some don’t really realise what the acute service delivers |
| Interviewer | So what happens then? |
| Healthcare professional | So we would then say ‘right! we can do this for...’... it’s like medications…some patients that don’t realise that when they’re discharged to hospital at home that we can order their medication from the hospital pharmacy because they’re still part of the hospital system, part of the clinical systems from the hospital. So we can provide and order their medication. So sometimes are like ‘oh I didn’t know you could do that for us!’ ‘oh yeah, let us know, we will go through your medications chart and we can order that for you, we can get that for you’ |
| Interviewer | Okay |
| Healthcare professional | And it’s like offering that security for them. But then it’s also when we come to discharge them to make sure they have got all the information in place. But then obviously we hand back over to the community… |
| Interviewer | Right |
| Healthcare professional | The community GP service that supports then; hopefully smoothly enough for the nurse to pick up from their community care that they need. |
| Interviewer | Okay |
| Healthcare professional | But there’s just…I don’t know, sometimes there’s part of that delivery that sometimes, you know, like, you know, transferring the care service into the district team’s service, you know, there’s always some sort of delay or it gets sent back or they might not have got it. It gets like…umm…don’t know…I know there’s pressures in the district nurse service so sometimes it won’t reach the intended…the right district nurse team. |
| Interviewer | Yeah |
| Healthcare professional | Then there’s, then there’s like…then the treatment doesn’t happen because the district nurse hasn’t received the instruction to take over the care of dressings. |
| Interviewer | Then you’d pick that up? |
| Healthcare professional | Yeah. Then we pick that up *again* and then obviously we have to flag that up with them after and send out the same information again. So there is…there are little…there are grey areas that, you know, we do our best to make sure we provide… |
| Interviewer | Is that because of overlapping services? |
| Healthcare professional | Probably because it’s crossing over of services |
| Interviewer | Yeah |
| Healthcare professional | And maybe there’s probably too many, I don’t know, people doing the same thing |
| Interviewer | It seems to me, correct me if I am wrong, that you’re between the two somewhat. You’re a hospital system but you’re in the community but not a community service either? |
| Healthcare professional | Mhmm |
| Interviewer | Does that create some confusion? |
| Healthcare professional | Yeah. This is just where identifying our service and making sure that, from the source, from when they’re discharged to the hospital at home service, patients have a correct understanding of what service they are going to receive from acute hospital at home. And how it’s going to be managed. So then there’s, then there’s less sort of grey areas. You know, we, we, I mean we don’t get, we might just get a referral from a ward and then we follow that referral. Then we start looking into referrals that are incomplete. And I think, generally, there are windows that still need filling in, and no information on the registered nurses responsibility is. So then they have to go through that, find out what the regime with the IV is, contact the consultant. There’s so much work that has to be done to get that patient discharged into our service. |
| Interviewer | Right. |
| Healthcare professional | When, you know, probably more, more work of identifying what is going on and trying to, to get, get the nursing teams to take on more roles. All these things are checked and double checked so all our role is to get the patient home and not all this delay of going through paper work and documentation that should have been done at the source |
| Interviewer | Yeah |
| Healthcare professional | And then we have to fill the gaps in with the referral because the referral is incomplete. And *then* you can make sure the patient is suitable or not |
| Interviewer | And that takes me back, really, to what I wanted to ask. That thing about the ‘suitablity’ of the patient. So what would the patient need to be able to do or what type of patient illness wise, or…? Lifestyle wise or anything…? |
| Healthcare professional | I guess you’re looking at what their condition is, and I guess, I don’t know, there must be sort of umm…an example of each type of infection; “this is what you’re going to achieve by treating it at home with these types of antibiotics” |
| Interviewer | Yep. |
| Healthcare professional | It’s all been done, it’s all out there. All these analytics are out there. |
| Interviewer | That’s clinically. What about anything else? We’ve covered the type of antibiotics to cover an illness, and about the blood markers earlier. Is there anything else about that patient that would mean you can take them or can’t take them? |
| Healthcare professional | Umm…I guess, umm…is there any social needs that might have an impact? Are they vulnerable? Is there anything that flags up with mental health issues that they need more support with? Are they…do they need any sort of…what’s thir moving and handling like? How mobile are they? Do they need any extra support when they are at home? So they have any extra carers coming in? |
| Interviewer | Can you still take patients in that situation? |
| Healthcare professional | We should be able to yeah. |
| Interviewer | Yeah? |
| Healthcare professional | That’s something we need to look at so that we provide a service for all. |
| Interviewer | Does it restrict it a bit? |
| Healthcare professional | Well it will do yeah. Because I mean, look, if you’ve got an external care provider, so the patient has got a package of care, and there in their supporting the patient two or three times a day and the patient might need to be hoisted, or they have got mobility issues going on then we will need to be more time specific to make sure we don’t clash or cross over with other care providers so it’s important that communication is in place to make sure that we don’t cross services and confuse the patient: “oh wait who are you?” so I make sure I identify myself as part of the acute hospital team, this is my uniform, this is my ID.  But yeah that will have an impact. But also, I guess, also, where the patient lives. How far out of our catchment area can we go to support a patient? Where’s the cut of the point of the service? From how far we have to travel n a day. |
| Interviewer | What would that be do you think? |
| Healthcare professional | Well there has to be a cut off point. You’re not going to be driving…what’s a realistic mileage you’d want to go to treat a patient 30, 50 mile radius? I mean 30 is comfortable radius you’d want to travel. But also when you start going out into other regions there must be this type of service in other trusts. If not why?! So that’s another thing that has an impact I guess.  Yeah. What is the location of the patient? How accessible are they? Stuck out in a rural community; that obviously has an impact. Does the patient have access? What’s the phone access like? Do they have a landline? Do they have a mobile? Mobile phone signal? All these things that would affect the communication |
| Interviewer | Which would make it less suitable to take them? |
| Healthcare professional | Yep! It could make them less suitable, yeah. Definitely. Umm…like I said, as a team member, driving, there’s a lot of impact on the mileage you do in a day to support the patients in the service. You know, and making sure you’ve still got…you can’t overextend the service because otherwise you’re putting your team members at risk by driving too many miles a day, being tired.  We’ve got the twilight service and I tend to find, with that service in particular, you’re driving out to rural areas of the community, it’s dark, A-roads, wildlife about, weather conditions. Just to provide a patient with antibiotics at night. Sometimes it’s not really ideal and maybe, you know, I think that has an impact. I think, maybe, to have more local patients. But, then you’d have to be more selective with your patient selection criteria… ‘that patient’s out in the middle of nowhere and we’re going to send a team out on a twilight to the middle of nowhere’. It might even be the first patient, the first time, they’ve just been discharged and the first person they see is a twilight team going out to the middle of nowhere, in the dark, terrible weather. Yeah you’re following the sat nav but that’s not always reliable…then for you to turn up there safely, provide a service, and then get home again. I think that part of the service is quite, is quite difficult. It has quite an impact on the team’s morale. And also you’ve got that patient expecting a service. |
| Interviewer | Yeah |
| Healthcare professional | It’s quite anxious for them. do people want to receive clinical members of staff at night? I don’t know |
| Interviewer | And if it’s the first time you’ve ever seen them |
| Healthcare professional | Yeah it can be the first time you’ve met the individual too. |
| Interviewer | That’s a really interesting point |
| Healthcare professional | So I think that, that’ll have an impact on the service as well. Umm…to make…going back to the selectivity of patients and their requirements and whether we can provide that support. You know, one shoe doesn’t fit everybody does it? |
| Interviewer | So, we talked about the…umm…the paid carers and people that go in to support the patient. Do you come across other sources of support for the patient? So we talked about professionals… |
| Healthcare professional | Well yeah because we also get patients that are in a care home environment. |
| Interviewer | Okay |
| Healthcare professional | So they might reside in a nursing home… |
| Interview | Right… |
| Healthcare professional | …Or residential home. So we will come across the support they have there. But then you have got the impact of the nursing home’s policies and procedures, healthcare relations. So there’s a lot of things we have to communicate with that care staff or residential home. They want to have our policies and plans so they know they’re getting a service they can accept because they’ve got another external care support, although we might all be under the National Health Service, we still have to provide a lot of documentation to make sure that they’re happy with us coming into *their* environment |
| Interviewer | It’s their responsibility too… |
| Healthcare professional | It’s *their* responsibility to have us in *their* environment to support *their* patients. They have to share with us confidential information about how we access the property, there’s key codes and ads that we have to access to get in there |
| Interviewer | Right, yeah. |
| Healthcare professional | To get in so we can serve the patient.  Sometimes you go into a *nursing* home and you’ve got nurses but they don’t provide full nursing support |
| Interviewer | Yeah, that can be a funny one, yeah.  What about is someone who lives at home? Or in those rural areas something like that? |
| Healthcare professional | Well there must be, there must be…well, obviously, you’ve got the district nurse team like we talked about but sometimes they don’t reach out that far. District nursing and GP services are reducing aren’t they? I mean, obviously, there’s more district ‘hubs’ and sometimes they don’t reach out that far to patients and they are quite isolated. |
| Interviewer | Right. Do you think you are more flexible than others? |
| Healthcare professional | I think our service is. Because we seem to provide more service, more of a clinical service than what a district nurses used to provide. I’ve worked, I’ve worked alongside the district nurses. I used to work in the community so… and there was a time where they would take on more…more services and that has reduced now due to the impact of surgeries reducing. So, I do find we take on more duties as what the district nursing team would do. Once-apon-a-time district nurses used to provide IV antibiotics |
| Interviewer | Okay, so why do you think they don’t? |
| Healthcare professional | I think it’s a case of reduced staffing. Probably, reduced skills. Perhaps nurses coming out aren’t offered the right training to give that service and deliver an IV. So, it’s limitations there within that service. Umm… |
| Interviewer | But you can pick that up as a service? |
| Healthcare professional | We can. Because we’re an acute team we will pick that up and manage that as part of, part of…I mean, if we’re providing…if they’ve come with dressings from whatever ward they were on, they would come with a dressing plan and the team would take that on as part of the service |
| Interviewer | Right |
| Healthcare professional | We’d take that as our responsibility as part of the service otherwise you can’t manage it holistically when you’ve got other services coming in and you can’t take responsibility for that part of their health. So, we should be doing it. Or if you’re managing IVs and they have a dressing that could potentially be infected and you’re pumping IVs into them… |
| Interviewer | Yeah… |
| Healthcare professional | If you’re not managing that as well then how can you…how can you regulate the IVs |
| Interviewer | Very true |
| Healthcare professional | That could be getting infected and you’re not managing it. Seems a bit pointless giving IVs then.  So as a service we are giving a very good level of clinical support; more than, more than what the department…I think this department is developing as more of a service, we are developing with the service we provide and if we need to retrain do something different and bring some new sort of service.. |
| Interviewer | Yeah… |
| Healthcare professional | Something that would, like…catchment to take more patients because, I guess, we have, like, our limits. We have got, at the minute where we’re selective, but if we had more skillsets we could take on a wider range of patients from the hospital. I mean, you know, you’ve got to be realistic about what the service is. But there must be areas where the patient is medically fit but…you know, we were providing support for patient s who were antenatal |
| Interviewer | Yeah |
| Healthcare professional | Was it peremisis? |
| Interviewer | Hyperemesis, yeah |
| Healthcare professional | Hyperemesis! So we had more…more catchment of patients but that service seems to have faded slightly and I don’t know if that’s because the policy has changed or…you know, umm…so there must be a greater scope for this service because it has to develop otherwise you end up doing the same old thing all the time. I think as a service it needs to grow and develop. |
| Interviewer | You said as a service it ‘can’ develop and you can learn new skills, is that because you are attached to a hospital that the scope is there to learn and do new things? |
| Healthcare professional | I think yeah. You still have to be governed don’t you? By the trust. But I think there are ways. I say, obviously, the service needs to grow and develop and you want to have a consistency of support for patients. There’s times where you might have four or five patients on the board when you have got a virtual bed space of 12 patients and you’re only providing four or five… |
| Interviewer | Right |
| Healthcare professional | There must be. There must be scope of improvement to make sure that board is full. You are providing a community service seven days a week |
| Interviewer | That goes back to the suitability of patients. What stops it being full then? |
| Healthcare professional | I think, I think it’s a lack of communication. I think it’s a case of…Yet again it goes back to how we’re promoted within certain departments |
| Interviewer | Yeah |
| Healthcare professional | And knowing what our service is about. Making sure the doctors, the consultants, the nursing teams fully are aware. It’s not just like “oh [clicks fingers] don’t Acute Hospital at Home provide that service?” “oh I don’t know I’ll have to check on that?”. So they must have…either we get more involved at the handovers of the department so that we’re fed, we’re fed the patients because we have a catchment of departments that feed us |
| Interviewer | Yeah |
| Healthcare professional | Which we know they’re good for viable patients so if we can try and address the lack of communication where it always seems to be that you get half a referral come through and then you’ve got to spend all this time trying to manage that, and then you’ve got to go through all the communication barriers trying to get them. And you can’t go on the wards because of all the Covid issues. So, then you’ve got to pick up all the pieces of that, sort of, incomplete referral. Then you’ve got to check with the consultant that they’re happy with that and whatever the regime is that they’re happy with the medication for that patient to *then* go home. It seems to be…it must be quite frustrating for the patients on the ward; one minute they’re going, then they’re not going, then they’ve changed the regime. And at times, sometimes, the consultants change the IV regimes because they know it’s not convenient for an IV infusion so they can have a pump. And they just change it! |
| Interviewer | Yeah |
| Healthcare professional | And…what…more thought needs to be in place to keep our board constant. In a constant flow with no gaps we could then take on more staff, make it a virtual ward; which is what its supposed to be and make it more community based. |
| Interviewer | So do you think…so you said you want it to be full. Do you think the patients want to be at home? |
| Healthcare professional | Yeah |
| Interviewer | Why do you think that is? |
| Healthcare professional | Generally, it’s a more stable environment because they generally have their loved ones with them |
| Interviewer | Mhmm |
| Healthcare professional | The might live with their partner, their wife, husband or whatever. They have that support, that family support…umm… |
| Interviewer | Well let’s explore that then because we’ve talked about carers, and district nurses and living in care homes and stuff. So let’s talk about what you just said that ‘people want to go home and their partners help’. With what? Care, emotionally, practically? |
| Healthcare professional | I think, for starters, emotionally, I think there’s umm, when you’re sat on a ward with all the other respective patients, I think you get quite isolated and detached but if you’ve got a respective partner at home that can help support you with your emotional needs and in your home environment. You know, you know your own environment and, you know, you can go to bed when you want, get up when you want, eat what you want. It’s not, the care isn’t forced on you. It isn’t regimented; with the support. You can pick up the phone and call your loved ones, you can watch whatever mind-numbing programme you want to watch on the telly [laughs] |
| Interviewer | [laughs] |
| Healthcare professional | And you’re not forced to pay charges for those services. It’s your, it’s your safe place. |
| Interviewer | So that’s why patients want to go home? |
| Healthcare professional | They want to go home, they’re isolated in the hospital |
| Interviewer | Yeah |
| Healthcare professional | If you were just sat there and receiving IV antibiotics once a day you’d still be regimented to the care routines but you could have it at home. And, you know, you can go outside, sit in the garden, anything. And that itself, that holistic needs will help, make you recover quicker. And we get, you know, patients are so relieved to be with their loved ones and partners. |
| Interviewer | Interesting. That, actually, leads me nicely to the next part of the interview if you’re happy to continue? |
| Healthcare professional | Yeah of course |
| Interviewer | So it’s about the experience of the patient and how they feel about it. And you said patients have a good experience and are happy about it? |
| Healthcare professional | Yeah, people just don’t realise that this service exists. And then they become quite overwhelmed:  “does this, does this service get offered to everybody?”  “well people who are suitable for the service”  “oh I just…this is amazing, this is a great service, I’m out of hospital”  And that just goes back to the communication thing |
| Interviewer | Yeah. Making people know about it? |
| Healthcare professional | Making people know about it |
| Interviewer | Do they need to be able to do things for themselves? |
| Healthcare professional | Well yeah. They have to be encouraged to be independent |
| Interviewer | Yeah |
| Healthcare professional | When they’re at home because they no longer have that 24 hour nursing care because we can’t provide that because we might only be doing a twice-a-day, or once-a-day, or we do the twilight service with them. So, we’re trying to encourage, promote independence so they can get back their independence they had. Hopefully their respective partners can help them with that |
| Interviewer | Yeah |
| Healthcare professional | They have to try and maintain a level of independence. They have to be able to provide, to provide a meal for themselves. They need to be able to take their medication independently. They’ve just spent several weeks in hospital with someone giving them their medication, putting it in a tub; “you take that”. So you do get deconditioned in that respect so you’re encouraging them to mange that |
| Interviewer | And do you think that’s a good thing? |
| Healthcare professional | I think it’s a very good thing, yeah. You’ve got to be able to have a level of independence and it builds your confidence. You can feel that the service we provide is very beneficial and it helps get back. Obviously get better to get on with you life. |
| Interviewer | Yeah. Umm…what about people who don’t have someone living with them? do they have other people? You said ‘husbands, wives,’ |
| Healthcare professional | Well. Some patients live soley on their own. Some patients have, you know, they would need…it’s to recognise the patients that are isolated and have been lonely and isolated for some time. |
| Interviewer | Right |
| Healthcare professional | And I think, you know, try and offer them support. You, know, how can we get some, get social services some support set up in the community. |
| Interviewer | Right. So you said ‘…for some time’. So it’s not their illness that’s made them isolated? |
| Healthcare professional | No. some, I mean, they may have lost an important part of their family unit, their parents have both passed away and they’ve never engaged, not in a relationship, family very distant so they’re isolated. Its for us to recognise that by talking to them and go ‘okay. Would they benefit from some outside support?’ We are, we are responsible because we’re going in to treat that patient so you want to try and do the upmst for them if you can; if they’re isolated, if they’re alone. They feel like they might need some external support. The lifestyle we live in now with the clubs and community support from years ago are dwindling |
| Interviewer | Right |
| Healthcare professional | And being reduced. To go to a community day center, or your local men’s club, or labour club aren’t widely available aren’t open and dwindling and closing which restricts people that are alone and don’t have family to rely on, it really does isolate people. |
| Interviewer | So how do those people feel about being treated at home? |
| Healthcare professional | They still want to be at home because it’s their known environment. Everything around them, that’s what they’ve lived with all their lives, all their adult live. They might be known to their neighbour, they might converse well with their neighbours but I think their priority is to still get home. We’ve had some patients that environmentally their conditions are quite poor and standards are quite unsafe but they still want to go home |
| Interviewer | Right |
| Healthcare professional | They might have lived that environment that we’d describe as unsafe for many years. Many many years but they’re happy with it regardless, irrespective of what…how someone else perceives they want to go home and we will try to support them environmentally if we can help through our more occupational therapy side of the department. We will try and help with that. Do they have a social worker involved with support? Is there any ting in their past medical history that they they’ve had support with? Are they looking for a package of care? All these things that we need to highlight…umm…we might be able to offer if they feel like they might need something.  But umm…I think it’s important to be able to offer emotional, the emotional support of they haven’t got any close family and they live alone. |
| Interviewer | Yeah. Okay.  So those who have got some family or receive support from someone else…what do they…do you ever find that they do other things for the patient when they’re unwell? Do they need things from their family, friends and neighbours that you cannot provide? |
| Healthcare professional | Yeah, I always…well…we, I…we have to maintain our professional boundaries so in terms of family they can offer more support…umm…whether its by going somewhere, picking the patient up and taking them out, that link up, that interaction. Where we can’t interact like that because we have to maintain our professional boundaries |
| Interviewer | What is your social relationship like with patients then? Not that you’re taking them out and things like that but when you’re with them? |
| Healthcare professional | Umm…I mean, always try and get them to interact and feed back to us. Me, personally, I’ll always try to talk to them like I know them and they’re often like ‘oh I know you don’t I?’ so I always have that rapport, I’m quite open with how I convers with the individual. Err…and if they need any help or they might want to have a walk in the garden we’re always trying…’oh, I’m out of milk’, ‘I need some stuff picking up, I haven’t got a car or anything’. we will always try to contact if they’ve got relatives but I will go out of my way if they needed something picking up, something basic to make sure they’ve got everything they *need.* To have that level of support and to know they’ve got that |
| Interviewer | Yeah. So you do some basic extra things? |
| Healthcare professional | Yeah if they were desperate for it. It’s not a real hardship. As long as the management team were happy with it; I wouldn’t be difficult to…you can’t just do things off your own back, if you want to do things you need to, again, someone else has to comfortable with that in the team. |
| Interviewer | That’s interesting because someone in hospital doesn’t need their own milk and bread but you claim to be a hospital service…that’s a bit of a grey area |
| Healthcare professional | Yeah, I mean, they might be discharged home and not have anything in the fridge, nothing. |
| Interviewer | But they’re not ‘discharged’ are they? |
| Healthcare professional | No they’re still in the hospital service. |
| Interviewer | So do you see that as an essential part of your role then? A patient is still in the hospital… |
| Healthcare professional | Absolutely, you have to maintain their nutritional needs. I think it’s part of my duty to make sure they’ve got grub in the fridge. You know, I would ask the question, as long as they were consenting and they were quite happy for me to help with that; it would be a case of ‘do you have a relative? Do you have a friend who gets your shopping? Especially whilst you’re at home having antibiotics’ and if you might feel unwell from that. You might have loose bowels, diarrhoea, you’re not going to want to go to the shops are you? Yeah so, ‘have you got someone who can support you with that? If you haven’t let’s do something about it’ |
| Interviewer | Yeah. |
| Healthcare professional | It’s no hardship. Obviously then feed it back to your nurse in charge and your line manager just to make sure it’s okay for us to do that. I mean they might have food vouchers; they might have food vouchers in place. They might be under the social services or say they’re in temporary accommodation if they don’t have a job and they’re receiving benefits and, and they’re really isolated. And, you know, they were receiving our service, the acute service, and they needed some support with their basic shopping then why not. As long as it was documented and part of our plan to help them |
| Interviewer | Yeah |
| Healthcare professional | I think it’s quite a realistic thing to do |
| Interviewer | Yeah. I like that, it’s a different perspective. That’s nice. So that nicely leads on, again. So perhaps you’ve been seeing this patient for a while and you have been doing the shopping…what happens when you’re leaving? |
| Healthcare professional | We’d have to set something up to make sure somebody else is taking over. I mean, you’d like to think, hopefully, by then, hopefully well enough or at a level where they are discharged back into the community service. Because this is what we’re faced with when the patient is still under the support of the hospital… |
| Interviewer | yeah |
| Healthcare professional | …once they’re discharged they’re back in the community service so then we need to make sure we hand all this over to make sure their GP service is aware of the situation. Obviously, if they have a social worker, making the social worker aware of the situation so that they can maintain the support and try and instil with the individual and set up some communication and networking with somebody else, some other service, RedCross service to help with their shopping, [local care agency] could come in and help with some support. Obviously, do they have a relative or friend who could help pick up that support so they’re not just; “right, we’ve finished with your treatment now. Here’s your discharge letter, here’s your envelope, goodbye!”  Do you know what I mean, you feel, you know, because we are responsible, so it’s nice to make sure you can hand that over and you feel…you know…well, say the patient we’re supporting was diabetic and they’ve got issues… regarding the community diabetic team, they’re under pressure so it’s difficult sometimes to make sure the patient is seen on a regular basis.  So, if we know the patient is struggling we can give them some additional support, we can give them some nutritional help, we could speak to a nutritionalist in the hospital; which they should be if they’re still in the hospital service and then we can find them some knowledge and education. They might have had it ten-fold before but at least we can feel we’re justified in what we’re doing so we can hand them back after they’ve finished our service with some knowledge, some support. At least we’ve tried, do you know what I mean? |
| Interviewer | Yeah yeah |
| Healthcare professional | We could go to…even the diabetic clinics they’ve all closed down. I went yesterday, or was it Friday? To get some information, some leaflets for a diabetic patient and its nothing. Nothing there. All the pamphlets have been removed and it’s like, where are you supposed to go? I guess everything is focused on the internet isn’t it? |
| Interviewer | I guess so yeah |
| Healthcare professional | You know, and the sister on the ward wanted me to get some information for a patient who was diabetic and was struggling with their nutrition but I couldn’t get that information so we could hand that patient back to community support.  Even though the patient was fully aware |
| Interviewer | They might not have been though. If you took an example of when they’re not… |
| Healthcare professional | Yeah, it’s like, exactly, we’re trying to provide that networking of information so we can hand that patient who has finished with the treatment and the service because their infection markers have come down and the consultant has said they no longer need IVs and can have a course of oral antibiotics. ‘Great, that can be managed, the consultant is happy, we can hand back to the community services’. But there’s always bits and pieces…we’ve managed, helped support them with their blood sugars and we’ve supported with that because they can’t take their own blood sugars and the diabetic nurses are managing that. But whilst in the service we’re managing that so there’s a crossing over of services |
| Interviewer | So you have to find the right person to hand them over to? |
| Healthcare professional | Yeah. Very challenging. You’ve got to make sure you’re communicating and handing over to the right person. Then I guess there’s always a lull in that service. Whilst you’re handing things over, using the internet…or via a letter, you give the patient a letter and that letter is transferring of nursing services over to the district nurse team… |
| Interviewer | Right… |
| Healthcare professional | Then that has to be physically handed over to the nurse and if they’re not receiving that instantly via the internet and into the patient’s notes and it’s ‘oh that patient needs to be seen’ then unfortunately there’s a lull in meeting their needs. But that’s down to the community side of care to try and deliver services more efficiently; we can only do so much, we just do the best we can for our patient and once we’ve discharged, we’ve discharged it’s difficult |
| Interviewer | What do you think they think about being discharged? |
| Healthcare professional | I think sometimes it’s quite hard for them because they’ve, they’ve relied on a service that’s, that’s really efficient. I mean they might have had some difficult times in the hospital and they didn’t receive the care they thought they’d receive, they might feel they’ve been treated unfairly and the service wasn’t, you know…or someone next to them was treated unfairly and they weren’t being delivered a good service so they come out with limited expectations of what *this* service will be like. And then they realise “Wow! that wasn’t what I expected from a hospital service!” |
| Interviewer | Yeah |
| Healthcare professional | And then there comes a point where that service ends so there’s also going to be the psychological impact and emotional impact when we finish the service. You know, I’ve had people who have said “it’s a shame your service is ending I wish I could have something like the team you work support me because it’s a great service and I’m not quite sure…who else is going to come and support me?”  I have had feedback like that. They are a little bit institutionalised with the support they have been receiving and then we come in with support that is efficient and it covers all their needs |
| Interviewer | Yeah |
| Healthcare professional | And then, obviously, that service comes to an end and they…because…also because of the impact of the reduced services from the GP practices…”oh I can’t get through. I’ve been on that phone! How many times have I been trying to call my GP for my medications?! How many times!? I can’t get through” this is feedback, I’ve had patients say “I’m sick and tired, I can’t get through to my GP, that’s on order, I can’t get that”. And then I say ‘oh, we can get that for you, we can get that from the hospital, that’s not a problem’ |
| Interviewer | So would you say you’re more accessible? |
| Healthcare professional | Oh definitely more accessible. We have a pharmacy at our fingertips. Generally, we only have to order it and it’s there. So that is an issue for patients when they’re discharged. And also, provide them with, maybe, enough medications to get them by until their GP practice pick up |
| Interviewer | Are you just using medications as an example or..? |
| Healthcare professional | As an example, yeah |
| Interviewer | Of something, you’re more efficient at? |
| Healthcare professional | Yeah of what our team is more efficient at. And trying to set up what their needs are. Because we’re providing a clinical service so that’s our main priority but all that around them, the clinical holistic care is something we’re aware of and support the best we can. Like I say, there might be environmental things that need to be looked at that we could probably help with. There might be some social issues that need to be looked at at we can help with…or we know somebody that we can contact that could help. But we are, you know, we can’t cover everything in the time frame that we have, because essentially everything reverts back to their community care and support doesn’t it? Otherwise, especially with our patient turnaround times we have to make sure we are providing a viable service for many patients by continually turning them over to keep our service proactive and efficient otherwise it just snowballs if we’re just maintaining patients… |
| Interviewer | What drives the turn over then? Why would they go? Why would it stop? |
| Healthcare professional | Infection markers! That’s when we go. As soon as their infection markers are at a healthy level and the consultant says they can be discharged then that’s when they go. |
| Interviewer | Okay, so if I can just sense check what I think you’ve been saying throughout. You go in to see a patient for an infection and you’re there for that clinical reason |
| Healthcare professional | Yep |
| Interviewer | But whilst you’re there you do a lot of holistic work, pick up a lot of other problems along the way. Some on which you can resolve yourself but others you have to refer to other services or family or someone else to do as well. |
| Healthcare professional | Very much so |
| Interviewer | And then when the clinical need, which we have said is infection markers and antibiotics, stops, then you see it as your role, as part of being a holistic service, is to ensure that those problems that you’ve identified are continued to be managed |
| Healthcare professional | Yeah. They need to be handed over to make sure that the community service is aware of that. They might have been ticking along, living in that environment for many years and we’re just touching on that and touching int the situation and we’re fresh eyes and ears coming into their lives and just might need a change, a new referral to be made that might make a bit of a difference. |
| Interviewer | Yeah. So that I find interesting as well. So some of the things you identify are because of the clinical reason you’re there? |
| Healthcare professional | Yep |
| Interviewer | And others are long term problems? |
| Healthcare professional | Yep |
| Interviewer | …that you’ve just encountered because of their chance encounter with a healthcare professional? |
| Healthcare professional | Yep |
| Interviewer | Okay. So is that a fair thing for me to say? |
| Healthcare professional | Very fair yeah. Because we can reach out to other services from this one to other networks. From other, what do you call it? Pathways! Interprofessional services because we can reach out further because patients can be limited by what their surgeries, their GP practice can offer and by the time their GP has made the referral and the appointment has come through it can be quite long winded but we seem to branch out further into professional pathways. And because we’re still attached to the hospital we can easily link back to services that would, obviously, benefit the patient because, obviously they’re still part of the service. To the speech and language therapists, the dieticians; we can connect directly to them whereas….and the physios…whereas out in the community they could take quite a long time to refer. Whereas we go straight into that. |
| Interviewer | So you’re quicker…so you’re a link back into the hospital for patients but you’re also a link into the community as well? |
| Healthcare professional | Yeah and we can diagnose these things quicker because we have got he support network |
| Interviewer | Fascinating.  Well I think that covers most of the main questions I wanted to cover although I did have one thing I wanted to touch back on if that’s ok with you? |
| Healthcare professional | Absolutely |
| interviewer | It’s just about your…you were saying about how when you go in you’re quite chatty and open with patients. I just wanted to know the sort of things you might talk about? |
| Healthcare professional | I always..so…i’m quite fascinated with what people used to do for a living so I find, generally, so most of our patients are retired of semi-retired so it’s quite interesting to find out what they did for a living. You know they strike up a conversation, you look around, you look at their artwork and find things that give you a bond to the patient…  “oh that’s a nice painting”  “oh I painted that”  “oh you’re an artist are you?”  “well I have a dabble.”  “oh ok, that’s interesting, what’s your style of artwork then?”  “come and have a look at the studio!”  [laughs] |
| Interviewer | [laughs] |
| Healthcare professional | “really? That’s very kind of you!”  But if you don’t ask these questions you’re providing a blank canvas of a service so it’s nice to ask these questions to create a better picture of what this individual is about and you can interlink. Like, I’ve spoken to patients and it turns out I might share the same work skill that I’ve gone through in my life.  “oh I used to do that”  “did you now?”  “I was a carpenter. You’re a carpenter. How interesting” |
| Interviewer | Mhmm… |
| Healthcare professional | “you used to fit kitchens? I used to fit kitchens! How interesting”  So I think in that way it builds a level of trust and I think individuals are more open to want to converse with you. Because, you know, on the ward they’re quite shut down aren’t they. Because, how often do you as, as a, I’ll say as an HCA, “what did you do for a living then?”  “what bought you to this hospital bed?” other than the accident or illness or whatever. You can’t ask “what did you do for a living?” because you haven’t got the time. But in the Acute [hospital at home] service you’ve got time to converse with tha patient and get a better understanding and things become more aware of what this individual is going through. And, you know, and what the partners’ perspective is and how the perspective relationships work |
| Interviewer | Yeah |
| Healthcare professional | What support they’re getting from the partner. |
| Interviewer | Do you have a relationship with the partners sometimes? So if they live with them…or not necessarily a partner but anyone who supports them or lives with them? do you have a similar conversation with them? |
| Healthcare professional | Yeah. So yeah, I would treat as the same. The respective partner I would have the same conversation, I’d be interested if they want to converse. sometimes they might not have the patience or want to share but I wold be quite interested in what they did for a living and they might have something of value they want to share with me; they might have a good cake recipe! [laughs] |
| Interviewer | [laughs] So how would you describe that bond then? |
| Healthcare professional | That bond is something you develop across your life. That bond, that sort of personal way of conversing with someone that makes them want to be open with you about their secret cake recipe [laughs] |
| Interviewer | [laughs] |
| Healthcare professional | You know what I mean? I think they feel that…umm…they feel comfortable. They have two strange individuals in their home, they’ve never met them before so it’s good to converse with them at a level that isn’t all clinical |
| Interviewer | Yeah… |
| Healthcare professional | It’s not in abbreviated jargon. And they’re going “ooo a human being who’s interested in my cake recipe!” you know, that sort of thing I think is quite important actually. Yeah it is. But yeah you know, they’ve all got a place with their partners, friends and families that come into their lives and it’s nice that we can interact with them. |
| Interviewer | I think that’s it [healthcare professional’s name] unless you have got anything else you want to say? |
| Healthcare professional | No I think that’ squite a umm… |
| Interviewer | Yeah I think you’ve done really well, not that it’s test or anything, but we’ve covered a lot |
| Healthcare professional | It’s nice to express and expand and have some feedback on the service |
| Interviewer | It is nice, yeah. You get to have a conversation that you wouln’t normally have. Umm…so it’ll all be written up and transcribed and used in my PhD prject that you’ve read about |
| Healthcare professional | Yeah I think it was a very thorough interview, [interviewer’s name] thankyou. |
| Interviewer | Thankyou |
| Healthcare professional | Thank-you for making me part of it |
| Interviewer | No thank-you! |
| Healthcare professional | You’re welcome. |

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