**Recording Details: P012**

R[[1]](#footnote-1): I’m technically known as [job title] for one psychiatric nursing home in [name of city] and one residential care home for people living with dementia in [name of city]. That means I don’t particularly get involved in the operational stuff but more on the strategic, high-level supervision of the management, etc.

Int[[2]](#footnote-2): Are they separate homes in different places then?

R: They are separate homes about 25 miles apart, yes.

Int: We’re specifically looking at older adults so can you tell me about the work that your organisation does with older people specifically?

R: Yeah. What are you defining as old, by the way, in terms of age?

Int: I think we’re going more on what the organisation goes by.

R: Right, okay. We don’t define particularly old but our dementia care home is obviously mainly older. We have a couple of early onset but still reasonably old going up to I think 97 is our oldest resident. There’s up to 25 residents there at any one time. In the midst of the pandemic there was actually a step-down facility so that means getting people outside of hospital into [name of care home], into the care home. They would spend anything from a few days to a few weeks rehabilitating and waiting for service packages or getting assessed to go home or to a nursing home or whatever. We dealt with a lot of old people including a lot of turnover of those but now for the last sort of year very much our standard, it’s a care home for elderly mainly living with dementia but obviously the dementia takes priority so we would have people in their late fifties.

Int: That makes sense. So within that generally then, how much focus is there on preventing loneliness and social isolation with your clients?

R: Well, it’s an interesting one, isn’t it? I’d say the move to a care home is one of the significant factors to stop that, isn’t it? In a way? Especially with dementia, obviously in a pandemic it’s been horrendous for people out there who are at home in a very, very isolated way maybe with one carer who’s a husband or a wife and that was an incredibly hard time for that little household. A lot of the time our old residents at [name of care home] have been coming into us having met a crisis point at home so I’d say at least maybe three quarters of residents that we’ve had there now in our permanent model have come from home. One of the key, I suppose messages isn’t the right word, but one of the key benefits is that actually a lot of that goes away, doesn’t it, really?

Int: Yeah. So what you’re saying is just by being there it’s almost started to address that isolation because they’re automatically less isolated.

R: Absolutely. So that’s a good thing. There have also been a lot of negative things, obviously, hasn’t there? Being in a care home in a pandemic at times, not now, thank God, but previously we’ve had quite a lot of times where there’s either been, okay for a limited amount of times that there’s been no visiting or extremely limited visiting, extremely restricted visiting and that has massive challenges, especially for people living with dementia.

Int: Yeah, definitely. Thinking back then to those early days of the pandemic when those restrictions were in place, what sorts of conversations were had in your organisation about how maybe digital technology might be used to prevent loneliness?

R: Lots and lots and lots. I think we did very well with it. The good thing is that we use Teams already so this is good, so there is a level of reasonable competence in some of the staff with digital technology generally. The options we had were things like Teams, Zoom, even FaceTime on people’s phones, etc. That sort of thing. We were very limited to using digital technology to drive the contact with families. That was good in the fact that that was there and available but the problem is just fundamentally that does not cut it very well with a lot of people living with dementia because they just don’t understand it. You can have a lot of support but you would have people not really engaging because, like this, you look like someone on the telly so you don’t understand that that might be your family member or you don’t recognise it as your family member, or very distressed or very confused by it. “Well why are you on the telly?” sort of thing. There is a lot of that.

We were actually really massively surprised as well that a lot of people really lived it, so that’s great. We had quite good conversations and funny conversations and people having a bit of a laugh about the fact they were on telly and so there was actually quite a lot of benefit from that but there was also, I’d say, a very, very big handful, even maybe more, a third maybe, who just couldn’t engage with it. Very, very supportive it was just not for them. They might have a couple of seconds and then just want to stop it.

Int: No, that makes complete sense. Were those issues things that you could foresee that you thought might happen?

R: Yes, absolutely, but at the time you’re very limited to what you can do so it’s always worth having a go with the communication because other communication forms were really, really basic where it’s like through a window. I mean that’s horrendous, isn’t it? With a family member sat outside in the rain with an umbrella with a phone speaking to their mum or their dad or their partner on the phone with no understanding. It was okay, don’t get me wrong. It was better than nothing a lot of the time but it was also incredibly distressing for people on both sides, sometimes to the extent that you just think is that really worth it? So it was difficult.

Int: You mention that obviously you’d been using Teams and things so the staff were quite confident but had you ever been using digital technology for the clients before the pandemic?

R: Yeah. I suppose [name of care home] is a bit of a tricky one because the care home we’re talking about here actually only opened as a result of the pandemic. That opened in April 2020 so I can’t really say anything on that one. With the psychiatric nursing home in [name of city], even though there’s adults from 18 onwards there are actually quite a lot of older adults there and we’ve had that for 30 odd years there. Definitely they have used absolutely technology previous to pandemic anyway. Not a lot but quite handy to have people joining in on a Zoom birthday party because their niece is in [name of city], that sort of thing. So it’s not completely abnormal.

Int: Yeah, so there’s been a place for that there but then it obviously just really ramped up.

R: More pressure on it, yeah.

Int: I had a look at the survey that you’ve done for us as well and you mentioned that you’d been able to provide tablets or iPads and things like that, so can you just tell me a bit more details about the actual devices and the types of technology you were using?

R: It’s a variety. We have laptops and we bought more laptops with big screens like the one I’m on now, so the HP 15” screen so essentially to make that big. We already had a couple of iPads floating about. The Welsh Government did a scheme like a digital inclusion scheme and they lent us I think at least two iPads through that scheme which was great and I think we had that for at least a year, which was helpful. We also allowed the senior staff who’ve got the company mobile phones, quite honestly to use mobile phones, because that’s the problem sometimes with Facebook and FaceTime. I’m never a fan of FaceTime but I also appreciate that a lot of our families use FaceTime as their normal thing so they would have to FaceTime privately with our manager who’s also on Facebook and do it that way on a little phone. So that’s difficult. We also now use little Samsung Galaxy tablet or something like that. Those sorts of things which are sightly smaller. On the whole I would say it was the iPads that we were using for that.

Int: You’ve mentioned then and it would be quite interesting to go into that a bit more about the different people who did really engage with it and it went really well and then the people perhaps where it didn’t go quite so well. You said the dementia was the key factor. Were there any other groups where it was better for some and not so good for others? Were there any similarities between the people where they felt different effects?

R: Yeah. This is just me putting into it but obviously being an older group of people their families, including sons and daughters, they’re pretty old and definitely husbands and wives are old and a lot of them, maybe even the majority of them, when we were saying, “Can you send us your Skype user ID?” Had no idea, had never done things like that. I wonder whether the ones that who are more successful in it have at least had some history in the family of using that, or maybe the families were more natural. It’s difficult to pinpoint it. With dementia communication is difficult anyway, isn’t it?

Int: No, that makes sense and that’s really interesting so actually for the client or the service user that you have it’s almost not entirely how they’re finding it, it’s also how the family are finding it.

R: Oh, definitely. Also, the time that we had to spend on the phone doing bloody IT support, quite honestly, for families, was massive and very, very tricky and very challenging.

Int: That was one of my questions anyway actually was to ask about how you came across any technical difficulties or support that was provided. What kinds of things were happening with that?

R: A typical example is that the iPads from the Welsh Government were set up with Skype, that was the usual thing. That’s okay. I use Skype at work every now and again and that’s fine but I wouldn’t think Skype is the social media communication of choice, I don’t think, is it? It’s probably a bit more business, isn’t it, I suppose? A lot of our families were having to set up Skype on laptops and phones and things like that. We don’t have a Facebook. It’s tricky, we were probably a bit behind the schedule in not having Facebook and we still don’t have Facebook for ourselves. Because Skype was there for the preferred route, the easiest route because you just go ‘call, Skype’ on the iPads for staff and it meant a lot of pressure on friends and family, well families, to do Skype at home, etc. They would often phone because we’d say, “It works with us to book a time, so like 11 o’clock, and we’ll try and Skype you,” and then you’d spend at least 20 minutes more Skyping them, phoning them, them phoning you saying they can’t figure it out. All of the usual palaver from digital anything, isn’t it? In a very stressful time. That was very challenging and frustrating for all parties, of course it was. There wasn’t really an awful lot of things we could do on that but it was definitely telephone support and thankfully we added on extra admin staff which we obviously paid for to literally just be there to be able to spend 20 minutes on the phone with Mr [name] walking him through how to put Skype on his mobile.

Int: I was going to ask because thinking of your situation in a care home and you must be so incredibly busy that that as an added factor, how did you cope with that? So you actually had the ability to get some extra staff to help.

R: Yeah, we did. We were lucky/planned, which is we have an admin team that works sort of centrally. For the two homes they dip in and out of admin, etc, so they can use that admin team. That admin team was made up of two people, one full time, one part time. We ended up increasing the contract of the part time one to effectively full time plus adding a third one on. This is a significant cost in order just to boost up the numbers of people available to help with communication. We kept that going because actually that’s really helpful because actually in the health setting now we’re under huge pressure with staffing and self-isolation, so actually those pressures have carried on they’re just different now. It still helps at least having someone to be able to chat on the phone to someone, not about Skype necessarily but just about anything really to allow that contact to be felt.

Int: The residents that you have that were keen to engage and keen to keep going with the technology, what do you think was their motivation around that?

R: They were not keen at all. Remember our residents, our clientele, fabulous as they are, they will be quite advanced with dementia. It’s very much something that’s driven by us as a service rather than them saying anything about setting up a Skype.

Int: So it was more, “Let’s have a go at this,” rather than, “Can I have a go?”

R: Yeah. There was absolutely no driver from any of them. I can’t remember a single time. When you would just launch upon them, so you wouldn’t even tell them, often we would get me, another staff member, whoever, to faff around with Skype and then literally once you’re up, great, fine, walk it through to the resident, surprise. That seemed to work. It sounds awful, doesn’t it, but for lots of them that seemed to work best of all because that was a lovely surprise.

Int: Yeah. No, it does make sense and, like you say, sometimes that bit beforehand with all the setting it up, I mean that’s just confusing in itself.

R: Very stressful. That’s obviously for families but our people would have been very connected, in their previous lives would have been quite connected into certain community things. A church put on Zoom services. Great. So we thought that would work really well. That was almost a complete disaster because you’re joining on Zoom and you put it on the big telly and that’s great, so that was quite good because it looks a little bit just like you’re watching a church service on the telly so that’s okay. What was very, very difficult was that church service was finding the communication, the digital technologies hard themselves so you’d have, “You’ve got your mic on,” blah, blah. That’s just distracting, confusing. Don’t really understand it. Frustrating. So that didn’t ever really work either and it was maybe a bit too distant so we had to abandon that which was a bit of a shame. Again, there was nothing really out there specifically for dementia where it would be really clear, calm, simple, easy to follow, that the sound was really good. Things like that really matter.

Int: I suppose you were almost thrown in a situation where you don’t know that until you’ve had to try it first and then see.

R: You have to try things, don’t you? You have to try things. Also, when we were in step down it wasn’t necessarily that everyone had dementia, not at all, because it was a step down [inaudible 00:17:34]. I think over time we had something like 60 something people come through the system in about 12 months. That puts a massive amount of pressure on the system to do communications for all of those different people and to keep them engaged with social stuff, which is virtually impossible, I think, really.

Int: Yeah, just the sheer amount and the time and everything that’s going on.

R: Yeah. Time is definitely a big thing because staffing has always been under pressure. It was under pressure before the pandemic in health and social care, there’s nothing new there. There’s nothing exciting there, is there? It adds on more pressure because especially with someone with dementia there’s virtually no chance that you could give someone an iPad and let them chat to their daughter for 20 minutes. That is highly unlikely to be successful so it really means that you would have to put a staff member onto that communication, which is fine, that’s okay, but again it’s just, right, okay, so you’ve got 25 people, that’s a lot of time, isn’t it?

Int: Yeah and fitting it in, like you say, so you had that sense of having to maybe schedule them in and plan them in but that doesn’t always go to plan as well.

R: No, it doesn’t always go to plan because also that person might be having a bad morning or a bad hour, disinterest. It’s hard, isn’t it? You lose that spontaneity.

Int: Just picking up on what you said about some of the family members themselves perhaps being older adults themselves, so did you come across any difficulties with – I know you said it was quite challenging – with actually engaging them in the first place like, “We’re going to do Skype.” What kind of barriers did you come up for them?

R: Just lack of skills and who can blame them? I get that. Lack of skills. There’s a lack of support out there. So in a pandemic maybe where, this is random, Mr [name] would have had this daughter-in-law come and visit him and help him with his iPad, that had all gone away, hadn’t it? It was a bit of a vicious cycle in a sense that they were at home mainly on their own not seeing very many people where a grandchild, a teenager might have popped in to help them with an iPhone, that had gone away. So there were some people and continue to be some people even to this day that just won’t interact that way. Quite a few. I mean it’s different now because we’ve got slightly less restrictive visiting so that’s good but it was such a relief when we were able to offer that.

Int: No, that’s interesting. It sounds like you’re almost at the end of a chain that was being affected further down by people not being able to get that technology support and there’s only so much you could do, it sounds like.

R: Yeah. The Welsh Government and our local authority were really supportive in helping, you know, giving us those couple of iPads just literally on a Friday afternoon. That’s fantastic. That’s really helpful. At the time we didn’t have WiFi throughout the building. That’s been corrected now, but at the time they were all 5G enabled and that was brilliant of the Welsh Government. Fantastic. We were heavily reliant on that but that’s not helping the person on the other end of the call, is it?

Int: Yeah. It needs both sides to work, doesn’t it? That’s [over speaking].

R: Yeah. Don’t get me wrong, there were lots of benefits and positive stuff and thank God we had it, but I know there was also quite a lot of people who just didn’t have the contact at all.

Int: Have you got any examples of a story or anything where it’s been really positive for somebody? I know you said there were some times where it was really funny or it went really well.

R: I’m not there operationally so I went in and did a few sessions with people and one of them was definitely when I was able to set up a session with two sons who both lived in [name of city] so they were not allowed to move at all. We did that in the office, got them all fine, great, and walked them through to their dad who was just so heartened and cheery. We hadn’t told him because it was a surprise because I thought well there’s no point really trying to explain it to this guy because he’s just not going to really understand the concept. He was just absolutely delighted and they were doing singing together and he’s a very, very religious man so he was doing his singing and blessings on them. It was just so sweet. They were thrilled because that dad, he had been in hospital for many months and so he actually came out to us. That was the first time that they had seen their dad, even digitally, because obviously hospitals aren’t able to support and who can blame them? It’s just never going to happen, is it? So that was heartening for them because they saw their dad and he looked well because he’d been with us for six weeks and put on loads of weight and was clearly jolly and he was crying. It was just delightful.

Int: That’s really lovely. It’s so good to know that there are those examples, especially like you were saying in a context that must be so hectic and challenging but it’s nice to know that there were those good success stories.

R: Yeah, few and far between though. I’d say mostly it was people just going, “Yeah, yeah,” and walking off or just turning it off and we’re just like, “Right, okay.”

Int: Yeah, so I suppose that would be the flipside of that question would be those examples where it didn’t go well but, like you said, it’s more where it was too distressing or too confusing and not the right thing.

R: I think a lot of it is just comprehension, isn’t it? There are so many challenges with communication on dementia, especially advanced dementia. This doesn’t work a lot of the time for dementia people, they need to see someone slightly to the right of them on their eyeline. You want to have quiet, calm, basic conversations. It’s quite hard to do, isn’t it, because even like this you feel like you want to fill a space, don’t you? Especially for families you want to just chat and, “Have a look at this.” It’s quite a lot going on so I’m not sure, I think it probably did the families better than the actual person.

Int: Well I suppose like you say even being able to have that visual to actually see the person probably both sides but especially for the family on the outside to see somebody when they couldn’t otherwise and just a telephone call doesn’t bring that so I suppose was there an element of that that even just to see them was quite nice.

R: I’m sure it was. I mean I can’t talk over them, obviously, but I also think there is probably lots of challenges to that which is it’s quite shocking to see someone. Also, if that’s your only proper contact visually, I think families, quite understandably and I would be the same, is that they were looking for issues and they were looking for problems and they were looking for, “Mum’s deteriorated.” That’s basically because they’re just not allowed in, are they? Who can blame them? You’d do the same, wouldn’t you, if it was your own mum in there. You would be doing exactly the same.

So I think there were a lot of challenges. It was lovely for lots of them to have that little chat. We have a lot of families all over the place and they would not have been able to travel anyway, would they? Maybe half of our families are local. That’s a lot of people that aren’t local, isn’t it? That was really the only way that they could do it.

Int: That’s it, it was all just reduced to that, wasn’t it? Quite a few times within there not knowing how long that would be the case for as well.

R: Yes, horrendous. Yeah.

Int: I don’t know if it’s something your organisation would do but if you’ve had any kind of chance to evaluate any of the use of technology or whether that’s something you plan to do to see how it’s gone.

R: You know what? We haven’t and we probably should have. I wonder if it’s a bit late in the day really now to do that. It would have been good to do that. We run surveys every now and again although, to be honest, the pandemic has put a halt to anything that isn’t absolutely essential, to be honest. One of the things that we do do is, ‘is your level of communication acceptable, okay,’ all the rest of it. I think people would say that we all did our best in a trying situation. There’s probably not much more that you can say on that. I think it worked some days and it didn’t work other days. Families were very frustrated by it because even when you do your best to book in times and slots, etc, if the care team on the day are one short and there’s a little crisis going on, they’re not going to prioritise the Skype call at 3:30pm.

It’s full of challenges without someone being there as a digital eagle really. I think that’s what we would have liked to have done but, again, there’s so much around the difficulties of employing someone to only do that, money, time, effort, digital skills. Also having someone there because we did think about moving one of the admin staff to basically just go and do that all day, but also, it’s difficult because that resident won’t necessarily know that person. That’s quite tricky to do as well so that was an idea that was floated but quickly left.

Int: Yeah, so because you’re almost balancing actually having the care staff provider is probably better for the person but also not so practical on a caring level.

R: Yeah, because that person will know the care staff, the care staff will know their good times, their bad times, the words that will encourage them. They just know them much more rather than like an administrator. Lovely as that person would have been we just thought it would be a step too far for an already challenging situation.

Int: No, that makes sense. I suppose you said there was some element of in the other home as well that they had used technology and they were accessing Zoom and things like that already, how do you see it going forward then now? I appreciate we’ve been in a bit of a strange time with the pandemic just now but how do you see the balance of face to face and remote technology being used?

R: In the psychiatric nursing home in [name of city], being a in a psychiatric nursing home that’s a very challenging resident. They’ve just automatically got far fewer family contacts. Literally a handful of people would have family contact or friends contact. That’s mainly phone. Sometimes on Zoom or whatever. They’re quite good at that, so I think that’s going fine. They have mainly face to face contact in whatever way so that’s great and they go out and all the rest of it. In [name of care home] I think we’ve pretty much abandoned online for now and it’s face to face. It’s so much more effective for people living with dementia and families want that, of course they do. Even the families further away are absolutely seemingly to prefer phone conversations and a single visit every few weeks as a maybe more nature thing for that family.

Int: That’s interesting. I know obviously you’ve mentioned about the staffing and the time but is there anything else you could see that would make technology a better part of that that could be done to incorporate it in a more successful way.

R: I just struggle to see without some really big improvements on the technology how that is going to work. Please God forbid if we went into a proper lockdown situation or much more restrictions, we would obviously have to look at it again and I think one of the things we would probably do is ideally run digital, family training, which is maybe a bit of coaching about how to talk, which is terrible, isn’t it? How to chat on Zoom or Skype or whatever with someone with dementia. It’s terrible because it’s just too busy and too far away from their actual relative. So I think unless there are some massive improvements in that I can’t really see how that will ever work.

Int: It’s really interesting to hear from you on it because it’s a specific area that’s got specific needs to help to get those people to feel less isolated but, like you say, you’re balancing so many different things.

R: I think the isolation and loneliness, the focus has been on, and I know this sounds terrible to say this but when you’ve got more advanced dementia your world comes in a little bit, doesn’t it? The focus has actually been the community in the home. By moving away from your home with just you, maybe on your own or with a husband or wife coming into a community like ours with activities, either one to one or a group and just being around people, that decreases your social isolation just by being in a place where there’s chat. Also for a lot of women it’s being in a community where there’s lots of women. We’ve got lots of men as well, don’t get me wrong, but I think particularly as a women sometimes there’s little sections and it looks like a little WI even though they’ve all got dementia and all talking about different things. I think you feel you want to be part of that a little bit.

Int: Yeah, there’s still that social element there no matter what, isn’t there?

R: Yeah, that emotional intelligence, that social intelligence is still there just in a different way, isn’t it? That’s very hard for families as well, isn’t it? Families take great comfort in seeing that their resident is being looked after, is quite happy, etc, so actually it’s decreased the pressure on the visit in a way. Their visit can just be a 20-minute visit and we’ve made an outside space as well, a nice garden area so, again, they can just talk about birds, about flowers. It’s not needing to put too much pressure on that single visit.

Int: No, that makes complete sense. That’s really interesting, thank you.

[END]

1. Respondent [↑](#footnote-ref-1)
2. Interviewer [↑](#footnote-ref-2)