Date: 11/11/2021

Time: 16:00

Location: Dorset county hospital, private office.

Participant Role: Staff nurse

START

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| interviewer | Right, hello I am [interviewer name], fellow member of the Hospital at Home team that we both work at so we already know each other. What I would ask you to do is to answer the questions as if you’re talking to someone who doesn’t know anything about the service because the person who is going to end up reading all about it and the data and so on isn’t going to know about it all. So any clinical things you say just give as much information as you can and don’t assume any implied knowledge that I may have. |
| Healthcare professional | Okay |
| interviewer | And did you sign the consent form? |
| Healthcare professional | yes |
| Interviewer | And you read all the information and so forth? |
| Healthcare professional | Yes |
| Interviewer | It’s being recorded and you can ask to stop at any point by asking me to stop and you don’t have to answer any questions you don’t want to is that ok? |
| Healthcare professional | Yep |
| Interviewer | Okay. So we’re going to start. And to get the conversation going if you could explain what Hospital at Home is, what you do and how it works? |
| Healthcare professional | I am a registered nurse and my understanding of Hospital at Home is that it is a team who operates as *virtual* ward for patients you are not *clinically* discharged from the hospital; they are still under the consultant who admitted them to the hospital initially but it is deemed that they can be cared for by the hospital at home team at home. The patients are not normally having an Early Warning score, are not needing close observations every hour, because we (hospital at home) are not able to do that. So, we go in for, normally, one, two or three treatments maximum per day. And during that time the patient has constant access to the team via telephone and if anything changes we can go out and see the patient again.  Some are…to sum up, we go to patients who still under the hospital consultant but go home for care. With that care comes an understanding of that their envi… home environment has to come into consideration. |
| Interviewer | Okay. Loads of great information there. Umm…so what…umm…what deems them appropriate then to be treated at home? |
| Healthcare professional | Well first of the patient needs to want to and consent to have their treatment at home. Sorry…”what makes them suitable”…well their home environment needs to be suitable and safe for us to work in. Also, if they have got any care needs they need to be addressed prior. I’m not saying we cannot take patients with care needs but anoandther agency like [care agency name] would have to be administered first. And the most important aspect with someone having treatment from Hospital at Home is that it is in the patient’s best interest; that they aren’t going to have a worse treatment and service at home than in hospital and it’s safe to do that. |
| Interviewer | Okay. You mentioned something about having a low warning score? What is that? |
| Healthcare professional | Yeah |
| interviewer | Can you explain what that is and why it’s important for it to be low? |
| Healthcare professional | Yes well the early warning score is just a tool used by [hospital name] and many other hospitals as a way of being able to assess and make sense of their vital signs. So you’re looking at their blood pressure, pulse, oxygen saturations, respiratory rate and temperature. For each of those vital signs you will get a score and you’re looking for a score…so if all those clinical indications for example their temperature in normal range will give you a zero but the higher the temperature goes or lower goes they will get a score. So the higher or lower the temperature they will get a score and that’s for each one (vital sign). So if someone is clinically needing, like, high dependency, or intensive care then they would be scoring about an eight which shows they are really unwell. So we use it as a measure of their clinical decision.  So sometimes we can patients with about a three but if it starts to go up we would want it to come back down. Saying that some of our patient’s scores are above three because their oxygen saturations are known to be low and they have a constant score of two or three but that might be normal for them. |
| Interviewer | Right so you want people who are fairly well, using this scoring? So a low score means they are fairly well? |
| Healthcare professional | Yeah. There’s nothing that…because we only go to see people between one, two or three times a day whereas on a ward they are seen regularly even if that’s just by someone walking ast them, that isn’t going to be happening at home so we need them to be deemed stable. |
| Interviewer | Okay and that’s because you don’t see them as often? They get less clinical interaction? |
| Healthcare professional | Yes absolutely |
| Interviewer | And how do people find that? |
| Healthcare professional | The patients? |
| Interviewer | Yeah |
| Healthcare professional | I think that is one of the considerations before they go home. Often, they have someone at home with them which is a great advantage that they aren’t alone. The patient’s relative, guardian or whoever’s part of their family or partnered with them then we include them in the care as well. |
| Interviewer | So that’s someone living with them? |
| Healthcare professional | Living with them or at least passing through regularly |
| Interviewer | Okay so you think that is a real benefit for a hospital at home patients then? |
| Healthcare professional | Oh yes, absolutely. It’s more advantageous for the patient to be discharged home if there is someone there or if there is someone to come and see them. |
| Interviewer | Yeah okay because you also talked about formal, paid care as well earlier on you said about packages of care or something. You said some people might need formal care? |
| Healthcare professional | Yeah because we don’t only take the walking well, we have been known to even take terminally ill patients and if that is the case then you just have to make sure that *everything*  is in place because macmillan team do that. But sometimes that servie Cn’t be provided and we have got capacity to do it and their needs are being met to the same standard…then basically, if a hospital at home patient is a t home they shouldn’t go without care that causes them to deteriorate. |
| Interviewer | Okay, because in hospital they would have 24/7 ‘care’ haven’t they? |
| Healthcare professional | Yeah |
| Interviewer | So why…what is it that is better for them to be at home then? If they tick all the boxes of the criteria they need to meet to be able to go home, is that better for them? |
| Healthcare professional | In my experience as a bank nurse for a year and a half and now as a staff nurse in the department; people eat better. This is what patients tell me and what I have seen; they sleep better, they’re happier at home, they’re with their loved ones at home especially with covid and reduced visitors in hospital then they get more interaction with their circle, their inner circle of care. They are more empowered too, their decision, their choices and to think they say that they do feel better at home and eating and sleeping and being in their own environment is better, they say it’s better for them. |
| Interviewer | That theory of empowering is interesting. Can you explain it a bit more? |
| Healthcare professional | Yeah I think the difference between the care in hospital and when you go into someone’s home; in hospital it’s like patients are coming into nurses territory because you know the rounds, policies and procedures or whatever and the patient is disempowered because they don’t know what’s coming next at first.  But then the role is reversed when you get to their home. One, you have to get consent to enter their home, and two they are empowered because they know what happens in their own home, they know when to eat, and they don’t get distracted by other things going on. Us as nurses take on more of a…more…more important for us to get consent for everything we do which in hospital it’s much more implied without asking |
| Interviewer | Interesting. So yeah with it being implied, is it almost he opposite way round that the balance of power naturally favours the patient at home compared to when in the hospital the power naturally favours the staff because eof all the routines and knowledge they have of the routines. Like, have you noticed that when at people’s homes? That they just…is just something that happens or something that you consciously try to do? |
| Healthcare professional | I think initially, when I started because you are gaining consent for where you put things, can you put the drugs there? Do I need to take my shoes off? Can I put the observation and clinical bags? When I’m taking observations where does the patient…when I’m taking blood where does the patient want to be sitting and where do they want treatment? And that is a conscious respect thing for people’s home whereas in the hospital you would just do it. |
| Interviewer | Yeah |
| Healthcare professional | So you’re asking what the patient wants and how they want it so it’s a subconscious thing because you are in their home. So, I’ve never really analysed it, but I definitely ask more than when I’m in the hospital. |
| Interviewer | Mmm |
| Healthcare professional | So I think, yes, it’s a definite. I sense that the patient seems to like that because it’s like they have control then. They’re in their own clothes, wearing their own slipers. They’re more empowered. |
| Interviewer | Yeah so when they feel more empowered. What does that lead to relationship wish, or how they are with you or what they say to you? Different to…well not necessarily different to hospital but, yeah, what are they like with you when they’re more empowered? Becaue they are in their own environment |
| Healthcare professional | It’s the choices that we try to create as much as possible. We can change our run order as much as possible but we have to consider all the other patients too. Like if they all wanted to be seen in the morning then we couldn’t do that. But as much as is possible we fit around their life. I’ve never really thought about this before but they don’t have to stop their life, their social life. When they’re in hospital, and especially with Covid, it all stops.  When an acute patient is at acute hospital at home they actually can do more things like go see a friend or go and do something and they don’t miss things and we try to adapt and change to that as much as we can depending on their treatment. |
| Interviewer | So how much is it lead by their health timings? Partly? |
| Healthcare professional | It has…well… for example there was a gentleman who hadn’t seen his granddaughter for a long time and it was at the same therapeutic time for his IV antibiotics and the need for it to be at that time was explained to him that ideally it will be given at this time but he was empowered to make that choice that he wasn’t going to have the treatment and saw his granddaughter. It wasn’t for us to pass judgment and he went on to miss a dose and went to see his granddaughter. But that doesn’t happen that often but he could make that own decisions; seeing his granddaughter and being really really hapspy and he didn’t get worse the next day. It doesn’t happen all the time because it’s not about galavanting about all over the place and you should be focussed on your health but he had the freedom to make that choice, and people can do that. But it doesn’t happen often.  There was one patient who used to go to the pub every lunch time. Not saying that is good for their health or not but then that was his choice and we worked around that as much as possible. |
| Interviewer | Okay so unpicking why it’s such a good thing that they can carry on with their life as you put it and that they have got a bit more freedom. What’s the benefit of that? |
| Healthcare professional | Well when you’re sitting in the hospital and you have only got he television and you make a few friends and acquaintances with, maybe, the people in your room at the hospital but those patients there don’t *love* you [laughs] and so no matter how good your rapport is when you’re with the people that you love you know they are going to do their best for you which is a great comfort for you as well. Which is going to make such a difference no matter how much you like the staff and the people caring for you hopefully have got people around you at home that you know care. So you’re in a caring, *more* caring environment. |
| interviewer | Yeah that’s interesting isn’t because in hospital you’re surrounded by people and less people at home so is it something about the standard of the people? At home |
| Healthcare professional | Yeah well going back to what you said about being assessed. We would not intentionally send anyone home who wasn’t getting the care or wasn’t able to care for themselves. It could be something simple like you want a glass of water; when you’re in hospital you ring your bell and you may have to wait an hour but if your partner or someone is there for you they would get it straight away. There’s that aspect of their care too. They (patients) do say they prefer to be at home. I haven’t met one person yet that, even on the rare occasion that they have to come back into hospital for more input than we can give, who wouldn’t rather be at home. |
| Interviewer | So what if they haven’t got someone with them? you mentioned paid and formal care that might need to be arranged. Or someone else? |
| Healthcare professional | Hopefully prior to discharge there will be a social assessment of their home environment, who lives with them and animals too who can be a great source of comfort. We have to make sur they have the mental capacity to make the cinical decisions to be treated at home; we wouldn’t send someone with dementia for instance home alone, so first the mental capacity and secondly the physical capacity to cope with washing themselves and dressing themselves and eating. That is assessed prior to discharge maybe by the nursing team but we would certainly be asking those questions as nurses: “who’s going to be cooking your meals? How do you cope?” Umm…So, once we know those basic needs are being met then we can go in and do the clinical input they need. |
| Interviewer | So if their clinical need isn’t able to be met ten they’d stay in? |
| Healthcare professional | If we can’t take this patient because they need a package of care or something then it would be up to the ward team to try and get a package of care prior to discharge. |
| Interviewer | Okay. So you don’t provide those sorts of things like which you just said? |
| Healthcare professional | Not as nurses on Hospital at Home we don’t. |
| Interviewer | Why is that? |
| Healthcare professional | Well maybe we should. That’s a good question. I mean, on our runs we usually go out with a healthcare assistant but I think it’s to do with the timings of medication and about getting as many patients home as possible. As a professional nurse, if we did a healthcare assistant’s job, although we do work collaboratively together, it wouldn’t be the best used of a registered nurse as a resource. So it’s not that we *can’t* do it but we have to focus on the cinical need.  On occasion we will g and see someone and they want a cup of tea or help with something and it isn’t time consuming. Someone might want to go to the toilet and their carer hasn’t arrived yet. But we don’t do it routinely because it isn’t a good use of our service. |
| interviewer | Mhmm. Okay. Good. Okay. So, that’s a good clear description of what it is and how it works. Can you think of…you’ve covered lots of strengths and positives to the service but can you think of any challenges? |
| Healthcare professional | Yeah. For me I think the main challenge at this time is that we used to have a consultant who oversaw all the Hospital at Home patients; even if they were discharged from the hospital by a different consultant they were overseen by our own consultant. That meant that…Oh I failed to mention that we have a junior doctor who oversees each patient’s medical needs and looks at blood results and requests bloods and liaises with the…all the different consultants that our patients can be under, all various types from the hospital…but one of the disadvantages now that some hospital consultants think ;out of sight, out of mind’ and then getting the patients to be followed up or make a change if their clinical condition changes for the better for the worse then their plan of change and medical care needs to change and we cannot change their plan without the consultant in the hospital; but the consultant can be slow at doing this. When we had our own consultant, we could speak to them and they could act instantly.  Also, if a patient is discharged from hospital and they were going to have a procedure the next day like an ultrasound or CT scan or an MRI scan; if they were going to have that on Tuesday and they were discharged on Monday then sometimes their scan gets wrongly cancelled and they have to wait. This puts the patients at a disadvantage by coming out to us. So, to midify that to take a patient we do ask “have they got any planned things like the MRI, ultrasound?” and if they do we either insist that the patient will be coming back for that or that we won’t accept them until it’s done.  So yes, out of sight and out of mind from the medical teams point of view can be a real disadvantage to the patient. |
| Interviewer | And do they…how do they find that? |
| Healthcare professional | I don’t think the patients know about it really. We don’t say about it. As nurses we come back and then badger the team on the patients behalf which takes a lot of time with the F1. So, we, I think, I think the patient is happy to be at home and it does eventually get done but the nurses just have to keep on trying to resolve it but it might take a couple of days to get done instead of in the hospital it would have only taken a few hours. But the patients, hopefully, don’t know because we don’t moan about it. We just come back to the office and sort it. |
| Interviewer | So it delays things? |
| Healthcare professional | It does delay things. It can. It..yes it can delay things so that is, in some ways, taken into consideration when we are planning on taking someone from the ward to look out for that. |
| Interviewer | Okay. Any other weaknesses that you can think of? |
| Healthcare professional | I think…weaknesses…not at the moment. |
| Interviewer | Okay, fine, not to worry.  Okay any other challenges to actualy treating someone outside of a clinical hospital setting that you might come across? Does that make sense? |
| Healthcare professional | I think the challenge is the actual environment that you are nursing in sometimes. For example, we’ve had infestations with fleas and relatives tht have been known to be violent and aggressive. There have been animals that are violent. So the environment, and you won’t know about that until we get there even though we ask “are there any hazards?” before we go to their home. But it’s subjective isn’t it? The patient will be, like, “no! There’s no hazards” but when you get there we find the carpet is squishing with cat pee and there’s fleas jumping everywhere but to that patient that isn’t a hazard but to us it is. So there are those sort of challenges to overcome. The environment. The next challenge can be the location, they may be up five flights of stair and you go with your anaphylaxis kit if you’re giving IV antibiotics or any drug, it might not be antibiotics; the patient might have an adverse reaction to the drug but the oxygen and the anaphylaxis kit is in the car and you’re on the firth floor. So by the time you’ve ran down and got back up [laughs] you might be a bit late. So this is something you have to consider when taking on a patient. If it’s the first time you’ve given those drugs you need to be prepared. |
| Interviewer | Right so is there something about a lack of access to medical support, diagnostic scans and stuff and also speed of treatment compared to hospital where the oxygen and the emergency drugs are right there on the wall in hospital? Is that a fair summary of the challenges? |
| Healthcare professional | I think that’s fair to say but, but, but to counteract some of those known problems the nurse that goes out to see the patients are quite experienced nurses so, I know the team doesn’t take newly qualified nurses, so our diagnostic skills are good so we know how to recognise an ill patient before they deteriorate. So we counteract those weaknesses with experience of staff.  Also, we leave a leaflet, a booklet with the patient with our phone number and contact number and we can be contacted up until midnight and outside of those hours they are advised to call 999 and 111. So the effective communication to the patient whilst they are still in hospital and reiterating it on the first and second visit so we don’t just say it once so that it is communicated consistently to the patient so that they understand that they don’t have to wait for us to come for their next visit. It’s like, we give this visit up until midnight, we’re not like district nurses who just come in and out, we’re flexible as we can be so call us with any concerns because we would prefer to know before instead of getting there the next day and it’s worse. So we are counteracting that lack of medical support and equipment by advising the patient to communicate with us. |
| Interviewer | Okay, do they call often? Do things go wrong? |
| Healthcare professional | I think once we’ve told them to call they’re good at calling. Usually it’s something little; well, to them it’s little. Like their IV pump isn’t working. Sometimes we give 24 hours of IV through an infusion pump and they don’t know if they don’t think it’s working or emptying. So they might call us if it’s not getting smaller or their arm is hurting.  I find initially they don’t phone but once they’re told repeatedly or they ask us the next day and we say “you *must* phone us” they get the idea. On the whole they phone about things that are appropriate, things they want to know. So no, we aren’t inundated with phone calls because we have minimised potential problems with effective care and communications. When they do phone we have to deal with. |
| Interviewer | How do you feel with it? |
| Healthcare professional | Depends on the phone call and the question. If it’s a patient we know is deteriorating then we would…well *I* would, if I thought here life was in immediate danger I would think how could I get them to hospital, how would they get to hospital. If they were close by we could go with a colleague, picj them up, put them in the back of the car and take them to the emergency department if that was the easiest and safest way to do it. If they had collapse and we had a phone call about that we would be calling 999 before going to help. If the patient was talking and breathing and wasn’t having any signs of immediate danger then we would go and see them and asses them. |
| Interviewer | And for the ore minor things like their pump wasn’t working? |
| Healthcare professional | Yeah depending on what they’re telling you wou wouldn’t be calling 999 for that, you would go out and see them if you could. |
| Interviewer | So ‘if you could’. What would stop you being able to go out and see that patient? |
| Healthcare professional | If you were busy with another patient. But we do work as a team so you could phone back to base and see if someone else could go or usually the phone call goes to the nurse who is in charge, they know what is going on. I might be around the corner from the person who has called but seeing a different person and the person in charge would get that call and then call you to ask if you can pop around to see Mr X or Mrs Y. |
| Interviewer | Okay, so afew other things I want to try and understand is how…umm…so you migt ave been at another patient…how many patients do you typically see? How far away are they? How long does it take to get there? How do you get there? |
| Healthcare professional | Yes, well going back to the disadvantages of Hospital of Home, and not for the patient, but for the rest of the hospital team. We would be like to be able to give clearer guidelines to the hospital teams. So, more of the hospital teams know what we did. It’s really difficult to make pro-formas which, like a flow chart, say ‘we take this patient with this medications’ so then they have tis pro-forma in front of them and can tick all the boxes and say with confidence “oh yes they will definitely take this patient” or “oh no they won’t be able to take this patient”. But because of our distances and we had a patient on the north of [English county] and then a referral for someone on the tip of [town at southern end of same English county] that eats into our time so we look at it more like capacity. So we might not be able to take the same condition with the same clinical presentations because of locations, workload and staffing levels.  So that is a disadvantage to the referring staff because one minute we can take a certain medical condition then the next minute we can’t. So when getting to the patients we try to max…maximise our service capacity by err…adapting patients to our cabilities then we can take as many as possible |
| Interviewer | As in putting lots from the same area together? |
| Healthcare Professional | Yeah from the same area and then devising our runs based on where they live so that one staff nurse isn’tgoing to north [English county] and then to south and then the other one going from south to north. |
| Interviewer | Okay, yeah, I get you. Okay…and…the other thing you said in passing was how that when you assess them ‘in hospital’. Is that where all the patients come from? Inpatient settings? |
| Healthcare professional | Well actually no entirely. I think it used to be but I have noticed we are also taking patients directly from medical clinics. So these are the sort of patients who have been into hospital wards but discharged with a long-term problem and then they would come into what we would call an outpatient clinic. So that could be respiratory outpatient clinic or cardiac outpatient clinic. Then without our service these doctors would have to admit the patient into the wards for antibiotics, for example. But now some consultants bypass the admission process into the hospital, communicating directly with Hospital at Home to see if we could go and look at these patients at home. So it’s not only the inpatients. It’s probably become more and more treated, preventing them from being admitted at all. |
| Interviewer | Yep. Great. Okay. Now. So, the other thing I wanted to start to talk about…so, your relationships with the patients is the next sort of section if you’re happy to carry on. |
| Healthcare professional | Yep |
| Interviewer | Well you said that sometime patients don’t initially call but then later on they are more comfortable calling and I wondered if that had anything to do with your relationship, and how your relationships develop over time. So if we just explore in general your rapport with patients, how it is, what makes it build what stops it building that sort of thing. |
| Healthcare professional | I think initially it’s about listening to them. when we…I say ‘we’ I can’t talk for everyone else but when we [laughs] ‘we’….sorry. When *I* go in I introduce myself, show my ID, ask if they have got any questions. Then answer any questions then if you don’t know you ask someone who will for them. I think, as nurses in a whole, that people trust you. It’s a lovely profession where people trust you and you have to do something dramatic to lose their trust. SO you automatically have their trust anyway. |
| Interviewer | Ah okay. |
| Healthcare professional | And then if you go back the next day and they ask you a question, you suggest they call ahead to ask this and then they know they can and they and the patients are like “oh we didn’t know, we didn’t like to trouble you” “oh it’s no trouble to have a phone call.  But rapport develops quite quickly I think in their own home in some way… |
| Interviewer | More quickly at home than in hospital? |
| Healthcare professional | Well I don’t know because in hospital if you start…there was some research done that showed that the patient bonds with the nurse they see first and are admitted by or something. I don’t know it’s more at home but by going into their house you are closer in their personal space and maybe that affects the, the…I personally don’t think I’m closer to patients than I would be compared to in hospital. However, I do see, I do see the advantage, I can see more of the holistic care in their own home because you’re not just seeing that… so, you can tell things, like, with their diet because you can see if they only have a microwave to cook with, for example, so you wouldn’t go advising them to eat lots of things like vegetables that they’re unable to cook there. I’m waffling.  When you are in someone’s own home you can see what health advise they might take and you can taylor the advice you give. So holistically, you’re not telling them things you know they would never do. It’s easier to be holistic; you get a wider, broader picture. So going back to this patient who said they had no hazards or anything, and you wouldn’t never know by looking at them, but their home was hazardous to health and detrimental to the healing of a foot infection. In the hospital they never knew that so they didn’t get better. |
| Interviewer | So being at home with them meant you knew what was right to provide? |
| Healthcare professional | Better and more appropriate treatment. Absolutely. Absolutely. So it was her foot and she was going on a soggy carpet and they didn’t think in hospital they would need a shoe for that foot or to suggest the carpet was cleaned or whatever. Once t home, if it was done in a gentle and non-judgmental way, “you might want to think about, just whilst your foot is healing, getting your carpet cleaned”. We’re in their home so we have seen their environment and you’re doing the dressing on the foot then you are going to be doing extra things along side it to get them better |
| Interviewer | So you’re telling them that as part of health advice? |
| Healthcare professional | Mmm, or if you see they have a nice garden but unable to go for a long walk you can so easily suggest “oh why don’t you sit in your garden for a while” because you know they have got access to that nice outside space that it would be beneficial for them to sit there. From a nursing perspective it is really quite rewarding. |
| Interviewer | Interesting perspective thanks. Okay. So, umm…the other thing, then…how long are you there each time? |
| Healthcare professional | At this moment it is quite nice in the sense that you are usually there for about betwenn half an hour and an hour if there is a complex dressing or something to do. But at the moment we are able to be patient dependant whereas sometimes when we are busier we may have to not chat so much [laughs]. But yes, between half an hour and a n hour depending on the ckincial need really. |
| Interviewer | Okay. And for how lomng, as in how long do patients stay on the books? |
| Healthcare professional | That’s intermittent as well. We do have regular patients who keep coming back like if they have a chronic illness they’re never going to get better from but will get an exacerbations where they need medical intervention from us.  Usually…well we can have patients for only two days if it gets them out of hospital quicker and gets them home quicker. Or, we can have some patients for two to three months. That’s not the ideal but if it suits them that’s fine. It depends on the clinical need. |
| Interviewer | Okay so what is the relationship like at the end…two questions; whilst you’re there what are you doing for an hour, if you’re there for an hour and you have drip going, what ese happens during that hour? And…no, let’s just start with that? |
| Healthcare professional | Mm, yeah. If you are a hospital at home nurse you need to like to talk and know how to listen. You pick up on so many things. So thinking about this one patient we had who was diver, but his house had nothing in it but we knew he was a diver and he had a sea horse tattoo so you’d go in and talk about diving and where he has dived and what he’s doing next. Patients like to talk about their interests.  Whereas you would see another patient who has pictures all over the walls and you start talking about one of them. So, you have to be interested in people. |
| Interviewer | Okay, so you’re using, you’re using |
| Healthcare professional | [interrupts] the environment |
| Interviewer | For… |
| Healthcare professional | To start conversation because people don’t, once you’ve introduced themselves and you’ve asked at the beginning and the end if they have any concerns or questions but it comes up anyway. |
| Interviewer | What it comes up anyway because you’re chatting? |
| Healthcare professional | Yeah I think so. If not you ask at the end. |
| Interviewer | And someone you have for two days, is that different ot someone you have for two months? |
| Healthcare professional | Oh absolutely, absolutely. With someone for two days it’s more about ging in and doing the clinical task you’ve got to do. You don’t have the time to develop that depth of knowledge. |
| Interviewer | Depth of knowledge about what? |
| Healthcare professional | Sorry? What did I say? |
| Interviewer | You said you “don’t have the time to develop that depth of knowledge”? |
| Healthcare professional | Oh the social knowledge and emotional knowledge. The things that someone, say for example, is depressed who is being the most happy and smiley person you haven’t known them long enough to ask about that or pick up the visual cues. If it was someone you have been seeing for a month or so and they are usually chatty but today they’r not then firstly, you notice the change, and secondly you have the rapport with them to ask ‘oh you don’t seem yourself today, are you ok?’ or ‘it’s normal to feel down’. So yes, the longer you are with the patient it’s easier to pick up a few things you wouldn’t after a few days. |
| Interviewer | So you mentioned rapport again. As if it develops over time? Is that right? |
| Healthcare professional | Well yes. But you do have to develop a level of instant rapport but there’s more depth of the rapport when you get into…more into their thoughts and feelings which develops over time. And those thoughts and feelings can impact on their health. To contribute to their health people want to be listened to and if they feel that their voice is being heard it’s…it takes time. I don’t think you can just develop that. |
| Interviewer | So do you think that is why you try to build rapport? As a health improvement tool? |
| Healthcare professional | I think better the rapport then the better holistic service you can provide. The more trust they have the more information they give. Or to just be a sounding board, I don’t know. |
| Interviewer | Yeah so you think…yeah so building that rapport makes them more open with you and therefore they give you more information. |
| Healthcare professional | Yeah. |
| Interviewer | And through that you might identify… |
| Healthcare professional | Other health needs or been something much more simple. |
| Interviewer | Okay. Umm…yeah, okay that’s fine. So is there ever anything else that you do for the patient? So you go in with a clinical task to do is that right? |
| Healthcare professional | Yeah |
| Interviewer | So whilst you’re there is there anything else you have to do or found yourself doing that you dind’t expect to do? You touched upon making a cup of tea and helping to the toiket. |
| Healthcare professional | Umm |
| Interviewer | It’s okay if not |
| Healthcare professional | The only thing I can think of is that I might think that there might be another intervention that is needed. I’d bring that thought back to the office. Not really something I would have to do. |
| Interviewer | Okay. So the next part is to explore a little more about your understanding of the people around the patient during their time with Hospital at Home. So, again, it came up a bit earlier that you felt it was important that they ahd someone at home with them or at least close by and coming frequently. Umm…can we build on why that is or what you know these people do for them? so examples of times you know someone has had to help the patients and what they do. And also, what sorts of people, who are they? |
| Healthcare professional | So ill say informal carer. someone has come out of hospital and someone is there with them, whatever relationship it is they become a bit of a carer for the patient. So part of our role is to check on the carers and get to know the carers name and what their ability is in supporting the carer. So we build up a rapport with the carer and it’s recognising that the carer is part of the recovery of the patient. They might end up getting exhausted. We had a lovely patient who had a chronic lung condition and was happily married. He got very short of breath so his wife ended up doing an awful lot of work. then her daughter and granddaughter got ill and we ended staying and talking to her for half an hour and pointing out to her that it’s okay for her to go out for a while and it’s okay to go and see your friends and it’s okay to do this. So although we aren’t looking after the carer we need to be aware of their needs because if the carer the collapses then the patient might end up coming back into hospital. It’s not exactly that we *must* protect the carer so the patient stays out of hospital but it is looking after the family within our, within our best ability because we might have access to things and know what is right to say to the carer to give them the ‘permission’ from a healthcare professional: “you *can* go out, you *can* make time for yourself. It’s actually vital that you do otherwise you aren’t going to be able to look after your husband”. So we provide…I say family…but we provide for the patients close circle automatically. |
| Interviewer | Okay so ‘carer’ you refer to that close circle that becomes a carer? |
| Healthcare professional | In my experience yes. |
| Interviewer | What sort of family member? |
| Healthcare professional | So it could be partner; whether that is wife, husband. It could be your son or daughter. Son and daughters often come in to support intermittently. Occasionally it could be good friend. |
| Interviewer | One more than the other? |
| Healthcare professional | Usually it’s a partner who is the main carer. |
| Interviewer | Okay and do you see them more? If they live with the patient do they become involved? |
| Healthcare professional | Yes absolutely. I think it’s quite vital that they do. Funny you should say that because it’s actually quite rare that the patient *isn’t* there. |
| Interviewer | Is that deliberate? |
| Healthcare professional | Yes. I’m trying to think of a patient who’s partner stays out the way. Maybe only a couple but nine times out of ten they’re there. The ones that don’t are usually the very independent type. When they do have a partner it is usually them who is most involved and you find yourself speaking to them quite a lot. |
| Interviewer | Okay and we are talking about ‘care’, what sort of care do they provide? |
| Healthcare professional | It will be those basic activities of daily living like walking, cooking, making a drink, maybe helping a patient move or get out of the chair. They can usually move but might need some physical assistance. And toileting. |
| Interviewer | Okay so the ones who don’t need that sort of thing…are they the ones who see you on their own? |
| Healthcare professional | Yes. Yes. I’ve never thought about that really but yes it is. So those who are more involved with the patient when we’re not there are also more involved when we are there. That’s what I have observed, yeah. |
| Interviewer | Okay. Umm…so when you…that’s interesting because my next question has been covered so…so similarly to the patients then, the longer term patients, does your relationship with family member or carer or whatever change over time compared to the shirter term patient? |
| Healthcare professional | Yes. Yeah…it…it deepens I think. The longer we have a patient it becomes more like you’re part of the furniture like a temporary family member who keeps coming in. So, for example they might be dressed up when you go in for an evening visit but you say “look, keep your pyjamas on, this is your home, this is your environment, don’t worry, you don’t need to get dressed up because we are coming in”. and the longer you’re coming in they are more likely to do that but at first they’re all dressed up. |
| Interviewer | Okay so they feel more comfortable around you as time goes on? |
| Healthcare professional | More comfortable yes. |
| Interviewer | Okay. That’s interesting. What do you think that makes them feel more comfortable then? |
| Healthcare professional | Well I think because you’re in there around their close circle and you’re phusically close to them that they feel close to you over time. |
| Interviewer | Okay. But think about how it develops though. There must be more to it than just being physically there? |
| Healthcare professional | Yeah. Well you’re talking to them and you get to now about their family, their dogs, their parrot, their tortoises, their like and dislikes where they’ve travelled then you get to know a lot of information about that person and because you have shown the interest they adapt over time and just trust you more because you know more about them as a person as time goes on. |
| Interviewer | So you find things out as you go alomng by being there. Personally and socially? |
| Healthcare professional | Yeah over time |
| Interviewer | How do you get that information? |
| Healthcare professional | The verbal cues and the surrounding cues like the tortoise or the parrot or ‘what made you do that?’. One told us “oh my husband used to buy me an animal every year” and then you got to know about the husband and those birthdays. It’s not like a set questionnaire; it’s just talking and seeing what comes up |
| Interviewer | Okay. And what about the different people. So let’s…if I can just…you’ve covered partners and close family who live with them, and maybe close friends…they’re clearly the ones who sprang to mind but is there any other groups of people or individuals who have any sort of involvement with the patient? |
| Healthcare professional | Well only the formal care agencies really. So someone who needs what we would call a ‘package’ of care if they don’t have family or the family can’t provide it they go in to do the care or the cooking or the cleaning. Or there is the district nursing teams but we don’t tend to cross obver with them.  So the important part of the hospital at home care in the home is to document what we have done and it is left in the home so the other agencies can know exactly what we are doing so things are not missed. We write what we have done. |
| Interviewer | Sure. Okay. Umm…so that’s…so the other thing. These people, do you find these people have to step up when they are more unwell? Step up their support? Are they not always their carer I think is what I’m trying to say but they are at the moment because thy are unwell? |
| Healthcare professional | Mmm it depends on the clinical reason. They might ave been the carer and the person has got worse or they might have been fully independent but now they need care? |
| Interviewer | So the type of patient is quite broad? From patients who were dependant on others even before becoming unwell and oppositely those who are completely independent? |
| Healthcare professional | There is a *really* broad spectrum. You can go from someone who needs an antibiotic for, say, a dog bite but is normally very very well all the way to a complex patient with complex needs who has multiple comorbidities like diabetes, chronic lung conditions, obesity and has developed cellulitis and needs IV antibiotics. But despite all that they have been deemed stable enough o be at home but they are more likely to deteriorate quickly and for complications to arise. |
| Interviewer | Okay, so back to the thought about…to get you thinking in a bit more detail if you can about the type of people who are involved with patients. If there is anyone else? |
| Healthcare professional | Yeah doctors. Even though our patients are under the consultants at the hospital that discharged them into our care the GPs sometimes get involved and even though that can be..umm…advantageous it can become confusing because too many ideas are involved. That’s why the communication between all those groups is so important.  So, for example different types of medications are turning up from the GP and some different types from the hospital, or the GP might arrange a blood test that we have already done so it gets done twice so that needs to be communicated well. |
| Interviewer | We covered what these people do for people didn’t we? |
| Healthcare professional | Yeah the washing and feeding |
| Interviewer | Yeah and the meals yeah I remember.  I think we are getting towards the end now then. So…let me check my list. do you ever come across people who didn’t have enough support. Perhaps a bit like the person who subjectively thought their house wasn’t a hazard, do people ever claim they are going to cope and then you go and they can’t? |
| Healthcare professional | I personally haven’t but I know a colleague who did and the patient had to be readmitted. The great thing about the Hospital at Home is that they have access straight back into the hospital. This person even had a maximum four times a day package of care and they weren’t able to cope so they had to come back in. It is infrequent but you have to look and be sure that being at home with Hospital at Home is in the patient’s best interest and if it isn’t one of us nurses will be telling the hospital consultant and the site manager that this patient needs to come back. |
| Interviewer | Okay…so. Okay. Hmm…that’s sort of, you have to try it to find it out sometimes? |
| Healthcare professional | Sometimes. Sometimes. This person was adamant and they had the capacity to make that decision. They were very ill but were adamant they were going home. So the in some ways…the ward got them home with the maximum care but the two hour gap between carers just wasn’t enough…so the patient came back but in some ways it was good for them to see that despite wanting to be at home it wasn’t in their best interest. |
| Interviewer | Fascinating stuff. I think we are drawing to a close here unless there is something else to add? |
| Healthcare professional | I would like to add one more thing. Hospital at Home team service runs well and it’s not just the same staff nurse and team going in all the time so it is really important that we communicate with each other in order to be consistent which means we can actually get the patient’s trust. So we all know *all* the patients not just the ones we are seeing so that we all know *all* of the patients. There’s nothing worse for the patient than inconsistent information because that will reduce their belief in the service. When we go in you’re better off saying “I don’t know about that yet”. But on the whole it’s important that the whole team knows as much as possible, then the patient won’t mind which nurse goes in. I think we do it well because we haven’t had any complaints to that nature but I think that is so important for any successful hospital at home service. |
| Interview | Yeah. Okay. So you rotate who sees who? |
| Healthcare professional | Yeah well because we are on shifts so we have early shifts which is 7:30 til 2:00, then we have a long day which is 7:30-7:30 and then there is a twilight which is 7:00 til midnight. Then everyone has got to have their days off so it isn’t going to be the same. That can be good because we can work to the individual nurses strengths. Like, if one nurse is particularly good at a task then they will go to see that patient. Effective communication written on the handover on the phone, the board, or the diary. That needs to be updated effectively every day. Like having the up to date blood results which we wouldn’t be able to access at the patients’ homes is really important to keep us all up to date. |
| Interviewer | mmm. so does the fact that you rotate who sees who, does that ever delay some of the positive…so is the reason you bought that up is to emphasise the important of being consistent? |
| Healthcare professional | Yeah because this service is a team approach and you go in and they tell you something then the next day the ssme thing gets asked again they will say “well I told [participant’s name] yesterday” but that information wasn’t relayed or the nurse that day hasn’t read about it then they will start to lose trust. I think what I’m trying to say that, although we are quite good at it, as Hospital at Home rolls out and gets bigger it will get harder and it’s important to be mindful of it. It’s really important |
| Interviewer | Especially considering how you put a lot of emphasis on the importance of rapport and trust for information gathering. |
| Healthcare professional | Yes. And it’s. yes. |
| Interviewer | It would delay the building of the rapport. |
| Healthcare professional | Yes I think so |
| Interviewer | Thanks for adding that. It’s a really interesting point that I’m glad we have got. So thanks |
| Healthcare professional | Thankyou [interviewer name]. |
| Interviewer | Cheers |
| Healthcare professional | Thanks. |

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