Int: you won’t be identified at all, anything you say will just be, you know, it won’t be traced back to you. Erm, OK. Can I just ask you to describe your experience in care and how you ended up in care, and what you do at the minute?  
Lucy: Yep. So I have worked for [company name] for three and a half years, where I, erm, predominantly work in a support office role. So I have 16 care homes that I manage the beds for, for all 16. I triage enquiries from the community, from erm, families, and I go and meet and I assess and then I allocate to an appropriate home and setting, then I coordinate their whole admission in. Then when they’re in, I go in and visit them and see how they’re settling, and then I do yearly clinical and acuity reviews with them and the homes as well, erm, for example if anybody – if their needs changed or their cognition changes or they, they, erm, require a particular house, I will arrange internal transfers to ensure they’re in the right environment. So that’s the main element that I’ve been doing for three and a half years, I work shift day, days, or what we call earlies, lates and nights, weekends, bank holidays, Christmas days, erm, I go in and work in all of our 16 homes regularly, because I have to, and because it’s great for my job because I know the residents and I can build a better understanding of them, and two because I don’t want to ever lose sight of why I got into care in the first place. Before I came to [company name] I worked at [company] for ten years, where I was supporting directly the elderly care sector, it was not in a regulatory role but it was day care so it was very low level. Erm, I have been the main carer for my grandparents for the last 17 years and have cared for my granddad right up until he passed away two years ago. So my love of care has always come from the fact that I’m a kind and caring person, I absolutely am passionate about opportunities, fair opportunities, erm in particular around capacity. And how sometimes it’s perceived that opportunities are narrowed, because of the lack of insight around that. So for me person centred care, opportunity and optimising how we support our residents is completely key for me. And that has been my drive for the last thirteen, fourteen years.   
Int: you sound very determined  
Lucy: yeah, give me a soapbox and I won’t shut up [laughs]. I am.  
Int: so you have a particular interest in capacity, is that sort of based on experience?  
Lucy: yes. Absolutely. And it’s, it’s, from my experience, it’s not that people or services or the community – so, to me sometimes people assume someone doesn’t have capacity because of the choices they make. Then they assume [emphasis] that what is available to them with regard to options is reduced, and so for me I very much like to give people who don’t always have the opportunity or knowledge [emphasis] to have a voice, a voice. Because they’re as entitled to a fair play and a full choice as anybody else.   
Int: definitely. It sounds like they’re very lucky to have you  
Lucy: I’m, I’m, yeah – I don’t, [laughs] I don’t, I don’t, I don’t have many, I suppose erm, with regards to workers, keyworkers, families – I fight for people that don’t always have the ability to do it themselves, and that is where my passion sits within my job. And I – I have such, an – a thirst for knowledge, around dementia and cognitive impairment. So for me, like you, you want to learn more, you want to train more, erm for me to be able to have a voice that will be able to help shape the way that we deliver care going forward? Because I know as well as you do, having worked from the floor level right up to where we are now – continence care, personal care is a large trigger for so many different reactions. And they don’t – you know, they call them “challenging”, “behaviours that challenge”, erm but what is the definition of a behaviour that’s challenging? Actually, continence care can be a trigger for challenging behaviours that are verbal, physical, they can actually be really emotional. You know, I have – and I’m glad that you’re gonna, obviously I won’t say names, you know I’ve cared for people that have been abused and when you provide that continence care they relive it. And actually as a carer that’s really upsetting, both for you and that resident. So it’s what you can put into place as the manager, the home, the care provider, the carer, to make that situation as least upsetting as possible. To me, what could we be going wrong with here? If we’re exploring this?  
Int: yeah. That’s lovely to hear, it’s a very unusual topic for people to want to talk about  
Lucy: oh, if you’re a carer you talk about poo all the time! It’s – poo, pee, pads – yep. It’s pads, it’s catheters – it’s a huge part of the job isn’t it? It’s the norm. If you work in this sector, it really doesn’t – you don’t even bat an eyelid.   
Int: erm, I would just like to pick up what you said there, when you said about how you’ve cared for people who have been abused and then when you’ve provided the continence care you’ve found that they relived that, and you said that was very upsetting, can you just sort of talk a little more about that and what your experience has been? You don’t have to name any names and if there’s anything you’re not comfortable talking about that’s absolutely fine, we can move on?  
Lucy: I won’t name any names, but I will give you, erm, so [sighs] one absolutely lovely lady, erm, was abused by her dad and her brother and her family, which we were not aware of until her cognition and her abilities to manage her own personal care required a larger input of support from carers. And what could have easily been misconstrued as being physically violent and “problemsome” which, I hate that, I use air quotes, do you notice I use those? It was actually that, it wasn’t that she was being aggressive or problematic or trying to stop us, it was because us supporting with such a private area of care triggered an emotional response for her. So, as soon as we would support with personal care, for her she went, she transported straight back to that happening, and it was the fight or flight for her. And she, she, obviously, was a fighter. Erm, and she didn’t see us as carers, she seen us as her dad. So she spoke to us and she would cry “don’t do that daddy” and other things. And for us, we had to, you know as a care provider we had to talk to our staff and say – we had to write very detailed robust care plans on exactly what, what we could, what we could do, how it could be done, we had to involve a multitude of professionals in that because it, you know first of all we had to do a best interests, was it in her best interests? Actually her skin integrity was quite bad so actually we had to planned interventions, and those planned interventions were agreed for the minimum [emphasis] so we got in, we did what we needed to do in the best way we could do it, erm and then we, then we, then we, we left this poor lady. As soon as you’d finished she stopped. And she’d turn round and say “thank you”. Because she came back and transported back, so actually do you know what, no new members of staff or green gilled went in to support this lady, there were only certain carers and key workers that could provide this certain level of intervention and care planned intervention, we tried to make sure that only staff that had a relationship, a very trusted relationship with this lady would go in, erm, and we did everything we could to minimise that level of distress for her. But do you know what, it didn’t matter how many times you did it, it still broke your heart. As the person who was delivering her care, and even though you would give verbal reassurance and try to hold her hands and say its OK, you know, we’re nearly done, you could see the amount of blind distress that she had. And you would just try to get it done as quickly, as swiftly, and as safely as possible so that you can just let her really settle down again. But that – that was, without a doubt, one of the hardest, hardest personal continence care supports that I’ve had to do.   
Int: that sounds really quite traumatic.   
Lucy: not because it was physical, because she was physical, it was because of the emotional trauma. And you – you, when you did not know what that lady had been through until you were a carer providing that level of support. And she verbally took you on that journey with her. And, and, and if you didn’t understand properly before, you definitely did by the time you’d finished. It was just, oh I just wanted to cuddle her. You know, no one should go through that sort of thing. And we had to do that level of continence support. We explored every other option that we could in a bid to try and reduce that, but sometimes it had to be done. But her cognition declined so much to a point that actually that then never became an issue anymore. So there was a time frame where it was clearly upsetting, but with a further cognitive decline that then didn’t, you know where I’m coming from.   
Int: so the progression of her dementia almost kind of helped?  
Lucy: it was a cruel to be kind moment, bittersweet.   
Int: yeah. That does sound really upsetting, just for you guys as carers, I mean, like you say it’s very difficult when you’re trying to console someone who doesn’t necessarily understand what’s happening.  
Lucy: yeah  
Int: so would you have to have quite a few carers? Or was it as few as possible?   
Lucy: we had, so we, the care plan was written up so that it had to be a minimum of two. Erm, with one to, to overview, one you know just outside the door in case a third person was required. All of that was obviously written in, erm, and one was, one was – you know how it goes, one’s to do the job and one’s to provide the, you know, some support and guiding around trying to like “oh love have you seen this?” which you know, we know didn’t work but we would just talk her through, try to let her know everything that was happening and that it wouldn’t be much longer and that so generally two, but if she was feeling particularly feisty it might have required a third. But that wasn’t very often to be truthful with you.   
Int: do you think it was, as you had two people, one sort of holding her hands and making sure she’s OK and the other cleaning her up and things, and this might sound like a strange question, do you think there would be one of those people’s job that was easier?  
Lucy: yeah, the one doing the actual – yeah, without a doubt, the one actually delivering the care, the pad change, far easier than the one – because we’re not allowed to hold, we don’t hold hands, we’re not allowed to do that, we provide erm restrictive practices but not completely hold, we don’t do holds but what we do is we restrict movement so that there’s less they can do from hitting out to themselves, not us, so you’ll still get the taps and the “ahhh” as the carer but actually it’s not that, it’s emotional. It’s what, what she said that hurt more than anything else. What she was reliving.   
Int: and having to go on that journey with her.   
Lucy: yep. But you have to remember, in the nearly 14 years that I’ve been involved, involved in this care sector that lady was only one of two where I’ve had to experience this level of emotive – what I call emotive continence care. Erm, and so, it hasn’t been very rare – sorry, it hasn’t been very common, erm, it was, you know, for me, it’s been quite rare but actually an element of this level is becoming more common. Not to the level that this lady was because that was quite rare, but, you know we think our ladies are from the era of world war 2, you know, from that, from those, from the world wars where sailors and and and you know the gents would come to port, and private areas were private, erm so, yeah, yeah.   
Int: do you think things will change in the future with different generations ageing?  
Lucy: oh yeah, because we’re far more erm, we’re not as private about our privates now are we? Er, and, our generation – you know the ladies in our, our homes that are still, you know, even with fluctuating or with a good cognition say “you’re a loose generation” you know, they do! They say “you’re a loose generation” yeah, “your skirts are above your knees!” and “your bikinis may as well not be there!” you know, we show more skin than the you know, generations of gone by. And we are a more sexualised – you know, sex sells. It’s one of the biggest marketing campaigns we’ve had for over 25 years. Erm, so what is acceptable now really wasn’t years ago. So continence care going forward might be more acceptable. But I also think we’ve also got a far more of a fight or flight [laughs] you know where I’m coming from, erm, there’s a fight or flight era and I think you might find we’re going to have more people who are gonna be physically non-compliant with the assistance of continence care. Or they’ll just run away [laughs]   
Int: that’s really an interesting observation, and not one I’ve heard before so that will give me something to think about!   
Lucy: well, if you think about it, think of the eras that are in our homes now, we are already seeing erm that some of – a lot of people are now in their 50s and 60s and cognitive impairments are being diagnosed much more earlier, so for us as a care home and especially what I call a care setting or a bedded care setting, erm, we’re finding that a lot of our newer residents are of a younger age – you know remember it used to be your average age in a care home, you know 70s and above, but actually we’ve got ladies and gents, 50s, 60s, that are now with us. Because of mixed Parkinson’s for example requiring younger cognitive decline, Korsakoff’s, erm, has been a large factor because of you know, the free will and love of alcohol, it’s so much more easily acceptable now isn’t it? Erm and alcohol has become, alcohol has become so much of a, a, a – the cog around social – erm, but we haven’t really thought about the effect of [inaudible] gonna be, you know so I, so, so, just think of those poor activity coordinators, that’s what I’m gonna say [laughs] think of those poor activity coordinators that are now going to have to provide engaging and enriching activities from ages 50 to 100. And what music do you put on the radio? That’s another one. You’re gonna have to have different rooms. There’ll be the start of the clubbing generation, the free lo- you know, the free love 60’s and then you’re gonna still have your – just coming to the end of that, of our – we’re losing that war generation as well, you know we’re coming to the end of that era, which is heartbreaking I think. You know, you probably agree with me, it’s heart breaking that we’re losing a whole – a whole era, a whole decade, all those memories, all that knowledge and experience and life, you know? But I’m sure Vera Lynn sings, songs will stay around forever   
Int: there will always be a dusty old CD of Vera Lynn in a care home somewhere  
Lucy: [whispers] I love Vera Lynn! My husband hates her [laughs]  
Int: [laughs]

Int: erm, so can I ask about an incident of incontinence you’ve recently dealt with. If you could just think about an incident, a time where you’ve assisted someone or anything, one that just pops into your head. Would you be able to just sort of talk me through what happened and tell me a bit about it?  
Lucy: so, I’ve been working in COVID positive isolation units and unfortunately one of the side effects from COVID is loose bowels. But I don’t know whether or not I should talk about that, because that’s quite…[pause]  
Int: if that’s what comes into your head, and you’re happy to talk about it, then please continue  
Lucy: I’m just trying to think. There’s a couple that come into my head and they’re either end of the spectrum. Do you want me to start with the first one?  
Int: yep!  
Lucy: so you’ve got our lovely little gent who’s an amputee, he’s full capacity and he just needs assistance using his bottle. And so, I’ll go. In I go, “hello darling, how’re you? Ohh OK no worries, here’s your bottle, do you want me to stay and give you a hand?” “no love I’m fine, you come back in in five minutes and I’ll give you my bottle back” No worries. I’ll pop outside the room, go back in, after 5 minutes I knock, “you done sweetheart?” “oh, blooming hell” “whats wrong? Can I come in?” “yeah, of course you can come in” and he’d missed the bottle and tiddled over himself and the bed. Er so I go in and I go, “you alright sweetheart?” and he’s like [inaudible] “bloody hell, I’ve made a right mess” and I, you just say “it’s alright, it’s not a problem, these things happen.” He’s embarrassed, ‘cause you know, he’s got capacity, erm, he’s generally quite independent, erm and you know nine times out of ten he can do it himself with no problem whatsoever. But it’s those other little times doing it where a shaky hand or whatever else, yeah, where you need some assistance, so I just kinda went in and went “it’s not a problem” you know, “don’t be embarrassed sweetheart, are you OK? We’ll sort this out together” and he’s like “oh blooming hell, I’ve made a right mess, gonna need to change my clothes.” So first thing to me is “lets get you up sweetheart, I’ll help you up” because he isn’t able to do it on his own, “I’ll help you up, sit you out, take your clothes off, do you want to have a wash? Would you like to have a wash? Give it all a wash downstairs so it’s all nice and clean again, get a bit of talc down there and all” Erm, so to me, he is my first priority. Take off his wet clothes, get him washed get him dressed get him re, you know, dressed again, give him back his dignity. Erm, and, for me that is the first, first thing, reassurance, it’s OK, you know what, this doesn’t happen very often sweetheart and when it does, that’s what we’re here to help you for, don’t worry, I know you can normally do this on your own. Get him up, get sorted, give him back his dignity. And then while he’s at the sink doing his face and brushing his hair, you know you give him something to do, he doesn’t realise that you’ve just whipped his bed, you know his bedding off, completely changed the whole bed, and sorted it all out and tidied the side of his room and everything else so it’s all bagged and put away, so that when he’s finished, you know, titivating himself, popping on his cologne, you assist him back to his, back to his bed, you know, that’s where he wants to go, assist him back to his bed, it’s made and it’s not a fuss, it’s not a problem. You know, that’s what you’re there to do and you just give him back everything that you can. Because there’s not a lot that that man can control, ‘cause if you think, if he’s with us in a home, it’s because there’s certain elements of his life he isn’t able to, or he’s assessed as not being able to manage himself. So what he has got control over and what he can kind of embrace, give him everything he’s got and then hand it back to him as soon as you can when something goes wrong. ‘cause I don’t want to deskill him, absolutely don’t want to deskill him. That’s, that’s, don’t even get me started on that one. [laughs] don’t get me started on that one. Erm, so that was the one, that was one where – and the other was, erm, [inaudible] is when, the other end of the scale, for me, was end of life. So we, you know, we had a lady, she was end of, end of life. Generally when you come towards your end of life pathway your food and fluid intake reduces quite drastically, so continence care becomes more like pressure relieving and keeping an eye on, on things and making sure you can keep clean and least level of infection. Erm, you know, they had, they they had a very loose bowel movement, so then in I went to do my support and realised that they, there was, they had [lowers voice] loose bowels erm and, for me, it’s about this person is end of life and it’s how can I support them with their continence care, especially around moving and handling, in a way that I can reduce any pain that, that that movement, and moving and handling, is is gonna be for them. So for me it’s get another member of staff. Go in together because that’s, you have to for that level of manual handling anyway I’m sure you’re aware, erm, go and get somebody, and do you know what I do? I – this is my religious, I know not everybody does this, I will, before I start continence care, make sure that I have everything there. Do I have a new pad, do I have wipes, do I have bags, is my water done, is it warm, warm water – nobody wants to have their selves cleaned with freezing cold water, you know, come on, I’d want to turn around and punch you in the face if you stuck a cold cloth on my bottom, erm, and then, do you know what I also do? Is I make sure I’ve got spare bedding in the room as well. I always keep, you know, one of the things that I’ve brought into the homes is that we have spare bedding in the room, because if you’re halfway through supporting somebody with continence care and as we know, if you lift and tilt ladies a little bit of wee wee, can, can drop out, and then come down on the bed, and then your poor resident is rolled and you’ve realised that you need bedding, how undignified is it for that resident for you to doff your PPE off, open the door and leave the room while they’re still with the other member of staff stuck on their side so that bedding can be brought into the room. Ah, pet hate. Number one. Before you start any continence care, have you got everything that you need? Is it all in the room? Then and only then, once you’ve got some nice hot water through and ready because lets be honest, we work in care homes and hot water is not always straight out the tap, [laughs] sometimes you have to leave it run for a little while til it gets there but you know you don’t want them to be out of their nice warm bedding and with their parts – you know, private parts open to the elements, while you’re stood next to the tap while you’re like ohh you know, chat chat chat, waiting for the water to come through so preparation is key, make sure you’ve got everything you need and make sure it’s ready. Only then do you, even though we look for implied consent don’t we, do you then engage. And then we have a chat, we make it as peaceful you know, as we can. Er but this lady in particular obviously you know I’d done all of that, and and when I was moving her, even though I – we have to roll, don’t we? It’s the [makes cracking noises] of their bones and their back, oh they pop off don’t they? And the, and you just, oh, “I’m sorry sweetheart, I’ll be as quick as I can” get you cleaned, do do do, pop back, oh gently round, and then do you know what I do? Pop their blankets up and then I hold hands and we have a chat. Settle them back down again. And if someone’s end of life, we do that regularly, we do that regularly anyway don’t we, but when they’re end of life then we do tend to spend a little bit more time and effort with that, with that resident anyway because, what’s the one thing as a carer you never want to happen? It’s to lose a resident and no one’s there and they’re on their own. No one should die alone. Er so yeah, there you go.   
Int: erm  
Lucy: I bet you’re thinking oh my god this woman doesn’t shut up  
Int: no no not at all, not at all, this is fantastic. Just a couple of things I picked up on while you were talking, erm, one of the things I noticed and this may sound funny, when you were talking about loose bowels or urine or faeces, you whisper it.   
Lucy: oh yeah I always do  
Int: is there any particular reason?  
Lucy: because, and do you know why? And this is one of the reasons why, it’s because if one of your residents is in a communal area, OK? Yeah you know what I’m gonna say now. If one of your residents is in a communal area and they need support with continence care, I’m not gonna walk in and stand in the room and go “[name], YOU’VE BEEN FOR A POO, YOU NEED TO GO AND GET YOUR PAD CHANGED” or, you know, or “OI! [name] IT’S YOUR FOUR HOURLY PAD ROUND, COME ON WE’RE JUST GONNA TAKE YOU TO YOUR ROOM AND CHANGE YOUR PAD” erm, do you know why? It’s because I’m used to going in, going down to their level, and going [whispers] “do you want some paper? Can I help you?”  
Int: it’s a habit?  
Lucy: it’s personal. It’s totally – it’s a habit. Because they’re continence care and how I support them is personal to them, absolutely no way – if I ever caught a carer doing that, or talking over a resident about somebody else, then they’d [inaudible] but yeah that’s fine, I tend to go [pretends to whisper]

Int: and when you’re saying you make sure you have everything before you begin when you’re assisting someone with continence care, is that something you’ve always done or sort of something you’ve learned from experience?  
Lucy: learned from experience  
Int: so what sort of led to this being the  
Lucy: learned from experience and the reason I learned from experience was because I was in the middle of assisting somebody and I did it, I did the check and I could see the bag, the pad bag and thought “oh yeah I’ve got pads [inaudible]” so I called somebody, we came in and we started, we got the bag out and it was empty. Just an empty pad bag. And then one of us had to go off and find another pad supply, erm and then do you know what we did? We had to pop that poor resident back, put everything back in place, go off, get what we needed to come back and restart again. That’s not a good experience, that’s not, you know, even though that resident had no triggers, no issues, quite compliant and quite happy to receive support for continence care, erm to me, it’s, and you’re gonna think that – customer experience, what do you mean by customer experience when you’re supporting continence care? ‘cause they are, they are, they are ultimately a customer, they’re our residents, they’re our family, our friends, erm, how would I feel? That’s what I say. How would I feel about that experience, that I’ve gone oh OK actually yeah you can have access to my private areas and support me with something really personal, I trust you to help me with this, and then I’ve got in there and you’ve forgot something, so I’m laying there, waiting for you to come back. Not acceptable.

Int: erm, have you every had experiences where, and particularly with people with dementia or a cognitive impairment, where you’re not at all prepared, because like you say you’ll be going to do something within the home and someone, one of your residents, will come up to you  
Lucy: yep, poo, yep, yep, that is, that happens all the time [laughs] it’s, that’s nothing, that is absolutely nothing out of the ordinary, you know when residents will dig in their pants, go to gardening, erm  
Int: go to gardening?  
Lucy: yes, they go gardening. Digging in their pants, and quite often our residents, you know if, if, [sighs] [inaudible] there’s certain levels of cognition where, erm, it becomes a habit if they’ve – soiled, erm and we as carers haven’t picked up on it quick enough, that they will become slightly agitated or they’ll go to [inaudible], try and get their hands down there like oh what’s going on, and all the will in the world and them, you know, it doesn’t matter how many carers you’ve got on the floor you’re never going to pick up on everything straight away. Perfect example of which, working at one of my care homes, walking up the corridor and don’t obviously use his name, erm George [pseudonym] walking towards me, George was a, erm, a, erm, walks with intent, literally never stops, constantly walked walked walked walked walked. George walking up beside me. George was – he loved to hold your hand, and take you for a walk, so walking up to George, “hi George sweetheart how are you?” “oh, oh oh!” like that with his hands and I thought oh he wants to hold my hands, put my hand out and he dropped two handfuls of poo in my hand, I had no gloves on [laughs]. And then he kissed me on the forehead and walked off. So I’m like, “George you gave me a present! Thank you sweetheart!” off I go to the toilet, bop bop bop, wash my hands, do do do, grab some gloves, and off we go to sort George out in the loo. Erm, so you have getting given presents of love or uh uh uh, making you happy, you know he wasn’t able to verbalise, that was his way of saying “can you help me?” Then we’ve got residents that will have mess, messed themselves, soiled themselves, and they tend to erm, they will dig or itch or try to, to readjust their pad to make it comfortable to sit down, and they’ve got faeces on their hands, and they’ll put their hands to, you know, on your hands, so nail care, hand hygiene, is op- is so important anyway, let alone the fact we’re in the middle of a pandemic, but you know, to me, keeping your ladies nails manageable, because not only for their tissue viability if they do tend to itch and, but also for faeces being stuck under there as well. Erm, and nothing looks worse than dirty nails. You know, over the top and underneath. So it should be part of your, your AMs and PMs, personal care and nail care. Erm, to make sure that you support your ladies with that. Erm, but yes, quite often, they’ll hold your hands and you’ll look down and realise that they’ve got faeces on their hands. That’s cool.   
Int: so when, when erm your gentleman George came up to you and gave you poo, how does that feel? Like  
Lucy: I laughed.   
Int: you laughed?  
Lucy: I laughed. It did not gross me out. Whatsoever. And do you know why? Because I think I’m just desensitized to that element of, because to me, do you know why I just looked down and giggled? One, because I couldn’t believe I’d [laughs] been silly enough to fall for it [laughs], and you know like, oh! That’s [laughs, inaudible] and I, and I chuckled to myself because I was like right, I’ve now got to try and work out how to open the door and not touch anything, [inaudible] try and wash my hands, so I had to call one of my colleagues and they just looked at me and were like “did you get a present from George?” “yep” and I’m like, and we chuckle, erm, and you sort yourself out, it is what it is, but I also chuckled to myself because quite frankly that lovely gentleman, bless his soul he’s passed away now, couldn’t verbalise that he had been to the toilet, he was a, he walked at a ridiculous pace, he almost ran everywhere, so erm for a carer, you wouldn’t really notice because he was never anywhere long enough for you to pick up on the smell, do you know what I mean?  
Int: yeah  
Lucy: yeah. So for him, that was his way of saying I’m ready for some help now. And then starts the trouble of trying to support a walker with continence care. Now that [emphasis] is hard.   
Int: what do you have to do in that scenario?  
Lucy: two carers, one to hold hands and to guide, to walk around the room, and the other to be going with the motion and be cleaning and doing continence care as he’s walking.   
Int: that sounds very difficult  
Lucy: it is extremely difficult. We will sometimes erm, try and guide, to hold hands so that he will stay st-static, erm and that will generally be to remove the pull ups and then to put the pull ups back on, but the rest of the personal care, the main part, is in slow move-movement. That – that was, yeah, they’re the hardest. When you’re giving mobile continence support.   
Int: so how do you – how do you plan for that?   
Lucy: [laughs] in the room! It’s just like oh, yep, in the room, erm, god I sound like such an old hand don’t I? In the room. Erm, has to, has to be in their room. You can’t use a communal area or a communal toilet. One they’re not big enough. Erm, rooms give enough room that they don’t feel that they’re being boxed in, erm and they won’t become agitated, erm, and you can allow them to erm, have their solace in their movement and their walking but within a controlled environment, or as controlled and safe as you can. Erm, and all of our rooms have got sinks and facilities so we’re quite lucky that our environments lend itself to supporting our residents in that way. Erm, so yeah, absolutely in the room. Without a doubt.   
Int: do you ever find erm, because I have had this experience before of the mobile continence care, one of the things I found really difficult to control for was erm, I’m not sure how to put this, things falling out of continence aids and things like that.   
Lucy: or they start going again while you’re doing it. Yeah  
Int: yeah?  
Lucy: yes. And you have to catch it in a glove. Yep. You’ve just gotta roll with it, haven’t you? It’s not predictable and you support with what you can and deal with what you can deal with while you’re there, erm, yeah, so when you – we generally tend to stay static for the erm, pull ups, ‘cause our walkers generally always have pull ups because your pads and pants and pads are just a nightmare ‘cause they pull the pads out, they throw them, erm, so er pull ups, what you do is you plan it. With your, you work as a team, and you work very quickly because you know you go down, you pull, you learn the tricks of the trade! Don’t you? You lift, and you, you drop and fold, you almost envelope it and then the feet come out and then you bag it, and then if, if for example something else happens as you’re going, you’ve got gloves on, you’ve got, you know your wipes, I actually even have, you know I’ve had a bin bag where I’ve been like oh! Oh! And then – in my career, I have had many residents that have passed their bowels in my hands.  
Int: so how does that feel, not as a carer, not as someone who’s supporting someone but as Lucy? How does that feel?  
Lucy: I just – it does not bother me. Because, at the end of the day if they felt comfortable enough that they, erm, sometimes, repositioning, the lifting of the leg, if they have, if they’re a bit bound up, then sometimes that repositioning and support and the care to be in a different position, they don’t do it on purpose. You know, the body is the body. It’s a function, it’s natural, and at the end of the day if I can assist them and they’re not going to have a pain in their tummy or generally feel quite crap, because that’s how we feel if we get all blocked up, it doesn’t bother me. Doesn’t bother me at all. I’ve dealt with more poo debacles in my career than I ever did as a mum. You know, I remember someone said “ohh you’ve had a baby,” when I was pregnant with [child’s name], “you’ve dealt with continence care for years! It’ll be easy when you have a baby.” I was like, that’s not what I was worried about. The nappies don’t bother me, it’s more than I can’t keep a plant alive for a week. I’m going to have a living child, you know? But no. Honestly, me as Lucy, doesn’t bother me. I actually see that I’m helping them in one way or another and if they didn’t pass, if they didn’t pass their bowels, how’re they gonna feel then? They’re gonna feel bad tummy, gonna be upset, and then what do we not wanna have to do? Medically intervene with enemas or anything else if they’re blocked up, you know try and do it as naturally as possible, if a little bit of you know cheek massage, you know, helps to do the job, bit of marching on the spot, bit of moving them around, side to side, knees up, whatever it needs to be. That lady, oh my god I totally forgot about that! One lady asked me, erm, so one lady was really constipated and she was non-mobile, erm and we were supporting her with her continence care and then erm, she was on her side and she popped her knee up, and she passed a huge [emphasis] stool, it was huge, and then afterwards she asked me whether it was a boy or a girl. Which I’ve – I’ve never had that before. And I, yeah, bless her, so that was definitely a first for me and for the other carer. And we just gave her a big cuddle and said “you’ve had a big poo! Well done!” [laughs]  
Int: do you think there’s quite a different way in how the people you’re supporting deal with continence care?  
Lucy: yeah because we also, you know, not everybody is is, is generally, yeah, so I’ve got four homes with complex, the highest level complex specialist households, so erm, they step from garner, from sectioning, into these households so erm, and, erm, I’m a level, I am a level 4 in maybo, high level mapper, you know, done it all, because it needs to be used when providing support with continence care. For the residents within this setting, and yeah, do you know what? When you have somebody you know is care planned where they are violent, and you know, it’s all about space isn’t it? And when you do continence care space becomes, yeah, so you’ve got, you’ve got what you call your natural arms length space, but when you do continence care you have to go in that zone. And the thing is, when you’re doing continence care for somebody that you know is highly, highly physically violent, you should never be doing it alone and two, the closer you are the safer you are. Erm so you know, if you’re kneeling down in front of that person to pull their pants up or to support them with that, hello? You know, you have two people, you’re side by side, you go together in a pair and you bring them up. But you know, that’s knowledge and that’s experience, and I’m not telling you Leah that I’ve not been punched in the head, because that was my fault, because of, I got too comfortable and I forgot, where I was, the person I was supporting, I knew that person’s needs and the person is only ever physic, physic, physical to you because they want one of two things, they want something from you or they want to get away from you. My fault. There you go. Don’t get me wrong it blooming hurts, you know, you’ll be surprised how strong some of our, do you, but you know, 70 year old lady with a UTI punches better than Frank Bruno. And that’s another part of it as well isn’t it, it’s those, it’s those behaviour, out of character behaviours, those UTI’s, those random infections, where what was something that would always be easy to do has become really problematic because the lady has decided she doesn’t like anyone today, and she’s decided she’s going to pee in the bin today, it’s just about love and understanding you know, it’s out of character, give her four days on her antibiotics, support her even though she doesn’t really like you for the next four days, after that she’ll be sunshine.   
  
Int: do you find that other staff have the same attitudes and feelings as you or do other people find it more difficult?  
Lucy: no. So I’m really, I’m, do you know what, I am truly blessed to work with the people I work with, because lets be honest I’m, erm, [company name], so when we recruit, should I say, when we recruit there’s a section as part of the recruitment where they find out whether or not you have a foot phobia or, or, or, or, do you know what I mean? You know, personal care  
Int: oh! Right I see  
Lucy: personal care, you have to not be afraid to touch somebodies body, to wash somebodies body, if it’s a man you have to pull his foreskin back and give it a good clean, you know, we will train our new staff in how to clean a penis properly. Erm, and we train with regards to continence care. Every element of continence care. And actually, you can’t become an established [company name] carer if you haven’t gone through your introduction and basics, if you don’t pass all of those competencies, and the biggest competency is values. And the way that you approach both your residents and your work and your colleagues. Erm, so I’m really lucky that I work with a group of people that have all passed those competencies. Don’t get me wrong, erm, there is, there is where, you know, there’s, you know when someone’s got D&V, you can smell it, you can smell the infection don’t you, you go in and you think “oh, MRSA” [laughs] that [retches] you, you learn the smell of infection. And you, as a carer, you know if that’s the norm or not the norm, and I’m not gonna say I haven’t come out of a room and gone “[retches] god, that was strong” urgh. And wearing these dire masks, the smell stays in the mask and you just have to change it as quickly as possible. Erm, so you know I’m really lucky but do you know what? Erm, that’s just care in general. When I talk about the physical and the complex and the planned interventions, that isn’t for everyone. That isn't for everyone and not all staff do it. You have to go through additional training, you have to go through shadowing, you have to go through competencies, there’s a lot more, erm training, knowledge based work, dementia workshops for example, you have to do the maybo, and you have to do the mobile static hold maybo, and you have to go through RA, so risk assessment training, you have to go through incident report, you know, incident report training, because when you do a planned intervention it has to be documented in a very specific way, erm so for me, what I would call advanced level continence care, it’s not for everyone. And in, those people that do the advanced, challenging continence care must have specific training and they must have ongoing continence, er, competencies, erm, just so they can make sure that they’ve still got a hand in, in all of the different aspects. [inaudible] I’m head of service, one of the top senior managers here at [company name] but I went through the exact same induction training as our kitchen workers, our carers, our domestics, and every single member of [company name] staff has. Even our chief exec has done introduction to care training. And she’s a registered nurse, she had to do it as well.   
Int: that sounds really good that everything’s across the board, everyone has to do the same training and everyone is on the same page. Do you think that really helps?  
Lucy: yeah, it breaks barriers. Massively breaks barriers. And especially at the minute due to COVID, do you know why it’s been important that everybody has done the introductions, everyone has done the mandatory training, everybody has done competencies, everybody, no matter what your job is, are all told at the beginning of joining this company that the person that matters the most is our residents. So this is what, they’re why you’re here. It’s pretty much what everyone says, everything we do is for them and they’re why you’re here. So when COVID hit, and hit hard, erm Christmas and new year, you know not gonna lie to you we went into business continuity. You know, we put ourselves in business continuity. We had a number of homes that had significant outbreaks, we had 1/5 of our staff work force that were COVID or shielding or having to furlough, and do you know what? We had residents that needed to come first. We went into business continuity, we shut our support office functions down, and we diverted all of our support office staff to the homes. We didn’t need to bring outside agencies in, we didn’t need to do any of that because, do you know why we didn’t do that? Because everybody that joins [company name] joins [company name] because our residents come first and they’ve all done the training so they were all ready to go, and that, that was our saviour. Absolutely our saviour. And don’t get me wrong, some of our administrators, so some of the guys that support our reception, some of our administrators, they didn’t want to do personal care, they didn’t want to do continence care but that’s fine, you can assist with meals, you can clean, you can go and make some beds, you know, everybody literally got assigned to a home, given a uniform, off you went. Three weeks we shut the whole of our support function down and everybody went to the homes. Including our chief exec.   
[doorbell ringing and dog barking in background]  
int: that sounds very good, sorry there’s a very persistent postman outside!  
Lucy: do you want to go and get the door? Go and get the door if you want, I don’t mind!  
Int: no don’t worry, I’m aware I’ve taken a lot of your time already   
Lucy: oh no that’s alright, I think, have you got any more questions? We’ve gone through so much haven’t we  
Int: hearing your stories is just brilliant. It makes me miss being in care!   
Lucy: you do when you’re not doing it, don’t you  
Int: yeah. I will ask one more thing if that’s OK?  
Lucy: yeah of course  
Int: when you tell people outside of care what you do, how do people react?  
Lucy: Do you want the honest opinion?  
Int: yeah?  
Lucy: a large amount of my friends are now working for [company name]  
Int: really?  
Lucy: yep. Yep. And those that don’t have got careers that aren’t around care. I’m gonna be honest, a large, I’d say about 70% of my friends are all in care [laughs] that sounds really bad. Yeah, about 70% of them are in care. One friend, who works in retail, and I tell her about what I do, and obviously because we get, obviously no names but you laugh and joke don’t you, and the one who works in retail is like “[retches] that’s gross”, she just thinks everything is gross, she even thinks supporting someone with a drink is gross, but this is the same person who actively says she doesn’t like people and she prefers cats and dogs, so it’s all in the person isn’t it. The other friend is far too active and fit and wouldn’t want to do anything that meant she had to get out of lycra. But no I am blessed. I have a lot of friends who have the same kind of life ethos as me, and I’ve never hidden my passion for fighting for older people’s rights. And care. And I have to say I’m obviously a bit of a, I’m quite motivating about it, because quite a few of the girls have started their careers after having their children with us here at [company name], or they’ve cared for their family and I’ve gone to them “why don’t you make this a career?” and they go “I didn’t realise I could” and I’m like yeah, come on, lets give it a go, and then they’ve never looked back. There will always be a need for care. We will not be out of a job. What does annoy me is the fact that we are classed as an unskilled workforce. You know as well as I do, jeez louise. Mandatory, statutory, just induction, training, competencies, your monthly reviews – wow. We are more regulated and we do more training than [whispers] the professional teachers association. Don’t say I said that, definitely don’t put that [laughs] that’s not part of your PhD! [laughs]  
Int: it is horrible when you see care workers so marginalised and put down.   
Lucy: what kept this country going for the last twelve months? Hopefully, it’s a workforce that won’t be forgotten very quickly after, I very much hope that some of my care staff and health and social care workers start to get recognised more. They deserve it, for sure. And that’s one of the reasons we don’t pay bog standard minimum wage, we’re one of the few providers that pay in line with the national living wage. Good carers are not easy to come across. Not everybody has got it and do you know what, quite often you’re, you recruit, you interview someone and they come across as really great and then you put them in that scenario and they just go – they can’t even start a, you know, go in and introduce yourself, have a chat, and even that for some people is really hard, really really difficult, without even getting to the “we’re gonna have a wash” or we’re gonna start continence care, just engaging in a conversation scares the bejesus out of some so we know at that point, I’m rally sorry but this career is not for you. You know, don’t pass go, don’t collect £200. Here’s your P45. [laughs]  
Int: [laughs]

Int: right  
Lucy: oh gosh I better go  
Int: yes I’ll let you go now, I’ve taken too much of your time, but thank you so much for talking to me and sharing your stories with me  
Lucy: you’re very very welcome and it’s been a pleasure, will I be able to see anything you, will I be able to have a good nose?  
Int: if I get anything published in journals or anything I can send you copies, my thesis will be something like 200 pages  
Lucy: can you condense that? [laughs] All the best of luck, it’s been absolutely lovely to speak to you and meet you  
Int: it’s been lovely speaking to you and thank you so much  
Lucy: you’re welcome! Bye  
Int: bye!