

Recording HC02

**I: Before we start, I just want to check that you are happy to be interviewed, and for the interview to be audio recorded?**

R: Yeah, that's fine.

**I: Great. All right. Well, to start, I want to know about your experience using video technology like Zoom, AttendAnywhere, or WhatsApp for consultations?**

R: This is all just relating to care homes, or is it also related to individual patient interaction?

**I: Well, we're trying to focus on care homes particularly, yes.**

R: Yeah, okay. So, yeah, sure. So we got invited to participate in a study in our role, working for XXXX, which is NHS Trust, and so there's a few doctors that work with them. So, basically, a new service opened in April, which is called the XXXX Service, and it was in response to Covid. So the plan, really, was to be supporting district nurses and patients in the community. So those that were felt wouldn't benefit from admission, that were unwell enough to need support, we'd be to keep them at home, so prevent them getting a risk of catching Covid in hospital and deliver almost as good as hospital care at home. So we're a team of doctors supporting that service, and I guess very early on, we were using video technology to try and communicate with the patients. We started off with AccuRx, because that was only what all the practices were suddenly using, and it seemed quite straightforward. And this is all just with patients, actually to start with and very quickly, I mean, that was quite difficult. Lots of the patients - because they were all elderly - the population that were using, even the ones with smartphones, there's a few... It's not actually that tricky, but there's a few steps to follow, you have to join the link at the same time as the doctor, it should then automatically connect, and maybe their phones aren't up to date or whatever.

So we very quickly moved to using the district nurses with their devices. So the district nurses would be visiting - the district nurses would be basically visiting patients anyway to check their observations, because that's something the district nurse had to do. So while they were there, they would do a video call with us. And actually that worked really well, because it meant the district nurses could hold the camera on the leg, if it was cellulitis, that the elderly person didn't have any pressure in terms of pressing the right buttons; and there was a nurse there to support them. So not so much care homes at this point, but I guess that was how we were using the technology. And, partly, because district nurses are just normal professionals with families, they were all much more familiar with using things like WhatsApp and FaceTime. So even though we were supposed to be using AccuRx, it very quickly became us using a WhatsApp video call and FaceTime, just because it just seemed quick, easier and they'd got our numbers.

So that was kind of how things were operating, and then probably a month or two in there was an issue with care homes and Covid. And, obviously, there was suddenly all these outbreaks of Covid, and people were realising that the care homes had sort of been neglected, to a certain degree; and, partly, because patients were being discharged from

hospital straight back to care homes, and then spreading Covid to their care homes. So there was a few new care homes springing up, one of which was called [care home]. So patients would be discharged from hospital to [care home], until they had a negative Covid swab, or partly just because they weren't fit enough to be at home, but still not well enough, but not too unwell to be in hospital. So that was when we started using AttendAnywhere, and doing more, I'd say, video conferencing with care homes. And, actually, we were the doctors that were responsible for the residents, whereas I think, in this job, normally care home residents are already managed by a GP practice, so they would have their own ways of interacting.

So, anyway, so we started having interactions with [care home], and as a completely new care home, there were lots and lots of teething problems, just in terms of getting used to the technology, the staff didn't... We didn't know the staff, and they didn't know us. We didn't really have a very rigid structure in terms of... Well, we tried to, but in terms of when the ward rounds would be, and who would do them? Who we contacted, and nobody's on a platform [?that 04:29] should be on the platform. And that was working well enough, I think, but still evolving, I would say.

**I: And...**

**R:** And so that's my involvement, but in NHS Trust as a whole, I mean, the doctors that do other remote ward rounds, I've got a colleague next to me, and she does ward rounds at... What's it called? At one of the district hospitals regularly, so she had... But that's at the hospital that was already there before, and they already had doctor ward rounds, so she's doing more of them remotely, which I assume is what a lot of the GP practices are doing too.

**I: So doing rounds and that sort of thing is what you're often doing then, is that your role?**

**R:** So our role in this job - not really - that is a sort of tag along role. Our role is still actually probably more about the one-on-one interactions with patients at home. So more the prevention of admission service in terms of whatever happens that day, who's getting ill that day. Whereas the care home is sort of in the background, that we're also responsible for.

**I: Okay. Yeah, so with the care homes then, what's your major role that you do?**

**R:** Yeah, so with the care homes - and this has changed quite recently - so there should be a ward round twice a week, and I think, ideally, each patient should be reviewed, or at least thought about once a week. And then if problems arise during the week, like an emergency, someone is feverish or seemingly unwell, then the care home can call us ad hoc, because we're actually here. So I'm not here every day, but there's a doctor here at hub in Stevenage from nine until eight every day, seven days a week. So we're always contactable, but I guess we're trying to manage it routinely and sort of pick up on and pre-empt problems before they arise.

**I: Yeah, definitely. If you can, yeah, try to pick up stuff before things get really bad.**

**R:** Yeah. And a lot of the resident GPs in other places, so we're all very used to doing ward rounds in care homes. But, obviously, we've not done them remotely before.

**I: No. Okay, well, that was my next question, is have you ever used this technology before?**

R: No. I mean, not in terms of patient interactions. I mean, I guess all of us have got like [unclear 07:02] and we do video calls with friends, but no.

**I: Well, what do you think has been some of maybe the advantages of using this technology for your patients, and your consultations?**

R: Yeah, I mean, obviously, in terms of reducing risk in transition over Covid, or [unclear 07:27], of course, that's the whole point of doing it, isn't it? So I think in terms of being able to operate safely, and there was worry, I guess, about us getting ill in the beginning; and so it alleviated lots of those concerns. And also, I mean, just from being a GP, we spent a lot of time travelling, faffing, parking and getting into a care home. I mean, obviously, it feels more efficient to be doing the rounds remotely, and you can review more patients in the same amount of time that we would do on the ground. And I think also, I guess, we don't... I mean, I used to always print off a copy of the notes, and to have my flaps of paper. But then there is something about being able to actually have a computer in front of you, and we've got lots of screens, opening up the blood results while looking at the drug history, whilst seeing the patient - that's useful. I mean, I don't love video conferencing, but [unclear 08:32].

**I: Well, can you go on about maybe some of the disadvantages then?**

R: Yeah. I mean, it's just not as good in terms of the clinical assessment that you make. So, I mean, I think a lot of just [unclear 08:52] about the rapport and the relationship you build up with the person, and it's just harder on the video. I mean, I think it's quite a hard group of patients that we're supporting, because they're ones that don't know us at all. So it's not like we've been their GP for years, and then they're seeing us on the video. And, obviously, they've been - they're probably quite ill, and they're then moved from hospital to this other odd setting. They're not seeing their relatives, and then they've got this weird face on a screen. So I think it does feel it's not always clear to them who we are, or what we're doing, even though we're trying to explain that to them. And also, in that way, they might not be as open to disclosing information. It does rely quite a lot on the person who's holding the camera for them, like are they sitting up enough, have they got their glasses on? And the amount of time we're trying to look at a wound or something, and they can't quite get the angle right, is difficult.

So I feel like in terms of making a diagnosis, I'm more confident in my diagnosis and my plan, if I've got the person in front of me, and I can touch them and I can see them. I can see how - I mean, you can see how they're breathing, but just you can tell if someone is sick, I think more easily, if you're there with them. And also just not having to rely on other people to do the blood pressure, and calculate the pulse and is it regular or irregular. I think - like I guess I have more faith in my own assessment than someone else's, just because I'm the one that's putting my name on a prescription. But it's also not as enjoyable, really, sitting there at a screen all morning. And I guess there's been a bit of technological issues with like the sound, and we had a bit of trouble with our headphones that they couldn't hear us. I had a few weeks where I basically had to speak to them on the phone, whilst looking at them on the

screen, because the audio wasn't working. Just - and that's really frustrating, and it's just ... So that was an issue.

I guess we've used AttendAnywhere, and I also have a job - a separate job - as a private GP, which is called XXXX, which you probably may or may not have heard of. But, basically, that's all done remotely and it's a lot more established system, I feel like it works better. But I think it's been running for like a few years, and so I'm used to consulting remotely, but with young, fit people. And this is with older people, and somebody else holding the camera. And also nursing homes are busy, so you might have a plan to call someone, and then something else comes up or someone else that wasn't going to be doing the ward round, then ends up doing it, and they don't know patients at all. And then they have to put their PPE on for every patient, so you're left waiting around. I mean, it's a bit glitchy, but it's doable.

**I: Yeah. No, that's a really good point, and I think you've talked a little bit about maybe not feeling as confident and things like that. But so it sounds like that using this technology sometimes didn't fit with your existing ways of consulting, especially when it came to older people, because you talked about your assessments and maybe not being as confident, or not getting enough information.**

R: Yeah, I mean, that's true. Enough to get by, but I wouldn't say the quality of the assessment is necessarily always as good. And, I mean, there's examples where that isn't the case, so we have a few patients that have... Might have been at this care home for a few weeks, and they see us regularly, and we get to know them. They might be a little bit more coherent and not have memory problems, for example, so you do feel a bit more attached to them, and you build up that relationship and they know what's going on, so there's obviously exceptions. It's also - it's almost harder to remember them as well. I think you remember a person when you've looked at them, and been close to them, more I think what they look like, than if you see them on a [unclear 13:20] screen. But, yeah, I mean, I've seen it as a needs must, but I guess I know that, obviously, people might want to expand these technologies and there are advantages.

**I: That's interesting, yeah, that maybe you're having a harder time remembering patients and everything as well. That's interesting, as well as they're having a hard time understanding what's going on, because of they're just looking at a screen and not an actual person, and you're kind of almost feeling the same.**

R: Yeah. There's a lot buy-in in the relationship with a doctor and a patient, like you have to give them advice and you have to feel like they're going to listen to that advice, and follow that advice; but they have to trust you enough to do that advice. There's something about writing prescriptions and giving the care home nurse the prescription, and feeling like they are definitely going to go and get that from the chemist. I don't - it's up to them, and it feels like things just happen, are going to happen. And, I mean, I think not that they've - I mean, and the... Yeah, it's just easier, and you can... You're in a room with someone and you can see the environment that they're in, you can see how that influences how they're feeling, how their care is. And with a screen; it's a small image and maybe when we have like... What's it called, PDR or something? We can virtually be in the room with them, and it'll be better.

But it's all right; it's okay, and because actually the kind of illnesses that elderly people get, or that are reversible, they are fairly... There's quite a lot of the same common conditions, so things like cellulitis or a urine infection, they're fairly straightforward, really, and that's good. If it was to be much more complicated, I think it would be tricky. But we get enough information from people to assess, and because we've got someone doing the obs. Or actually if there's a rash or something, you actually can't see rashes and things very well on a moving video, but we can have a photo uploaded to the notes and then that's quite useful; and a photo would be better of a rash than a video.

**I: Okay. Well, I know you mentioned this before when care homes were having issues, and sometimes scheduling. But so I just want to make sure that you - that's what you're doing is that you schedule particular times for calls...**

R: Yeah.

**I: ...and this works, or does it not work?**

R: Yeah. No, so we used to have a system of new admissions would come in at - I think we used to do the ward round with new admissions at ten, and then we'd do existing patients ward round two. So that was what we would do, and then it was up to the care home to inform the admin staff of the new admissions, and who needed a review. And then we have like a sort of scheduling book on our computer, so we can see what people are expecting. And then we go on to the portal and [unclear 16:32] admission, or at two. But, obviously, it requires both members to go on the portal and, to be honest, doctors are probably worse at going on on time...

**I: Oh really?**

R: ...than anybody else, with something like [unclear 16:44]. Yeah, so that's how - that was how we operated it, but actually it became that there weren't actually that many patients. So now we've changed it to just two days a week that that happens. And I think our system does have - our issue, I suppose, is that I actually don't know how many patients are in the care home at any one time. I'm probably a bit of a control freak, and I want a bit more ownership of what is going on in that care home. But because that's just not the way - there's not been great communication, actually, with this care home, and the manager has just changed over. But we really rely on them to tell us what they need, so if they don't tell us what they need, we won't know to check in on that patient. And our service - I guess our service is a bit different to a GP practice, because we are different doctors every day actually here. So I do sometimes think it's not great, like things could easily be missed if a certain doctor hasn't read the previous doctor's notes, or missed something. So the care home I was involved in has that issue, but my colleague who manages another one, she is always the doctor that manages that care home. So I think that would obviously be better [unclear 18:02] knowing her continuity with staff. She is following the plan through.

**I: Yeah, that's really interesting and a good point, that in your situation that's a little bit different, because there's different people constantly working with the care home. But**

**there's maybe a different experience if you're the only one working with that care home, and you're well-versed and have a rapport with all the patients, it sounds like.**

R: Yeah, I think so. And just there's been times when a doctor might have ordered a blood test, and that blood test hasn't happened, but no one's really noticed because that doctor then wasn't the same doctor that did the next ward round, and then it gets noticed a month later. And, I mean, there's not been any harm really that's happened, but just... And it's partly because if the care home had someone in there that was really on it, and keeping a note of all the plans, and, again, that wouldn't happen. But I think they are having the same problem in different staff coming and going, and they did have a Covid outbreak and some staff had to be ill. It's like no fault of anybody's, really, but just it's not exactly working smoothly all the time.

I: **Yeah. No, I mean, if you've got staff having - you have a turnover of staff, and you've got staff that are having to be away because of illness, or because they've gotten Covid, or if they have to isolate because they've been exposed to Covid, it's really hard then to be consistent. And things like that with constant staff turnover is a big problem in care homes, yeah, definitely.**

R: Yeah. And then the care home that we're managing, it's not actually a nursing home, it's a residential home. So the staff there, they're not nurses and, actually, there's a bit of... Like, for example, we didn't realise that they can't do a urine dipstick, for example. Or even some of them might not even know what a urine dipstick is - the staff. So there's a bit of a disparity, really, between what our expectations of what they can do. And, actually, it does really vary, and having worked in those different areas, some care homes are very different to another one, in terms of the experience of the staff, or the type of residents that they have. And this one, it's sort of got a hodgepodge of all sorts of different types of patients, so it is difficult, I think, for them.

I: **Yeah, I think you're - that's a really good point, is that every care home is different, and how the staff are and how residents are, is very different depending on the home and that's a really good point. Well, I know you mentioned sometimes there being issues when you had conversations, so what were...? Can you tell me a little bit more about those conversations, or communication issues?**

R: Okay, do you mean with the patient?

I: **Yeah, with patients or even staff, if you had problems communicating with staff as well.**

R: Yeah, so I'm just trying to think, so like having a conversation with someone. There's one guy who was quite low in mood, so you're trying to explore his mental health on a video, which is quite difficult. Just to get him - just hard to get him to open up about it, and without those kind of body language cues, that kind of... And I guess it's just hard to get much information, and also some of the older residents, they tire quite quickly. So it's not like you can ask them lots and lots of questions, so I suppose you have to just ask the really important ones, which don't necessarily give you that much information, really. So I tend to sort of introduce - like say who I am, how are you, have a bit of friendly banter opening up the conversation, and

then it's kind of things like have you got a pain anywhere? How are you feeling? Quite open-ended questions, I suppose, and then you might home in a bit on the bowels, or the chest, or the mood, or whatever is the main issue.

And then you kind of have to leave it, I think, really, to just sort of focus on the personal issues. But I think - I guess what you're getting in the video, really, is actually what they look like. Are they alert enough to look at you, understand you? Do they look hydrated? What is their skin colour? Can they support themselves? Do they look - is their breathing laboured? I think you don't get much out of what they tell you, generally, and would get a lot more from that visual look of them. And I like seeing the patients, and I think I probably would do more video calls maybe than some of my colleagues with patients at home, just for that look, just to see, just to eyeball them and think, right, okay, they don't need an ambulance, or... Because I do think it's quite hard for staff, and nurses even, to describe all those sort of gut feelings [unclear 23:09]. But, yeah, in terms of communication - and, I mean, normally they can hear you okay, if you're slow and looking at the camera, and the volume is up.

I speak quite - like the Queen's English, I think, so I think probably they can understand me most of the time. And I can - and I guess I can't always understand what they've said, but then the nurse who is with them can normally interpret. Or actually the nurse might yell what I've said, so you do need someone else in the room with you, with the patient as your facilitator, actually, just to make sure they've heard you, or to move them, to help them lift up their [unclear 24:08]. I mean, I had one guy with scrotal swelling, like a testicular swelling, and we managed to see that with the video, which was good, so we can sort of manage enough to know, right, okay, that is the problem, you need this treatment. But I did feel - I felt a bit awkward asking to look at that part of the body on a video, but it was okay - needs must! And he was really contented, and there was a chaperone!

**I: Well, I mean, that's really interesting, actually, and you may be - compared to in person that might have felt different, yeah, asking him to lift or pull down his trousers.**

R: Yes, and I think video-wise, a doctor should never ask a patient to expose a part of themselves on a video, actually. I think the guidelines would be they can send photos and things, but I guess in certain circumstances, like this one, that felt like the only option, and it felt okay. But it's not ideal, but just you're there, he's ready, and you're talking about it. Just a quick look, and make sure it's not contorted or twisted, actually it was safer than trying to figure out the logistics of getting a photo that was clear enough. You know what I mean? But, yeah.

**I: No. Well, I mean, you mentioned having somebody else there to help facilitate it. Was there anything else that helped ease it, helped when using this technology?**

R: I mean, I think it's definitely better with headphones. We do have some quite good ones, and it's just - we just have those... Doctors are not qualified at all in IT problems, we're like awful! And I don't think I'm alone in that, so it's just a nightmare because we had to suddenly get all these new things, so like Microsoft Teams, AttendAnywhere, AccuRx, which are not that difficult, but just because there's so many of them, and to log in for each one. But we did get these headphones, which are good, so it's obviously better having



headphones with a microphone. We were also in this - this job that I do we're in this council building, actually. So we're in this big, open room, so it's a bit embarrassing when you're like yelling, because everyone can hear what you're saying to these elderly residents, like you ideally want to be in a little booth. But, I mean, I think what's probably the most useful is having a facilitator that knows the patients, and that knows, to be honest, you want someone that knows everything about them. What their medical history is, what drugs they're taking, who their relatives are, that can get you their relatives phone number just like that.

Also what's really helpful, actually, is if they've done the obs beforehand, so, as doctors, we really like to know, as a baseline, what's the blood pressure, what's the heart rate, what's the temperature? And, quite often, they haven't done that, whereas if they... And they do them when you're there, so you say, well, can you do it, and then it takes a bit of time. So they've got those [unclear 27:12] different to you, then that's good. I think it's probably helpful to tell the patient in advance this is going to happen. And as patients - and as certainly patients get more familiar with it, it works better. I wonder if, like in this care home, for example, they could have - not like a poster necessarily - but just to sort of... They must have like a welcome pack or something, these are the doctors that are looking after you. I don't know, just I think, to them, they're just like, oh, hello, what's going on? And knowing - just to save us having to explain everything all the time. But, no, I mean, the biggest gripe is technology if it doesn't work, so if the technology works and the picture is good, that's better.

**I: Yeah, definitely. If you have issues with the technology, then whatever happens is... Isn't as important if you can't hear or see the person, or your connection is really bad.**

**R:** No. And when you worked in care homes before Covid, you might be like, actually, I've worked in practices where it's normally [unclear 28:29] so you would still do a round one morning a week. And then, obviously, if there's emergencies we would still have to see them at other times; but, normally, similarly, you would try and do it all at once. And you tend to go around with a nurse, and they're with you, so they know what the plan is and then they nearly always would get you to write some notes, which is a pain. But we do it, because it helps with communication. And I guess when we're doing the same thing, we're technically doing the rounds with the nurses. I don't know if the nurses - well, they're not nurses, actually, they're the care home staff, but I never feel quite as confident that they understand what the plan is. So they are there, but you're not really sure if they're listening, and you assume they're listening, because they're holding the screen. And if you're telling the patient, okay, we're going to give you some antibiotics. So after you've done the round, I tend to say, let's just recap and we'll go through each patient and say what the issues are.

And then with the care home we work with, we've started - they ask for an email, so we also send them an email, which I do think is worth it, just to make sure everybody is clear what's happening, what's expected of them? But that is a big clunky, or repetitive because you're essentially making a decision, telling the patient, then going through it verbally, then sending an email, and actually also writing on the notes. So some doctors would write in the system, the one we use here, so they'd be typing the notes. I don't do that, because it's not - it's too



distracting, actually, so I find it easier to look at the patient as much as possible, and do what I've got to do. I might scribble - hand scribble a few notes, but then I would type up my notes at the end. So it is quite a long-winded process, but probably still shorter than driving there and getting PPE [unclear 30:17]. But, yeah, certainly I don't think that would help if you're not looking at the patient. Whereas, normally, if they're in a room with you, you can type while chatting, can't you, a bit?

**I: Mm. Yeah. Yeah, but you did... Yeah, that's interesting that - do you feel like that's slowed down the process of care, or anything by having to take all those additional steps, or...?**

R: I don't think so. I think it probably means that it's a bit more thorough, and a bit more considered. You're writing - if you write your notes as you go along, as doctors often do, and it's like littered with typos, or you might forget to scribble something down. Whereas, actually, if you do it afterwards, it probably does make a better entry. It's just - I mean, it's just double-checking, and checking and I actually don't think that's bad thing, it's just a bit laborious, that's all. But, yeah, and then - and I don't know if all doctors do that, and we all have our own way of doing things. Some doctors probably would just type as they went along and maybe not even write the email, and think, well, I've told the care home, it's up to them to make note of it.

**I: That's a good point, yeah. I mean, every-...**

R: One issue that... Yeah, well, we just - we've always sort of wished that care homes had access to the notes in the same way we do. And I think there are steps towards that, like electronic drug charts and things, but like the way the district nurses, they have access to our notes and that's quite good. And they can see what we're thinking, and see what we're writing and it would be helpful, actually, for the care home to know that, too. But we're not there yet.

**I: No, no. Yeah, if there was a way to make everybody see access to everyone's notes, and everything. Yeah, that sounds like that would help maybe, because then you wouldn't maybe have to send an email, and they can have access to it on the system, or wherever you're storing it.**

R: Yeah, absolutely.

**I: Well, you've kind of talked about this a little bit, but is there anything that's hindering your use of this technology?**

R: I mean, not really, because we kind of have to.

**I: Yeah.**

R: I mean, I think the IT issues would hinder it, and I've done one where it was just on the phone the whole time, so it didn't have the benefit of a video connection. No, not really, and I guess there's some cases... And no patient has ever refused, so that's good. And I think most of the nurses and the... They really try, and I actually think - not so much the residential staff at the home - but that the nurses really like it, actually, because there's some sort of

camaraderie, especially in the initial lockdown. I think it felt like the district nurses were just sent out, and they were on the front line exposed to all the risks, and we're in our little house, our little, safe office. And it felt nice to feel like we were there with them, because they'd call us with really sick patients that they wanted to know, shall we admit them, shall we not admit them? And just being able to make that decision for them, so they didn't feel like they were carrying the weight of this sick person, was really, really helpful. And just being able to be in the home with them, even though on the video you can sort of see they're relieved.

And when you say to them, would you like to speak to the relative, and they're like, yes, yes, please and you can just tell. So I think I feel like the district nurses really, really appreciate that, because I guess they know that they write down their notes, and they're... Sorry. And they write down their notes, and our decisions are based on what they write. So I think they feel quite accountable, whereas we're seeing things, we're making our judgments and then we're more accountable. I think nurses feel a bit uneasy about that, which I understand if they're not used to that sort of responsibility. But [unclear 34:46]?

**I: No.**

**R:** I mean, probably stuff like a lack of confidence in knowing what we're doing. We none of us really had much training, but not that I want more training necessarily, but just, it was all just like thrown at us. And, actually, some of the doctors, I don't think, use it actually, because there's normally two of us, so in at a time. So there might be one in a pair that is a bit more comfortable with it, because they've got used to it. And so I guess it's just confidence in using it, and it's just having access to all the different log ins, and they've got some little, fiddly things, like AttendAnywhere is only on Chrome, which you just might not know. Just things like that. And I guess just being distracted, like if someone [unclear 35:33] but you know you've got a call at ten. Suddenly it's like ten past ten, and you're in a bit of a flap, it would just be easier just speaking on the phone. But you've got to find your log in, and you've got to open up your computer, then the headphones wouldn't work. In that way, it could be more stressful than needed.

**I: Yeah, just kind of some of the logistics of doing it sometimes can be a little bit of hinderance.**

**R:** Yeah. I mean, in the same way, you've got to do a visit and you can't find your car keys, and someone's blocked your car in. I mean, it's life again! I'm just going to put my charger in. Sorry, hold on.

**I: No, it's all right. Well, you've kind of mentioned a little bit...**

**R:** Sorry, I can hardly hear you very well. Hang on.

**I: All right, no, go ahead. Is that better?**

**R:** Hello?

**I: Yeah.**

R: It's all right. Yeah.

I: **Okay.**

R: I'm like the worst person to do this, because I'm not great with technology, but...

I: **It's all right. Can you hear me?**

R: Yeah, I can. Sorry, I can.

I: **Okay, that's fine. All right. Are you okay?**

R: Yeah. Did you ask something else? I didn't get the last question.

I: **Yeah. I'll say it again. Well, were there any specific situations or specific residents, or events in which it worked really well, having video calls?**

R: Yeah, there was one lady who - she was probably 70-something, so young-ish for our cohort, who, basically, she was having blood tests every day. So we reviewed the [unclear 37:44] she was quite educated, and wanted to know what was going on. And so that worked quite well, because we could also look at her and check how [unclear 37:53]. She liked that, and she didn't want to [unclear 37:57] she was quite ill, and didn't want to go in. So I think it - and because she was under our service [unclear 38:06] it felt like a positive interaction, and it felt like an admission that we'd prevented, which is actually our whole remit. So it felt like, yeah, it was just a successful story and it was improved by the video, I would say.

I: **Well, what about - are there any specific situations or residents, or even events where it didn't work very well?**

R: I'm trying to think. I mean, I wouldn't say it didn't work very well, but in some way you just, you know straight away this is not going to work, that you just, you'll give it a go. You might speak to a nurse, and you realise that the patient is too unwell to really engage in talking to you, that you'd just get as much information as you can, and looking at them. And then you just move on to what is going to be helpful, which might be getting some collateral history from the nurse, or from someone else, or you might go to a relative or something instead. But I think - or the example when you're spending hours trying to connect, and it's just wasting everyone's time. So you send the AccuRx link, and you're waiting and they're not connecting. You send it again, and they're still not connecting. You phone them up, and say did you get my link? And then you just think, look, let's just not worry about this. I think that's more for patients at home, and I think in a care home it's okay [unclear 39:44] know the staff and you can just say, okay, that's fine, thank you, let's do the next person. And, actually, what did work well, which I think is important to mention, is that being able... Using the video did allow us to - has allowed us to do death certificates, which if we hadn't seen patients on the video, we actually wouldn't be able to do a death certificate, if they died within so many days without seeing a healthcare professional. In which case, they might need a post-mortem and that's traumatic on the families. So I think in that way, that's positive, even if we hadn't eyeballed them.

So, yeah, but I don't think we've made mistakes based on the video, if you know what I mean? I was trying to think of an example where adverse harm has happened, and I don't think we've seen the video and thought, oh, they look fine. But then they've suddenly had a heart attack and we think, oh, if we had examined them, would that have happened? I don't think - I'd say that it's not worth [unclear 40:45] assessments in any way [unclear 40:48] assessment, it's either enhanced it, or not added anything.

**I: Okay. Well, I know you mentioned that you'd have care home staff help you with the calls, and join the calls. Were there any particular situations when they were definitely there... There were - well, were they always there?**

R: So...

**I: Can you say that again?**

R: Sorry, I tried to change the volume and it's gone pear-shaped. So they were always there, whether it's in the care home; they would always be there in the care home. Because I think what happened was, is our service gave them a device that then they would... That was only used [?for the 41:36] AttendAnywhere, so they were always there ready with it. And I think that was generally helpful, because the main issue with that is just having somebody who... I mean, they're not difficult to operate, so the care homes can probably manage, but it depends [unclear 41:51] without any problems. And occasionally it would disconnect and they had to reset, but that was okay. And I think the most helpful thing is if someone knows the patients, but that's whether it's remote or not, really. And someone who is quite confident to move the patient, and get them to do what we need them to do, and to re-explain what we've asked them to do, or didn't hear at the same time, for example.

**I: Well, how did you feel, or how did the consultation feel... I know you've mentioned that sometimes you maybe weren't as confident, but how did the consultation feel compared to a face-to-face encounter?**

R: Yeah. So I've kind of mentioned this already, I think.

**I: Yeah.**

R: That just it doesn't feel as natural, it feels harder to show compassion and empathy. It feels, as I said before, less - I have less conviction that they [unclear 43:02] what I want them to do, or what the plan is. I have less - so I don't know if I've actually said that very well, but... Yeah, it feels a bit more clumsy.

**I: Yeah. So is that the same feeling you get if you had - if you did it over the phone, or...?**

R: No, I think it's probably easier over the phone, but not always. I think partly just because it's someone else holding it, and they might move the screen, or the screen might freeze, or... Sadly, if you're speaking to a deaf person on the phone, it feels very, very similar. And you just realise this isn't going anywhere and you might have to say, okay, let me speak to your sister-in-law, or something. And I guess they're probably just a bit more used to speaking on the phone, and we've got our [unclear 44:01] sense of being on the phone. I think a doctor's

[unclear 44:03] developed a sort of style, and [unclear 44:07] to interact with patients, and it might just be that we've not developed a video style yet, maybe. Or just the way you like walk someone into your room, or that [unclear 44:22]. Yeah, I think it is - it does feel - not always - but can feel a bit unnatural.

**I: Yeah. That's an interesting way to put it, is that kind of it doesn't feel quite as natural as being in the same room with somebody.**

R: No. And just because I do have this other job, which is with younger people, that they're obviously very used to like video conferencing. It feels more comfortable, because I'm used to it, they're used to it. Yeah.

**I: I know you just mentioned this briefly about with the engagement, but so do you feel like the person's understanding and participation in the conversation then was impacted by using video technology?**

R: Yeah, I think so, maybe because there's another - maybe because there's someone else, there's a third person involved and holding the video. Yeah, I think so [unclear 45:28].

**I: Yeah. So I know you mentioned this a little bit before, but so do you think they just didn't... They weren't - you mentioned two things: that sometimes they weren't understanding what was going on; and then you also mentioned sometimes they'd have a really hard time participating and disclosing as well?**

R: Yeah. I think part of it is - it's just they're just so unfamiliar with this screen. I mean, if it's you're a resident at home, and a person at home and you have been told to connect to your video call, you kind of are engaged in the process. You know what's going to happen, because you have to connect to it, and the doctor...and we've spoken to them before. But these ones - the one sitting in a care home, I mean, there's just suddenly a video thrust in front of their face, with this unfamiliar face on there. And, I mean, I don't look particularly doctor-y, but I don't think any of us... We don't wear white coats, and we're not all grey men with glasses. None of us might look like how they imagine a doctor to look. And then but they've also moved from these different environments, and they've just come out of hospital. You know what? I think on a lot of levels it's going to be - it's difficult for them to know what's going on. So that's definitely a challenge. But, yeah, then also maybe they're not sure how to put [unclear 46:50], because they're not used to it.

As I say, they'll answer a few questions, but then you sort of have to just move on and do the physical side of things. And I wouldn't say that it ever - you'd ever really do more than five minutes with an elderly person on a video in the care home, but then maybe these are quite older, quite... Ones that have been quite sick, and are recovering from Covid. If that answers your question?

**I: No, I think that's a really good point to make, is that a lot of times when you're talking to them, they've just been in hospital and they're... They're just - they've just been in about a really bad condition, and that's going to impact anyone, especially if... And then you're being moved to a different context, and a lot of things going on. It sounds like, yeah, that**

**would all be really sometimes maybe confusing and you don't really know exactly, maybe understand what's going on. And then trying to have a conversation - yeah.**

R: Yeah. [Unclear 47:57] occasions in England, health care happens to them, rather than with them. Half the time, even if you're very coherent and with it, doctors are not very good, really, at explaining as things go along. You have had this, you've had a blood clot, you've had this, we have started this medicine. So it's not that collaborative in that way, the whole time. So then when it's another face, I think they always... They seem quite tired, actually, of just, oh, another person to talk to, actually. But like - so we have to really work hard to win them over enough to build a bit of a rapport up, and to get them to open up, if they are feeling low, or if they have a symptom that's worrying them that they've - you don't know - had for ages, but no one's listened to, or...

I: **Yeah, that's really hard if they have - if they're seeing a lot of different people, it's hard to build up that rapport. Yeah, definitely.**

R: And normally with the elderly, they're quite frail people, there's normally like an advocate for them, like their relative, and often it's their daughter, or someone younger who will be really fighting their corner, and phoning up the GP and representing their needs. But, obviously, they haven't been allowed to visit them. So I do think, in some ways, these older residents have been... Sort of struggled to get what they need, because there's not [49:28] to ask for it for them. And, I mean, I guess the staff will help with that too, but just this care home is in a slightly tricky situation, because it's new and the staff have, and yeah.

I: **Yeah, it's not like a typical care home, but just seeing that person for an extended period of time. Well, so do you think that any of your - the outcomes of your calls have been altered by using this technology?**

R: Yeah, I do. So I do think there's been lots of outcomes that have been influenced just in terms of, yes, they are well enough to stay at home, or, no, like they're dying. There's quite a lot that are dying, actually, and a nurse might say, or someone say to you, yeah, they're not really eating and they're not very well. But just seeing them and you can think, actually, yeah, I agree, they don't look like they've got more than a few days to live. And, in which case, we will book an end-of-care pathway, end-of-life pathway and make sure they've got medicines. And that's definitely good for a person, to make sure they're comfortable at the end of their life. There have certainly been diagnoses that we've made with the video, literally actually things like rashes. I think abdominal pain is quite good with the video, actually, because you can tell they're not distended and you can get someone to push the tummy and check they're not wincing. So you kind of know they're not obstructed, or peritonitic. I think the chest is harder. I mean, you can obviously see if they've got laboured breathing, but it's that kind of how sick are they, that you get that's helpful.

So certainly it helps to decide, yes, I will prescribe antibiotics - no, I won't. Or, actually, that swelling is significant enough; I'm going to prescribe a diuretic tablet for water, for heart failure. So, no, I think it has changed the outcome.

I: **Okay, yeah. It sounds like it's helped it in a positive way, actually?**

R: Yes. Because these ones - because they're not nurses, you wouldn't really trust the staff to give you a good enough clinical description to make a decision, so we need the video [?more 51:42]. Whereas I think if there was - if it was a nursing home and there were nurses that were saying this guy has got swollen legs, it's pitting oedema, I would trust that enough to prescribe. Or if the nurse said to me that chap has got cellulitis, I would trust a nurse and I would prescribe antibiotics over the phone. Whereas if it's just a layperson, or it's just a carer that doesn't have much medical knowledge, I would want to either see a photo, or see the patient to make that decision.

**I: So thinking about this, especially talking about the different relationships that you have got with nursing staff versus regular caring staff, do you think the relationships that you have with the care home staff have been influenced by using video?**

R: And I think our relationship is better having - using video. We've sort of had hilarious moments about how ridiculous technology is, and we've sort of... Like you them, and you recognise them, and have a bit of chat about how they're doing. Like we were upset when they did have a Covid outbreak. Also, in that same thing with the district nurses, this camaraderie, that they're the ones getting sick patients, just feel... I think they, again, like having contact with doctors and knowing they can call us any time, and putting a face to the name. It always felt like nice and positive, friendly, mutual [unclear 53:09] working together for the good of the patients kind of relationship. Yeah, so that was positive, for sure.

**I: So you felt that with the district nurses, and did you also feel that with care home staff that you were doing things for the best...**

R: Yeah.

**I: ...of the patient?**

R: Yeah, I did. I felt like we were helping them. And I felt like - it felt like we were guiding them through situations that they felt a little bit unfamiliar and uncomfortable with. I felt like the care home were a bit frightened, because it was all a bit unknown and they weren't sure what to do. They didn't know who to go to for certain questions, and I feel like they felt supported by us. And part of the reason I sent them an email, was because you could tell they really wanted that; like sort of written to feel like they're not carrying all of this responsibility. And they used to panic quite a lot when someone was quite ill, so I think being able to have the video and them to know that you've seen this ill patient, and say to them it's okay, we've seen this before, I'm going to prescribe this, it will be okay. Or just to say, yes, I agree, they are dying, that's okay, I will phone the relative and tell them that I've seen them and that that's the situation. I think they definitely felt like we were supporting them, and yeah.

**I: That's good to hear, that they're feeling supported and especially... And easing their concerns as they came up, so they didn't feel like they were dealing with them on their own.**

R: Yeah. And so even though it's a bit annoying for us with the video, and it felt needed, I think. And, yeah, beneficial actually for the staff, even if it's maybe not making a huge difference to



the interaction with a patient, I suppose it's helping the staff feel more empowered and supported - it's worth it, I guess.

**I: That's really good. Yeah, that's really interesting. Yeah. Well, what - could you see anything else going on about other people in the home, or anything else going on in the home when you would have these calls?**

R: So not really, we couldn't. Not really, actually, because I guess there's only... I mean, they have an iPad, but you don't really get a good look around the home - you could nosey around. We did - just this is a sort of side point, but at the beginning of the pandemic there was a few concerns about a couple of care homes, maybe not following the right procedures with isolated patients, for example, so do a bit of investigative phone calls and things. And I suppose you can see that they were putting their PPE on correctly, or you could see around the patient's bedside, like have they got a table near them to access their drinks? Have they - do they look comfortable? But you didn't really see the residents ever. I mean, I guess they're all quite isolated, and, yes, we'd get walked down the corridor.

**I: Okay, you did, yeah.**

R: Yeah, but didn't really see much. I don't - I still didn't feel like I could do a tour of a care home. Do you know what I mean? Yeah.

**I: Yeah. Well, along that same line, how confident that you may be able to pick up on any potential safeguarding issues?**

R: Well, yes, and that's where I was thinking, would I... I don't know, if there's someone who we think has got Covid, and then I could see there's like another resident in the room with them, I'd be like, oh, that doesn't seem right. But I don't know if it would be - I mean, I think it's better than not seeing anything, isn't it? I think we'd probably be able to pick up on odd interactions between the resident and the staff. So if we said to a member of staff, oh, could you just help roll Mr XXXX over, and then if the patient is like recoiling and looking really frightened, I think we would see that. And, obviously, if there was visible harm, like bruising or whatnot, or obvious neglect, like if they're lying in their faeces, I think we would see that. But I think it would have to be pretty obvious for us to notice, I think, more subtle signs of safeguarding or abuse, I think would be really hard to spot.

**I: Well, do you think you are able to discuss and share about safeguarding concerns and issues, if you had any?**

R: Yeah, I think we would. I haven't got any examples of safeguarding concerns. I mean, we'd certainly chat about residents in a fairly multidisciplinary team way. So sometimes we might be there, and there might be a district nurse there, so you might chip in, or if there was a relative who was asking difficult questions, we might talk about the relationship a relative might have with a patient. I mean, I think if I thought there was a safeguarding concern with a member of staff that I was doing the video call with, I don't know how comfortable I'd feel to address that with them on the video call. But, I mean, I would feel comfortable to escalate that further to my line manager, or maybe just speak to the manager of the care home. But that is a bit like a sensitive conversation, and, obviously, if you were going to just say

[unclear 58:45] you're supposed to tell the person you're doing it, I wouldn't do it, and I'd be more likely to do that if I was with them face-to-face, but not on the video. Because it would feel - it would feel a bit hard to corroborate. It feels less sens-... I'd be less certain, I think. Almost like you don't trust what you're seeing on the video, quite as much as you would trust what you've seen with your own eyes, possibly.

**I: Yeah, you might be - yeah, you maybe want to double-check, or do something else because you don't feel as confident, it sounds like?**

R: Yeah, you might think you've seen something that doesn't look right, but then you might convince yourself, oh, actually, that was probably just like an old stain, something else, or... Whereas if you saw a bruise or bloo-... Just, I guess, particularly with the video because it's moving, it's actually quite hard to see things clearly. And I know this from my other job, and I might see a woman with acne and her skin looks amazing on the video, but then she sends a photo and there's lots of real, obvious spots. The video isn't always quite as sharp, because it's movement, I suppose.

**I: Yeah, that's a good point, actually, and sometimes you might be better if there's a photo, rather than the movement, which sometimes can't quite capture it.**

R: Mm.

**I: That's interesting. Well, those are the last of my questions. I'm just going to open it up to you to say, is there anything or any other information regarding your opinions, or your experiences that you think would be really useful for me to know?**

R: I think I've told you everything. I mean, I don't want to sound really negative, because I think... And the thing is, I guess my experience is possibly, slightly atypical, like I wonder if I'd been working with a care home that I knew already beforehand, and I already knew the residents, would be a bit easier. It would be like, oh hello, it's funny, do you remember me? Like now you're seeing me on video. And also I would have some idea of the geography of the building. Do you know what - like you can imagine it more. So I think, I mean, I do think GPs I've spoken to, quite like remote ward rounds, actually, because quite often when you visit somebody in a care home, you might say hello out of courtesy, but it doesn't actually change much actually seeing them in person. So we've actually - it's avoiding always unnecessary trips, I guess, but still doing the hello. So, no, I do think it's good in some ways, but I don't know if... I don't think it could be the only way that doctors are interacting with people in residential homes, and I think they do need some physical face-to-face direction as well.

**I: So that would be how you - going forward, do you think that there needs to be both, and both need, could be put in place then?**

R: Yeah, I think so. I think - so we have this model of having an initial assessment, and then reviews. And I think in an ideal world, the initial visit would be better face-to-face, because at least then you've met them once, you have a sort of relationship with them and you remember them. You actually examine them top-to-toe as like a baseline, so if anything

changes you're more aware of it, I think would be better and better for the patient, in an ideal world. But, obviously, it uses resources and is not necessarily safe infection-wise.

**I: That's really interesting. Yeah, I mean, we'll see what happens, especially with Covid and kind of put things up, yeah. Well, that's all the questions and everything I have. I just wanted to let you know that I do - if anything else comes up, feel free to contact me, but... And I just wanted to let you know that we do have - because you have agreed for us to hold on to your information, so that we can send you the preliminary findings when we get them, so that you can...Yeah, so we can send you those. So I just wanted to remind you that we do have your contact details still for that, and make sure you're still okay with that?**

**R: Yes, I am. And, I mean, I hope that was helpful?**

**I: No. Yes, it is really helpful. I think your experience is different from maybe some other GPs, and who have regular visits and stuff, or that's a very different experience, because you're involved with a care home that's suddenly come up and kind of put together, and is a very specific role.**

**End of Transcription**