Date: 27/04/21

Time: 11:00

Location: DCH office

Participant Role: healthcare assistant

START

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| interviewer | Okay. That’s going. Hello [participant’s name]. You know me because we work together because we work together but I’m here, we’re both here, in a different role to get information as part of my research project. So, are you happy that you’ve read the information sheet and signed the consent form for this project? |
| participant | Yes, certainly. |
| interviewer | Good. Thankyou. And you know it’s being recorded? |
| Participant | Yep. |
| Interviewer | And the interview will take about an hour…umm…if you don’t want to answer any questions you don’t have to, and if you want to stop at any time just say ‘stop’. Is that alright? |
| Participant | yeah |
| Interviewer | And at the end of any section I’ll ask if you’re okay and happy to go on etc.  So, the first part of the interview is about your roles and responsibilities within the hospital at home service. So let’s start with that…ummm…what is your role? |
| Participant | Generally, to introduce myself to the patients who are at home and to go along with the qaualified member of staff and to take observations and assist the qualified member of staff with anything that we deem necessary. |
| Interviewer | Right, so what sort of things are ‘deemed necessary’? what do you do? What are the tasks? |
| Participant | To help with taking bloods, to help with doing dressings if you’re doing arms or legs, to make them comfortable and do the dressings easier and pass things that are needed in sterile situations. |
| Interviewer | Mhmm |
| Participant | And recording the observations on the Vitalpac and storing them and letting you, the qualified staff I’m working with if there’s any issues with the observations whether that be a blood pressure too high or too low, temperature too high or too low and umm…resps if they’re in the normal range and anything else that I may think could be an issue |
| Interviewer | You said…sorry, for clarity, ‘Vitalpac’. Can you just explain what that is? |
| Participant | Vitalpac is an app that is on our phones at hospital at home that enables us to store the observations of patients and then it goes, as far as I know once it’s loaded, the information is loaded onto the phone and onto a system in the hospital that will make anybody that needs to know, if things aren’t in the normal range. I can’t remember the team that’s in the hospital but they look out for anyone who’s dangerously high or dangerously low and get involved sometimes. But, because the patient is at home we would bring them back in. |
| interviewer | So it’s a system that you store patients observations on and then anybody who needs to see them, can see them? |
| Participant | Yeah. |
| Interviewer | Okay. Who…so who’s involved in that team? |
| Participant | Oh what do they call them? they come around the wards |
| Interviewer | Outreach? |
| Participant | Yeah the Outreach team in the hospital have got access to anyone’s who is dangerously high or dangerously low or in the red for whatever reason and then if they are, then obviously, we would get the patient sent back into hospital and the observations would be registered again and then they would be involved if necessary if the patient was very poorly |
| Interviewer | Right, okay. So that’s good support. And works even though they’re at home? |
| Participant | Yeah. |
| Interviewer | That’s a good bit of extra support for the patient |
| Participant | Yeah |
| Interviewer | And you explained there…well you started to touch on that this is part of a hospital system? |
| Participant | Yeah |
| Interviewer | So can you explain how that works? That they’re still part of a hospital system… |
| Participant | They’re still under the hospital systems so our nurses and our team are constantly in contact with the doctors at the hospital. The patients should really be in hospital but if they’re well enough to be at home then it’s a system where they’re not taking up a bed and they’ve got some support at home in the form of family and they’ve got us coming in regular and a contact number for us if things did go…did go wrong at home from 7:30 in the morning until midnight with us if necessary.  And the doctors in the hospital are keeping regular updates on how they’re doing at home and we’re keeping them updated with information from whether they’re doing well or not doing well.  The doctors then come out, well one of the doctors goes out with the nursing staff to see the patients if it’s deemed necessary for anything that they’re a bit concerned or unsure about. So they’re still in contact with the hospital constantly. |
| Interviewer | Okay. That sounds really good. So what’s the sort of typical patient like then? Or what might be wrong with them? |
| Participant | The bulk of our patients are needing IV antibiotics, usually from having, or recovering from a chest infection or knee infection or hip infection or a serious bladder infection…or sometimes an abscesses in their liver or…anything that the doctor in the hospital thinks they might need antibiotics for but the patient is doing reasonably well but needs longer term antibiotics we can do that at home in a safe environment with the hospital keeping an eye on how it’s going. |
| Interviewer | Okay. That’s good. And you’ve just sort of said that when you see the patients you’re usually with a nurse as a team. How does that work? |
| Participant | Yeah, so there’s always one nurse and one HCA. Or there could be a qualified nurse with a doctor. So there’s two teams in the morning; one could be the doctor and the qualified nurse, and the other could be the qualified nurse and the HCA. So there’s two people going out to patients most of the time. And that means you have support with each other because these patients are still deemed poorly enough to need a hospital so you need to be prepared for anything that might go wrong…or deteriorate. The patient could deteriorate and not respond to the IVs. Or, it could be for dressings, sometimes it’s not for IVs. Sometimes it could be Clexane injections or for warfarin…I’m trying to think of other reasons why we might go out. That’s the main ones. |
| Interviewer | Okay..umm…okay…umm…do you think umm…what do you think of the service as a whole? What are it’s strengths and weaknesses? |
| Participant | Oh I personally think it’s a fabulous service due to the fact that the patients can actually be at home instead of in hospital. Having worked on an orthopaedic ward I’ve seen a lot of patients who are recovering from a hip or knee and they get an infection and they spend weeks in a hospital bed, in a cubicle on their own, no family around them; and they’re just there to have antibiotics three times a day and they’re well enough, eating, drinking, walking around but they’re in hospital not only taking up a bed but they feel as if they’re wasting everybody else’s time because they’re not poorly and they feel they could be at home. Services at home are very limited because district nurses don’t do IVs. So Hospital at home allows people to not take up a hospital bed, not take up the nurses time and be at home with their family and their stamina and their mental health will improve by being at home…and their independence and eating and drinking what they would want to be eating because it’s not hospital food; although I think it’s lovely some people don’t like it. So it’s nice to be able to have their own choice of food and have their partners at home and relatives. It has to be so much better for them than being in hospital. |
| Interviewer | mmm…do you think you can unpick why that is? Why they feel that all those things you said; eating their own food, being around family…ultimately they’re having the same treatment that they’d be having in hospital…why do you think those things make a difference to their health, if the health need is to have the antibiotics then they go home and have the same antibiotics, why is it better to be at home? |
| Participant | Well, because they’re at less risk of picking up other infections like MRSA, ESBL and things like that…and they’re more mobile |
| Interviewer | Why are they more mobile? |
| Participant | Well they’d be going up stairs at home, pottering around doing their own things, going out to the kitchen and making their own meals and making themselves a cup of tea whereas everything is fetched for them in hospital. I mean, n my experience doing ward work and home care, people lose their strength and stamina and ability to mobilise because they’re off their feet most of the time. They’re sat by the chair by the bed and not going off wandering or going off to the kitchen. So, unless they purposefully put themselves out to have a walk they don’t walk anywhere. Then they go home and they find out they can’t, and they can’t do stairs because they’ve lost their strength and stamina. And it’s very important when people get older that they need to keep what they can do otherwise they don’t do it they won’t be able to do it. So it’s the old saying isn’t it “if you don’t use it, you lose it”. |
| Interviewer | Yeah. So, that’s with mobility. What about other things you mentioned like eating their own food? Do you think that benefits their health? |
| Participant | Oh gosh yeah! So if they’re eating food in hospital and they don’t like what they’ve been given then they aren’t going to be very happy, they aren’t going to eat well, some people are very fussy about what they eat, some people like the hospital food. It’s different for each individual but those people who are very fussy, or unless they’ve got family bringing them food in, then they’re not going to eat much which means they will get a bit weak and frail and they prefer to be at home to be able to eat and drink what they prefer to eat and drink and their usual routine which enables their bowels to work better because they’re eating what they’re used to. We all get a routine with what we eat regular and your bowels get used to it…for them. And your bladder becomes normal so you drink more because you got accessibility to get that instead of having to ask for it and bother people to get yourself a fresh jug of water to drink. So you do all that at home so you’d be more nutritionally healthy. |
| Interviewer | Yeah. Cool. There’s a couple of points you said there that I’m going to come back to in a minute. I just want to ask you…umm…whether…so, you’ve been through how you go and do the bloods and the observations. Is there anything…do you find yourself doing anything beyond their health work that you’ve been advised to go in and do as a team? |
| Participant | Not on this side of things. Not when we go in with the nursing staff. its not very often we have to do anything, any extra than delivering the ntibiotics. The patients understand that we’re there for that. |
| Interviewer | Right |
| Participant | And if it came up that they needed us to get them a drink before we left then they’re usually able to do it for themselves. But no, very very rarely do we need to do anything other than the antibiotics. |
| Interviewer | So it’s interesting because you’ve been describing all the things the patients do like getting their own drinks, walking to the toilet, eating what they want, going up and down the stairs…so they’ve got…I mean, do they *need* to be able to do these things before they go home then? |
| Participant | Before they go home, absolutely. |
| Interviewer | So they need to be a certain level of patient that you can take. So what would happen if a patient wasn’t able to make their own food and drinks for example? Would they come at all? Would there be a way around that? |
| Participant | There would be a way around that, in that it’s very rare that it happens but there are occasions I think, very occasionally, where there has been one or two patients, I’ve only been here just over a year. That we’ve had a patient where they have had to have the care as well. So, we’ve been giving the antibiotics but the care side of it, our D2A side, have had to go in to help them with shower and dressing before the acute side have gone in to give the antibiotics. |
| interviewer | So that’s a separate care and support system? |
| Participant | Yeah |
| Interviewer | Righ, okay. Good. And you also said a good thing about patients being at home is that they had the support of their family. Does that impact…does everyone need to have family support? |
| Participant | Not always. But I think, if they didn’t have family then they would need to be more able. Now, we have got one or two patients who are little bit frail so their family help them up and down the stairs and do the food for them and help to administer their drugs, their medications. But that’s…I’m just thinking of one we’ve got at the moment who lives over in [nearby town] and his wife does an awful lot for him. |
| Interviewer | Right |
| Participant | So there is occasions where such as him, if he didn’t have his wife at home I don’t think he’d be able to be at home having the acute side. But the majority of people are quite able. |
| Interviewer | So they’re quite able or they’ve got good family support. So that means you can just focus on the health work that you’re going in to do? |
| Participant | Yeah |
| Interviewer | Right. That’s interesting. So what sort of things does this wife do in that example? |
| Participant | Well, I think his wife..umm…does, makes sure he’s alright going up and coming down stairs because he’s a little bit wobbly on his feet; and she’d cook his meals for him. |
| interviewer | Right |
| Participant | Because he wouldn’t be able to stand and cook a meal. He does have a wander about the house, he does walk about but not a great deal because he’s unsteady but he does, he can toilet himself, he can wash and probably dress himself so I think mostly she does his meals because he is elderly isn’t he? |
| Interviewer | Mmm interesting. So we’ve been through the positives there, is that a negative of the service when people need support? Or that they can’t come if they don’t have support? |
| Participant | Well no because if they need support and they’re on their own then they can have a care team that can help if that’s feasible…as long as they’re ok at night. So they would have to be okay on their own at night, obviously. Then people could come in to care; morning to wash and dress, lunchtime for meals and then evening for something to eat and getting ready for bed. Then we could still go in with the IVs. But, if the patient…umm…is so poorly that they can’t have anybody, or they need someone at night and they need help to mobilise to the toilet themselves, or they can’t get themselves a drink then it’s a bit iffy whether they can have antibiotics at home, or whether they can be seen by us at home. |
| Interviewer | So they’d have to…? |
| Participant | They’d have to stay in hospital. |
| Interviewer | Right, okay, that’s given me a good picture of how it all works and what sort of patient you have. That’s interesting, thank-you. Umm…okay. Can you think of any other sources of support that the patient’s have? So what sort of family members? We’ve talked about wives a few times but what other family members or types of support do people have? |
| Participant | Well if somebody was at home alone, and they’re having IVs and they’ve been quite poorly then they’re going to need family support to wash their clothes, family support for shopping. I mean the shopping has to be got and fetched to the house for the carers to be able to do meals for them. and obviously they’ll need their washing and everything done and the house cleaning. And obviously everybody’s house is very different and individual but the person has to have that support around them, and if that can’t be given then the carers…well the carers are there for physical care and food and washing and dressing but not for washing the house, and putting the washing out on the line and not for shopping. So that’s the sort of thing that can sometimes be very difficult if they haven’t got the support at all |
| Interviewer | So when you said ‘carers’, are you talking about paid support? |
| Participant | Paid carers, yeah. Because some people do pay somebody to come in once a week and do the shopping for them if they haven’t got family |
| Interviewer | Right, so some people have got paid support who do personal care and meals for them? |
| Participant | Yeah. |
| Interviewer | But then they also need a different sort of support for other things? So like a mixture of support? |
| Participant | If they’re on their own yeah. |
| Interviewer | Interesting. So who might do the things that the paid carers won’t do. So if the paid carers won’t put the washing on the line, or hoover round, who might be involved with that? |
| Participant | Well you’d think it would be sons, daughters, umm…umm…neice, grandchildren, ex-wives, ex-husbands sometimes! |
| Interviewer | Allsorts! Sort of extended familes. What about friends and neighbours? |
| Participant | Friends. Neighbours do. Sometimes the neighbours come in and help with the shopping if they’re very good neighbours. Sometimes they will always offer support for the patient with emotional support, having a chat and a natter… Umm…when they’re on their own if they haven’t got family around. Yeah |
| Interviewer | So the emotional support is important as well is it? |
| Participant | Yeah |
| Interviewer | So do you think the emotional support is better when they’re at home or in hospital? |
| Participant | Or at home! Unless they’ve got nobody at home. But in hospital they don’t get time do thet. The staff haven’t got the time to give emotional support unfortunately, more’s the pity. So at home they’d get more because they’ve got neighbours pop round, they’d have friends pop round, they’d have family pop round, they might have grandkids pop round. Sons and daughters. But if haven’t got anybody, sometimes they’ve got friends who might pop round. |
| Interviewer | And what…So what about yourselves. You said you just go in and do the health work that you are there to do. Do you provide any emotional support? |
| Participant | Well yeah. I think when you’re delivering the antibiotics and doing the observations you chat friendly with them. |
| Interviewer | Mhmm… |
| Participant | Umm…you give them some support, encourage them to tell you if they’re worried about anything, have any concerns. The nurses do that as well. And then, sometimes you’re there for quite a long time whilst you’re doing the IVs. Some of the antibiotics can take, well, 30 minutes to go through and you give them a bit of support and someone to talk to. |
| Interviewer | Mhmm…so what do you talk about? |
| Participant | TV programmes, the garden , what they used to do when they were working, what family they’ve got and where they live, whether they’re close or not, whether they’ve got people who pop round.  You can get quite a lot of information of how they’re eating, whether they’re eating well by asking them whether they cook and how they’re doing |
| Interviewer | Okay. So you having a chat… |
| Participant | [interrupts question] …As a bit of a tool to find out how they’re eating, whether they’re okay. |
| Interviewer | I see, that’s interesting. So what would you do if you found out that they weren’t coping with something? So through one of you chats you find they don’t have any support and aren’t eating well; seeing as you said the team doesn’t..isn’t able to provide additional support with things like that. |
| Participant | Well if I felt they weren’t able to have a good meal then I’d talk about things that I know who do delivery of meals, of microwave meals. We can offer them a brochure for that can’t we? I can’t remember what it’s called now but there’s a place that delivers frozen meals and they come in and put it in the freezer for them. So that’s a lot easier for them if that’s what’s needed. So, if they’re not eating properly because they can’t cook or they’re not able to cook for some reason, they’re not managing well, then you offer things like that. You find out whether the family is bringing in the right food for the patient’s needs…you can usually tell that quite quickly from what’s in the kitchen fridge and that sort of thing. And you just get a general idea of what they’re eating and things. And we weigh them once a week to see if they’re losing weight. And obviously, if they’re diabetic you need to check that they’re eating sensibly, but you can only offer advice and at the end of the day it’s whether they take it up. You can only give advice. |
| Interviewer | True. Because… |
| Participant | Because they’re going to do what hey want |
| Interviewer | Opposed to being in hospital where there is a bit more control over their diet. |
| Participant | Yeah because you can get a patient who is diabetic and they aren’t eating sensibly then their blood sugars, because we take their blood sugars sometimes when they’re diabetic, can be a bit high so that’s not good if they’re eating the sugary things and drinking sugary things. So you’d advise them what to knock off, or what not to have, or what to have in place of it. But it’s up to them at the end of the day when they’re at home because their life is their own. |
| Interviewer | Right, so they have to take more responsibility for things? |
| Participant | Yeah. Yeah at home yeah. |
| Interviewer | Right. Okay. Now then, what do you…so we’ve covered strengths and weaknesses…what challenges do you come across that stops people being treated at home compared to in hospital. Thinking about time, physical obstacles, where they live, the resources available to you, that sort of thing. |
| Participant | Well, umm… |
| Interviewer | Does that make sense or not? |
| Participant | I’m not sure what you mean. |
| Interviewer | Umm…so… |
| Participant | Obstacles that stop someone being at home being treated at home instead of in hospital being treated? |
| Interviewer | Yeah. |
| Participant | Well night care would be one thing. So if the patient was disorientated, forgetful, early stages of dementia, that sort of thing then getting out in the night you could end up coming in to see them in the morning and they’re on the floor and have been on the floor all night. So that’s one. |
| Interviewer | Is that because you don’t work overnight? |
| Participant | Yeah. So if someone is being treated in hospital then they’re having 24 hour care; with us they are not supposed to need 24 hour care. So they’re meant to be more independent, so we can’t treat them if it is 24 hours unless they have some care support at home. |
| Interviewer | So that’s back to people having support at home and being able to look after themselves a bit. Anything else that stops, not even stops, but makes you job harder perhaps? |
| Participant | I can’t really think of anything… |
| Interviewer | Okay… |
| Participant | I suppose having the antibiotics three-four times a day. Having to having antibiotics four-times-a-day is a no-go! From what I’ve heard they’d have to change them. So the doctors decide to reduce it two-times-a-day or to three- times-a-day if they’re close to the hospital. So if they’re too far away from our hospital where we are, from our office, we can’t be travelling over to say [town on the edge of catchment area] three-times-a-day so we either have to change what they’re having so they’re just having the pump or they’re having IVs once-a-day. So that’s a big challenge so depending on what antibiotics people are needing to have but that’s the decision of the doctors in the hospital. Then they look at what we can offer and they tailor it to what we can supply. So, like, if they’re close to the hospital we can do three-times-a-day. |
| Interviewer | Mhmm |
| Participant | But four times is a no, no. |
| Interviewer | Yep |
| Participant | And, umm…a long distance is a no, no for three times a day. So it depends where they live, what they’re having and how many times they have to have it. |
| Interviewer | Okay. Yeah, okay. Makes sense. Anything else you can think of? |
| Participant | No |
| Interviewer | That’s good. Okay right…what about your relationship with the patient; how do you find that? When you’re in their home and… |
| Participant | I find it, I find it relatively easy. I have done home care for a lot of years so I…I would like to think I respect that it is their home and they have to welcome us into their home and if they feel at all uncomfortable or….or threatened by us then they have every right to say they don’t want us in. Or..umm…but generally, I’ve never come across that thank god. And..umm…I’ve always gon on with people very well and I think you have to go in their with an open mind and a caring attitude and a flexible approach to people. Let them take the lead and go with what they really want and need. |
| Interviewer | Do you think that’s a different dynamic compared to in hospital? The nurse-patient relationship? |
| Participant | I think so because in hospital they…they will just accept you coming and doing whatever without their say so, in as much that it’s their expectation that is different. Their expectation at home is that you’re coming into their home which is very different than going into their hospital bedspace to deliver care. Although I would treat them the same anyway; I would always treat everybody with respect, and listen and pick up body language and go with it. I work with people that way. But it depends; I’ve always got on well with people so I’ve not found it an issue |
| Interviewer | So how long do you have the patients for? |
| Participant | Usually four to six weeks. |
| Interviewer | So quite a long time then? Does the relationship change from the start to the end? |
| Participant | I can do yeah. O can become much more comfortable |
| Interviewer | Yeah? |
| Participant | Much more jovial and they…once they…they can be fearful when you first go in wondering ‘how is this going to work?’ ‘how is it going to fit in?’ and what we’re going to be like. Once they’ve met us all they relax, they chill, they usuall…we always get good feedback and a good response and they’re usually very happy to have us and are sorry to see us go. |
| Interviewer | We will come to that later actually, about what happens when you leave. But that is a really interesting point that we will come back to. Umm..what about with the family then? Or the other aspects of support. Does you relationship with them change in the same way, similarly, or differently? |
| Participant | If it’s the same family member all the time then, yeah, it can be…they can be a little bit wary of us at first or anxious. Then after a while… because they’re thinking the house needs to be perfect, everything needs to be spot on [laughs] |
| Interviewer | Right [laughs] |
| Participant | Because they think we are going to be looking at that and critising then they realise that we will accept them for what they are and how they are and they accept us for who we are and what we are and then it all becomes easier and more relaxed. In most cases, I’ve not known it any different really. |
| Interviewer | Okay. What about umm…if it’s a neighbour or someone else giving some support. If you’ve been going in for a long time do you find the support from the neighbour changes? Umm…does the support they provide change? Or with a family member even, does the support they provide change? Do they step back or increase? |
| Participant | I don’t think umm…I don’t think their expectation of us is anything other than delivering the antibiotics; so I don’t think they do change, I think it stays pretty much the same providing they understand the service; which they seem to. Most of them understand the service before we go in; they understand that we’re there to provide antibiotics and not care so it always seems to work out quite well. Whatever they’re doing when we first arrive they carry on doing. |
| Interviewer | Okay, interesting. Okay. Lovely. So that finishes that section which was all about your roles and responsibilities and that sort of thing. Are you happy to carry on to the next section? Some of which we may have covered and this section is all about service user experience. So are you happy to carry on? |
| Participant | Yeah. |
| Interviewer | Okay. This section is going to ask you about the experiences of patients..umm…so generally do you think they have a positive or negative experience? |
| Participant | Oh definitely positive. |
| Interviewer | Right. And again, it says here, to explore the pros and cons. I think we’ve probably covered most of it but is there anything else, like positives and negatives? |
| Participant | I think the only time that it could be negative is that people want their life back to normal, where they don’t have people coming in and out; If they’re happy, content and they’ve got family all around them then I’m sure they’re be happy to get rid of us but they’d rather us that having to stay in hospital. But yeah I expect they’d like their space back. If we’re going in three-times-a-day they then must find that their life is on hold but they also appreciate this service and appreciate that they’re at home and not in hospital and the feedback we get is very positive. Generally it’s very positive. |
| Interviewer | So do you think you disrupt aspects of their life, then? |
| Participant | I’m sure we do. |
| Interviewer | Do you get in the way of other things they should be doing? |
| Participant | Maybe. They want to go out and do things but they have to wait for us to come at a specific time. |
| Interviewer | So do you go at times to suit their medical needs? |
| Participant | So if they want to go for a walk then they might say to you in the morning, “what time are you coming in the afternoon? because I’d prefer to have a little trot over to the beach” or “I want to go to the shop” or “I’m waiting to go somewhere” or “I want to go to the hairdressers” or “I’ve got a doctors appointment”. So then they have to tell us that is so we can be a bit flexible or we would tell them that “we have to come at that time, you make that appointment around that time or go for a walk when we’ve gone” |
| Interviewer | So in some circumstances its driven by the health need… |
| Participant | Yeah the health need |
| Interviewer | And sometimes it’s driven by their other needs as well? |
| Participant | Yeah |
| Interviewer | So you can be flexible… |
| Participant | If we were going in to do a pump once a day at, say, 2 o’clock…ish! Between two and three...but if they’re having antibiotics three times a day then they have to have a certain gap between so you have to go at six hours between then six hours again. That’s just a figure, you know, I’m not saying that’s definite but you know, you have to deliver the antibiotics evenly through the day, spaced out. |
| Interviewer | I get you. But the ones you were saying about… |
| Participant | The pump |
| Interviewer | …the pump once a day. You said you’d have to go between two and three. What if they were doing something else between two or three? |
| Participant | So you could and see them a bit before. If they’d got an appointment between at two you say ‘right we’ll get there for half-past one’. If they’ve got an appointment until three, like a doctors appointment then we can do it a bit later on. If they’re coming to the hospital then we can deliver it in the hospital, which we’ve done before haven’t we? |
| Interviewer | Yeah |
| Participant | So when they come in to see SDEC [same day emergency care unit] we can deliver the antibiotic there. So, there’s a bit of flexibility there. |
| Interviewer | Okay. Okay. So do they need to come into hospital? Can you just explain that a little bit? |
| Participant | So sometimes they need to come into hospital to have bloods taken, or have a scan… |
| Interviewer | Is that part of the service you’re providing? |
| Participant | Part of the service the doctor who is overseeing it all provides. |
| Interviewer | Right, so sometimes they need to come into hospital. Who brings them into hospital. |
| Participant | For the day. Sometimes the family bring them in, or they get trabsport to bring them in. |
| Interviewer | Right so there’s some things that can’t be done at home? |
| Participant | Yeah, well they can’t have a scan or an x-ray. And sometimes bloods can be very difficult for us to take bloods from them. So they may have to come in for them to be taken by the phlebotomist |
| Interviewer | How do people find that? |
| Participant | Umm…they don’t mind it. They know that that has to happen from time-to-time to see how they’re progressing and what the bloods will show. They understand that it’s better than being here all the time isn’t it? So generally they accept that. |
| Interviewer | Right, okay. That’s good. Okay sso considering all the nega…’negatives’…all the cons that we’ve discussed do you think there is anything that can be done to improve the service? |
| Participant | No I think it’s as good as it could be. I think it’s very efficient and it’s good and it does what it’s supposed to and I don’t think there’s anything we could do to make it any better or easier really. |
| Interviewer | Okay. Fair enough. By trying to think of some of the negatives that we have talked about…or some of the challenges…is there anything we can do about them? |
| Participant | Well they were patients not having 24-hour care, or doing the washing and that sort of thing. I don’t think we should get involved in any of that; I think that is how it should be. So patients shouldn’t go home if they were really poorly, they should only go home if they’re well enough to go home. |
| Interviewer | But do they sometimes? |
| Participant | Very occasionally. They may go home when they’re very poorly but that’s usually the patients choice? |
| Interview | Or do they go home when…umm…and then it turns out that they can’t do things? |
| Participant | They’d come back in. |
| Interviewer | They can’t do the washing… |
| Participant | Or the meals |
| Interviewer | They’d come back in to hopsital? |
| Participant | Yeah. Sometimes. Yeah. |
| Interviewer | So that’s something…so you think that’s something that can be improved upon? |
| Participant | Yeah but it would be something that’s generally picked up quite quickly so we could put some care in place. And do the D2A. |
| Interviewer | Right. |
| Participant | But the night time would be an issue sometimes. Generally when the patients don’t cope it’s when they’ve gone home when they have been advsed not to. |
| Interviewer | Mhmm |
| Participant | They want to be at home but they’re not being realistic about what they can and can’t do. So although we throw all the support at them they still can’t manage and they end up falling and ending up back in hospital or they end up deteriorating and ending up back in hospital quite quickly. So then they end up back in. |
| Interviewer | Okay. That’s fair enough. So, what would happen…umm…in the circumstances where you’re providing…no, you’re not providing but someone else is providing extra work like the washing or cooking the meals or something but then the health need is done. So, they’ve finished their antibiotics and you discharge them. What happens then? Do they continue being supported? |
| Participant | I’d hope so yeah. I’d hope so. Until they can do it themselves |
| Interviewer | Right. But you can still discharge them? |
| Participant | We can discharge them from the acute side of things. It can…generally it would have been recognised that they needed care before then if they do. But the antibiotics have improved their health so they may be better and able to do more for themselves. But they’ve still got their friends or family support or the care that has been put in there to support and make sure they don’t go downhill and that they keep improving after the antibiotics. |
| Interviewer | So sometimes the…the reason they can’t do things is because of the ill health that you are treating? |
| Participant | Yeah, yeah |
| Interviewer | So if you’re treating it you’d hope to see some improvement in their ability to go up the stairs or make their own dinner for instance? |
| Participant | Yeah |
| Interviewer | Do you see that happen? |
| Participant | Yeah so for instance, the chap that we’ve been to this morning. He was very very sleepy when we first started going in and not doing his housework and things at first. He was able to feed himself and get himself drinks; that sort of thing but he was very very tired and not as lively as normal. But as the antibiotics have been given to him he’s improved; like today he’s got more interst in the house and keeping it clean and the things he wants to do. And he’s got more interst in cooking his meals and he’s awake more and he’s more jovial and by the time we leave him he will be back doing wat he could do before he was ill doing what he could do. |
| Interviewer | Okay |
| Participant | And he manages very well considering. |
| Interviewer | Okay. Interesting. So now that we’re sort of talking about the time that you discharge them; one of the things you said that you do in addition to the health need that you go in to treat is to provide some emotional support. It’s not why you’re there but whilst you are you’re chatting and you said ‘people are sasd to see you go’. Is that why they’re sad to see you go? Because they will ose some support? |
| Participant | Yeah I think some people who do live alone and are a bit on the lonely side, when we’re going in they say things like “I’m going to miss you chaps when you stop coming in” and “I’m going to miss the company” and “I’m going to miss your faces and someone coming in everyday”. And then, you know, they could go back to having nobody from having company every day from going in to once, or even three times a day. Which is a bit sad really. |
| Interviewer | Yeah. So. Yeah. So if they benefitted from having your support…so did they benefit from having your support with other aspects of support do you think? |
| Participant | Well maybe, umm…some people would benefit from having that sort of support. Some people would benefit from having people to chat to and that might make them think they should go out more. Or maybe they should go to a day centre or something to get some company. So if they enquired about that then we could find out from the social team if that’s what they wanted but, obviously, it’s up to them. And then some people ar quite happy to get their lives back and not have somebody coming at 8 in the morning and then again at 2 and then again whenever; “oh thank god that’s over”. |
| Interviewer | Do you find that’s generally someone who has other people around them? |
| Participant | Yeah they’re happy to let it go. |
| Interviewer | Yeah |
| Participant | Because thay’ve got other people, family support, cleaners coming in. sometimes they will say ‘I’ve got so many people coming in, it gets a bit wary’ and I can understand that. |
| Interviewer | Yeah |
| Participant | And then for other people they look forward to it and enjoy the chat. |
| Interviewer | Interesting. We’re doing well here [participants name]. Well I think that’s the end of that section too. We’ve covered the last question through chatting which is about how beong discharged makes the patients feel; positives and negatives. You’ve covered the spectrum about people being happy about it and others feeling sad at times as well. So, thankyou for that.  Umm…so reaching the end of the interview now. Is there anything else you’d like to add about your role in the service? |
| Participant | I don’t think so. I think I’ve covered everything |
| Interviewer | And anything else about improving the service? |
| Participant | No I think it’s perfect as it is [laughs] |
| Interviewer | [laughs]. Fine. Well lots of what you said is very interesting. You might remember from the information sheet you read, and the consent for you signed that there may well be another interview at the end of the research where we will use use interviews that I’ve done with patients to reflect on how they feel and you can discuss our findings there. |
| Participant | Yes, that will be interesting. |
| Interviewer | That’s it, thank you very much for your time |
| Participant | That’s alright. |
| Interviewer | Thankyou. |

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