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An Exploration of the Experiences of Home Health Care Assistants working through the COVID-19 pandemic

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DECLARATION

We, the undersigned declare that this thesis entitled ‘An Exploration of the Experiences of Home Health Care Assistants working through the COVID-19 pandemic’ is entirely the author’s own work and has not been taken from the work of others, except as cited and acknowledged within the text.

The thesis has been prepared according to the regulations of Dundalk Institute of Technology and has not been submitted in whole or in part for an award in this or any other institution.

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List of Abbreviations

ADLs	Activities of Daily Living
AHCP	Allied Health Care Professional
CPAP	Continuous Positive Airway Pressure
HCA	Health Care Assistant
HCO	Home Care Organisations
HCP	Health Care Professional
HHCA	Home Health Care Assistant
HSE	Health Service Executive
IPC	Infection Prevention and Control
JD-C	Job Demand Control model
JD-R	Job Demand Resource model
JD-SC	Job Demand Support control
MDT	Multi-disciplinary Team
PCC	Person-Centered Care
PIL	Participant Information Leaflet
PPE	Personal Protective Equipment
QQI	Quality and Qualifications of Ireland

WHO World Health Organisation

Operational definition of terms

Ageing-in-place	Ageing-in-place is a term used to describe supporting older people to remain living in their communities rather than living in institutional settings such as long-term care facilities (Department of Health 2019).
Community-dwelling adults	Those who remain living in residential homes, availing of community services and amenities, unlike older adults who reside within a nursing home or other communal living organisations.
Health Care Assistant	Health care assistants (HCAs) provide direct care to patients across multiple care services whilst supporting Allied Health Care Professionals (AHCPs) within a healthcare team (Conyard et al. 2019; Health Services Executive 2018).
Holistic Care	Holistic care is a term used to describe supporting an individual as an emotional, physical and social being.
Home Care Organisation	The organisation that arranges and provides the services to deliver home care services.
Home Care Services	Home care is an over-arching term used to describe the care services provided by healthcare professionals within the care recipient's home (Vaartio-Rajalin and Fagerström 2019).
Home Health Care Assistant	Home health care assistants (HHCAs) are HCAs who work within home care services, where the point of care is located within the care recipient's home.
Job demands	These are physical, psychological, social or organisational aspects of the job that require physical or emotional effort from the employee, consequently at a cost to the employee (Bakker et al. 2003).
Job Resource	Job resources refer to any physical, psychological, social or organisational aspects that may be implemented to

	achieve work goals, reduce job demands and stimulate personal growth and development (Demerouti et al. 2001).
Multi-disciplinary Team	Refers to all health and social care professionals involved in a clients care. Members of an MDT may include but are not limited to, Doctors, nurses, Carers, Social workers, social care workers, Physiotherapists, Occupational Therapists, Speech and Language Therapists.
Older Adult	The term *older adults* refer to adults aged 65 years and over.
Person Centred Care	In this study, person-centred care is used as an umbrella term to encapsulate the different terms used to describe placing the individual receiving care at the centre and focus of the process
The COVID-19 pandemic	The WHO initially declared the novel coronavirus outbreak a pandemic on the 11th of March 2020.

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They say it takes a village to raise a child, and I have since found out it takes an army to complete a thesis!

Thesis Abstract

An Exploration of the Experiences of Home Health Care Assistants working through the COVID-19 pandemic

Background: The number of older people living in Ireland and globally has grown in recent years. The demand for home care services in Ireland is predicted to rise exponentially. However, home care organisations face challenges with the recruitment and retention of Home Health Care Assistants. Job resources have been shown to positively influence an employee's experience of their job whilst also positively impacting retention rates. Literature on the experiences of home health care assistants (HHCAs) working in Ireland is scarce, and the resources required by HHCAs to remain in post are predominantly unexplored.

Aims: This study aimed to understand the lived experiences of HHCAS.

Objectives: The objectives of the study were to; (1) To explore the experience of delivering care as a HHCA, (2) To establish how work demands affect HHCAs (3) To identify resources needed to support retention of HHCAs.

Methods: A Qualitative explorative study consisting of online interviews with ten HHCAs who had a minimum of six months of experience working in home care settings. Thematic analysis was undertaken on the data.

Results: HHCAs experienced challenges and demands within their role before the COVID-19 pandemic. Some of these challenges were emphasised as a result of the COVID-19 pandemic. Additionally, the COVID-19 pandemic introduced new challenges within the HHCA's job. The challenges outlined by HHCAs included; time pressure, challenges to providing PCC and social isolation. Finally, this study identified that HHCAs require resources that enable them to provide PCC optimising their ability to make a difference in their clients' lives.

Conclusion: Participants explained that their jobs as HHCAs required more than completing tasks yet also a personal and emotional connection between them and their clients. Participants described this emotional connection also extended towards their co-workers as they described a sense of community support they experienced from their colleagues. A key area that participants identified was the need for social inclusion among HHCAs. Additional research is required to establish how the addition of these resources may influence the work experience of HHCAs. Given the current recruitment and retention issues faced by HCOs across Ireland, this research offers valuable insight into the resource needs identified by HHCAs, namely the recognition of the value and

importance of HHCAs to establish a positive rapport with their clients through delivering PCC.

Keywords: Home Health Care Assistants, home care services Ireland, Community-dwelling older adults, COVID-19, Person Centred Care, Resource needs.

Chapter 1 - Introduction

Globally, it has been predicted that 1 in 6 people worldwide will be 60 years or older by 2030 (World Health Organization (WHO 2021). As people live longer, they are more likely to develop multi-morbidities, declines in their overall well-being and reduced ability to carry out activities of daily living (ADLs) (WHO 2016). A recent report outlines that at least 142 million older people worldwide cannot maintain functional ability or meet their basic needs (WHO 2021). Functional ability refers to the ability to meet basic needs, ensure an adequate standard of living, learn, grow and make decisions, be mobile, build and maintain relationships, and contribute to society (WHO 2021).

Supporting older people to remain independently living at home has been shown to have many benefits for the healthcare system, including reducing the length of hospital inpatient stays (National Institute for Health and Care Excellence (National Institute for Health and Care Excellence 2016; National Institute for Health and Care Excellence 2015; Murphy et al. 2015). Furthermore, supporting older people to remain living at home has been shown to promote ageing-in-place policies, respect the care recipient's choices and wishes, and improve their quality of life (Walsh et al. 2020; Department of Health 2019; Sixsmith and Sixsmith 2008). Home care services support older people to remain at home in their community for as long as possible (Health Service Executive 2021). Such services can reduce the demand for long-term residential care by prolonging the individual’s ability to remain living at home (Kusmaul et al. 2020).

Like many countries, Ireland has seen an increase in the projected life expectancy of its population, with the number of people aged 65 and older projected to increase by 78% by 2030 (Horgan et al. 2020; Keegan et al. 2020). The figures from the most recent Census of Ireland report have shown that the number of people aged 65 and over has risen and now accounts for 19.1% of the population (Central Statistics Office 2017). Data from the 2016 census

revealed that in Ireland, of those aged 65 years and above, 94.7% remain living in community-based, private dwellings as opposed to communal settings (Central Statistics Office 2017).

The demand for home care in Ireland is projected to increase by a minimum of 44% by 2030 (Wren et al. 2017). SláinteCare is a main healthcare reform programme in Ireland, aimed at progressing Ireland towards universal healthcare in line with other European counties by promoting a transition to community-based care. (Department of Health 2019). SláinteCare focuses on providing people with the correct care and support at the correct time and location (ibid). Traditionally, home care services in Ireland were provided by either publicly funded or voluntary organisations (Walsh and Lyons 2020). However, to meet current and growing demand, an increasing amount of home care in Ireland is now provided by private-for-profit health care organisations (HCOs) (Walsh and Lyons 2021; Murphy et al. 2015). Public home support provision relies heavily on sub-contracting private-for-profit HCOs (Mercille and O'Neill 2020). Home care services are predominantly provided by health care assistants (HCAs). HCAs providing care in domiciliary settings rather than long-term residential or hospital contexts shall be called Home Health Care Assistants (HHCAs).

Recruitment and retention have been identified as one of the most significant challenges faced by HCOs in Ireland (Hunt 2021; NCCN 2017), resulting in home care services facing significant staffing shortages (Hunt 2021; Markkanen et al. 2021; Home & Community Care Ireland 2020; Walsh and Lyons 2020). Before this study, literature on the challenges and experiences of HHCAs working in Ireland was scarce. Furthermore, literature addressing the factors that may influence recruitment and retention issues among HHCAs was also lacking. Additionally, literature relating to the experiences of HHCAs working during the COVID-19 pandemic was unavailable before commencing this study.

With the population of older people predicted to continue rising and the emphasis on supporting older people to remain at home, research into the work of HHCAs and the factors that influence recruitment and retention in the sector is timely. To address this gap in the literature, this study aimed to understand the lived experiences of HHCAs.

The objectives of this study were:

1. To explore the experience of delivering care as an HHCA.
2. To establish how work demands affect HHCAs
3. To identify resources needed to support the retention of HHCAs

Thesis Outline

This section provides an outline of the thesis structure and a brief overview of the contents of each chapter. Chapter two examines the literature on Ireland's home care service provision and the role of HHCAs. Chapter three provides an overview and explanation of the Job Demands and Resources theory (Bakker and Demerouti 2017) and how it relates to the work of HHCAs. Chapter four outlines the research design and methodology used during this study. Ethical considerations and the ethical approval for this study are also discussed in this chapter. Chapter five presents the findings, while Chapter six considers how the findings fit within the current literature.

Chapter 2 - Literature review

2.0 Introduction

The purpose of a literature review is to present an overview of previous studies and their findings relating to a specific topic or interest. This chapter presents a literature review that provides context and background to the systems within which HHCAs work and the legislations and policies that guide and support home care services. Whilst exploring these topics, this literature review also addresses the increasing demand for home care services and HHCAs within Ireland and beyond. Literature was available to examine elements of a HHCA's role, namely, time pressure, zero-hour contracts, and challenges with autonomy and safety. However, the variables that can positively influence the experience of working as an HHCA were lacking. Hence, a gap in the available literature was identified, addressing the resources HHCAs required to complete their daily tasks.

2.1 Literature Search Strategy

Scoping reviews enable a researcher to gather and synthesise existing knowledge on a topic whilst also enabling the identification of current gaps in the literature available (Peters et al. 2020). A systematic review enables a researcher to gather all available research on a specific topic using a clearly defined systematic method (Ahn and Kang 2018). Neither a systematic review nor a scoping review was employed during this study due to time contrasts and lack of pre-existing knowledge on the experiences of HHCAs working in Ireland. However, A systematic approach was employed to complete a narrative literature review as part of this study. This systematic approach involved consulting with a librarian to develop a literature search strategy. Following this consultation, databases were identified and the author used key words and terms to search for relevant literature. Titles and abstracts of articles were scanned for appropriateness and were included if they were relevant to

the research question. Where there was broad commonality, the more recent publications were prioritised. A narrative review was chosen as, before this study, very little was known about the role and work of a HHCA working in Ireland.

Literature searches were conducted using the DKIT Library guides, searching databases such as EBSCHO host, CINAHL and ProQuest. Books were also reviewed from the DKIT library and online library sources. This literature search also used relevant websites and publications, including Research Gate, The World Health Organisation, The Department of Health, The Central Statistics office and The Health Service Executive. Keywords used in these searches included *Home Health Care Assistants, Domiciliary care workers, Home Support Workers, Job demands, job resources, Home Care and Ireland. An Example of the serach strings implemented can be viewed in table one.*

Concept one		Concept two		Concept 3
Health Care Assistant		Working Environment		Variable
• Health Care Assistant OR • HCA • • Healthcare Assistant • Home Health Care assistant • Home Support worker • Home Support	AND	OR Home Care OR Residential OR Community dwelling OR Acute Setting OR Nursing Home OR Community	AND	OR Ireland OR United Kingdom OR UK OR Northern Ireland OR Republic of Ireland OR Covid-19 OR COVID

• professional carer • professional caregiver • domiciliary care assistant				OR Covid-19 pandemic OR Coronavirus OR Job Demands OR Job Resources

Table 1 Search word-strings used during the literature review.

Some previous studies on the experiences of HCAs in Ireland were completed by Conyard et al. (2019). However, this study included HCAs working across all sections, and HHCAS were only a subsection of this study. Some studies had been completed in other countries such as England, Sweden and America, yet many failed to address the job resources required by HHCAs. Furthermore, before this study, the literature on the experiences of HHCAs in Ireland and the job resources they required was scarce.

Research on the experiences of HHCAs began to emerge in the late 1980s, with Donovan (1989) exploring the experiences of female HHCAs working in New York City. Interestingly, HHCAS in this study also reported similar experiences to HHCAs recently, citing a lack of role progression and contracted hours (Donovan 1989; Conyard et al. 2019). In the 1990s, literature began to emerge on the experiences of HHCAs. Most of this literature related to the experiences of HHCAs working in America and Canada (Neysmith and Aronson 1996; Weiler 1998). It was not until the late 2000s that literature relating to HHCAs working in Northern Ireland began to emerge (Fleming and Taylor 2007), and later again, in 2012, until literature relating to HHCAs working in the Republic of Ireland was published (Timonen et al. 2012).

Core studies referred to throughout this literature review are outlined below. In a study of 19 Home care workers in Sweden, Swedberg et al.(2013) explored the experiences of HHCAs providing 24-hour care to patients with complex needs. Significant findings from this study included the need to support HCAs with their needs for training, supervision and support from various HCPs (Swedberg et al. 2013). Also, in 2013, Cavendish (2013) published a report outing the findings from An Independent Review of Healthcare Assistants and Support Workers in the NHS and social care settings. This review included HCAs working across various settings and geographical locations across the UK.

Kusmaul et al. (2020) investigated the link between empowerment job satisfaction and retention of HHCAs in America. Additionally, in a study among HHCAS supporting older adults with multi-morbidities, Sterling et al. (2020) explored the link between the provision of training and job satisfaction among HHCAS in America. An American study which emerged after this study was commenced evaluated the impact Covid-19 had on HHCAs, their clients and the managers who supported them (Markkanen et al. 2021). This study was qualitative, with a sample population of home care clients, HHCAS and HCO managers. The main findings of this study included the increase in psychosocial demands experienced by HHHCAs during the pandemic.

In an Irish context, Murphy et al. (2015) completed a study on the use of formal home care services among older adults in Ireland. The interviews used in this study were carried out during the first wave of The Irish Longitudinal Study on Ageing (TILDA). Drennan et al. (2018) published a report based on the findings of a systematic literature review on the education, role and function of a HCA in Ireland. This study also evaluated the titles and definitions associated with the role of a HCA, an overview of the work profile of a HCA in Ireland and the educational requirements of HCAs in Ireland. This report, published by Drennan et al. 2018, guided the review of the role and function of a Health Care Assistant published by Health Services Executive (2018).

Another study in Ireland focused on the perception of time concerning home care services for older adults from the perspective of family carers, HHCAS, and members of the older persons MDT (McDonald et al. 2019). A study completed by Conyard et al. (2019) explored career satisfaction, well-being, skills, and experience of HCA in Ireland. HHCAs were included as a sub-group of this study. This study provided a context of the work experience of HCAs in Ireland.

2.2 Background and Context

Many countries, including Ireland, have seen an increase in the projected life expectancy of their populations (WHO 2021; Horgan et al. 2020). Currently, the number of people aged 60 years and over is larger than that of children under five globally (WHO 2018). The Irish population is increasing, and so is the number of older people living in Ireland (Central Statistics Office 2017). As people live longer, they are more likely to develop multi-morbidities, declines in their overall well-being and ability to carry out ADLs (WHO 2019).

Ageing-in-place is a term used to describe older people having the ability to remain living in their communities with some level of independence rather than living in residential care facilities (Grimmer et al. 2015). Supporting older people to age in place has been shown to respect the choices and wishes of older people who want to remain at home while improving their quality of life (Wiles et al. 2012; Sixsmith and Sixsmith 2008). The WHO's goals for healthy ageing are to optimise older people's functional ability (World Health Organization (WHO 2021). Supporting older people to remain at home in environments that support and promote their independence and enhance their ability to learn, grow and make decisions enables them to continue contributing to society, reflecting the aims of the WHO guidelines for healthy ageing (WHO 2020). Within an Irish context, Sláintecare, the current programme for health care reform, has prompted a movement towards community-based care where

feasible. It is recommended that the workforce supporting older people provide care centred around the older person (WHO 2016).

Home care is a community-based service to support older people to remain at home for as long as possible (Health Service Executive 2021). Home care services were introduced in Ireland in 1972 and initially supported older people with household tasks such as cleaning or shopping. Since then, the role has evolved, and the support provided by home care services now includes support with daily living activities, such as washing, dressing, incontinence care management, and meal preparation (Institute of Public Health in Ireland 2018). Support with household duties is provided through home help care packages (Murphy et al. 2015).

Home care services in Ireland are predominantly provided by Health Care Assistants (HCAs) (Drennan et al. 2018). The title HCA has many different pseudonyms in the literature, such as nurses' aides, healthcare support workers, personal support workers and healthcare assistants (Conyard et al. 2019). This thesis refers to HCAs providing care in home settings as Home Health Care Assistants (HHCAs). HHCAs have been referred to as home task attendants, domiciliary care workers, and community healthcare assistants elsewhere in the literature (ibid).

2.3 Demand for Home Healthcare

Growing ageing populations and policy changes that focus on enabling people to live more independently in the community have dramatically increased the demands for home care support services (Strandell 2020; Horgan et al. 2020; Parsons et al. 2018). Private, for-profit HCOs are routinely subcontracted to address the rapid demand for home care services for older people in Ireland. However, as Timonen et al. (2012) reported over a decade ago, policies and legislation to support and regulate these HCOs and the HHCAs working for them have still not transpired at the same rate as the increased demand for

care needs (ibid). There is an increasing issue with the retention of HHCAs, resulting in staff shortages amongst HCOs. Drennan et al. (2018) have predicted that retention rates of HHCAs are to deteriorate while the demand of the ageing population continues to grow concurrently. For those who have expressed a desire to remain at home, home-care services implement person-centred care (PCC) by respecting the person's wishes and supporting them to remain at home for as long as possible (Landers et al. 2016).

2.4 Person-Centred Care

Many healthcare services across the globe have recognised the importance of PCC within their practices, stimulating a shift from a medical model, delivering care in hospital and residential settings, to a "person-centred approach" to care (Santana et al. 2017). One of the first explanations of PCC advised medical professionals to assess the patient as a whole, to understand and treat them as unique human beings (Balint 1969). PCC may also be referred to as client-centred care, person-centred practice, or resident-focused care (Ebrahimi et al. 2021).

PCC focuses on supporting the individual receiving care to be involved in all decisions regarding the care they receive (National Institute for Health and Care Excellence 2015b). The National Institute for Health and Care Excellence (NICE) guidelines direct that the person receiving care should be actively involved in the decisions regarding the type of care they receive, where they receive it, and who they are from (National Institute for Health and Care Excellence 2016; Cavendish 2013). Furthermore, Kitson et al. (2012) have proposed that for effective PCC to be delivered, care services should promote participation and involvement of the person receiving care, establish appropriate and effective rapport between the caregiver and care recipient, and finally, provide an environment and culture that embraces the implementation of PCC (Kitson et al. 2012). Furthermore, according to Coulter and Oldham (2016), implementing PCC is a multi-level task involving treating

the person as an individual and including their family, medical, and support services in decisions regarding their care.

The WHO has recognised PCC as a critical competency of HCPs (Santana et al. 2017) since providing PCC enhances the quality of life of the care recipient (National Institute for Health and Care Excellence 2016). Sanerma et al. (2020) reviewed 742 articles to explore the definition of client and person-centred care in home health care settings and found that PCC is a vital and ethical component of home care services (Sanerma et al. 2020). Cavendish (2013) reviewed the jobs of healthcare assistants working within the NHS in home care, acute, and community settings and found that providing good quality PCC requires more emotionally and physically from HHCAs (Cavendish 2013). Schaufeli and Taris (2014) echoed the findings of Cavendish (2013) and described the emotional or physical energy expenditure required from an employee whilst providing care.

A study that evaluated the experiences of HCAs working in nursing homes found that HCAs are often torn between providing PCC or adhering to the strict task-orientated system within which they work (Kadri et al. 2018). Likewise, HHCA's daily duties have become heavily task-orientated, causing them to rush with and between clients. A study completed with 109 home care workers in Ireland found that insufficient time allocated to HHCAs to complete tasks has been cited as a barrier to providing effective PCC (McDonald et al. 2019). HHCAs describe being hindered by strict organisational structures, company and government policies, and time constraints (Kusmaul et al. 2020; McDonald et al. 2019).

2.5 Role of Health Care Assistant within Home Healthcare

Although the roles of HCAs and HHCAs overlap, the HSE have identified that differences exist between the two (Health Services Executive 2018). In a study completed by Conyard et al. (2019), HCAs reported working in various

healthcare settings, such as nursing homes, hospitals and home care settings, with job responsibilities altering between care settings (Conyard et al. 2019). Similar to HCAs working in a hospital or nursing home settings, both Conyard et al. 2019 and Gannon and Davin 2010 found that HHCAs also provide a range of support services, including but not limited to nutritional support, meal preparation, personal hygiene support, assistance with dressing, light household duties and social engagement.

HCAs provide direct care to patients across multiple care services. The primary role of a HCA is to provide PCC to an individual whilst supporting the implementation of care plans and support as advised by members of the client's multi-disciplinary team (Health Services Executive 2018). The job responsibilities of HCAs are guided by the needs of each client (Cavendish 2013), with job responsibilities of HCAs usually focusing on providing support with:

- Communication
- Breathing
- Intimate care
- Death and Dying
- Mobilising
- Maintaining a safe environment
- Washing and dressing
- Food preparation (Health Services Executive 2018b).

Kusmaul et al. (2020) identified the location in which a HCA works, the hierarchy structure of the organisation within which they work, the tasks expected from them, and the hours of work are some of the differences observed between HCAs working in acute settings and those working in home care. These experiences differ from HCAs in institutional settings, but since each domiciliary setting is unique, the roles and experiences of HHCAs also differ. For example, as Kusmaul et al. points out, HCAs in acute hospital settings generally work within a team, compared to HHCAs, whose work is primarily one-to-one with the clients they support (Kusmaul et al. 2020).

A further division between domestic care packages, also known as home help and care packages, often called home care, can be seen in publically funded home care providers in Ireland (Murphy et al. 2015). The job descriptions between those two roles differ and contrast accordingly. The role of HCAs providing home help focuses more on supporting clients with activities within and around the home, such as light household duties, cooking or food shopping (Health Services Executive 2018). Compared to the role of HCAs providing care packages that focus primarily on supporting clients with daily living activities as outlined above. The overlap and confusion between role requirements of the HCA has led to variances in the education requirements and delivery of HCAs.

2.6 Education and Training

Unlike education programs for nurses and other HCPs, the education and registration of HCAs remain unregulated in many countries (Duffield et al. 2014). In a study of 19 Home care workers in Sweden, Swedberg et al. 2013 found that a lack of training can present many challenges for HHCAs, contributing to increased burnout experiences and reduced job satisfaction (Swedberg et al. 2013). Drennan et al. (2018) found that the formal education and training of HHCAs in Ireland can vary significantly between HHCAs and their colleagues and between individual organisation requirements.

Unlike other HCPs, HCAs have no legal obligations to complete specific training. However, recommendations have been made for HCAs to complete at least a level 5 National Framework of Qualifications (NFQ) qualification (Conyard et al. 2019). The Quality and Qualifications of Ireland (QQI) promotes the quality and integrity of higher and further education in Ireland (QQI 2018). The NFQ compromises a ten-tier framework ranging from level one (basic learning) to level ten Doctoral and Higher Doctorates (Indecon International Economic Consultants 2017; QQI 2018).

The HSE has previously advised that HCAs should have completed all eight modules of the QQI Level 5 course before engaging in employment as HCAs (Conyard et al. 2019; HSE 2018a). However, the advice for those working in the private homecare sector differs. The HSE's minimum requirement for HHCAs working in private HCOs is to have a minimum of two modules of a level 5 QQI award completed before commencing work as a HHCA (Conyard et al. 2019; HSE 2018a). Two of these modules must include; 'Care of the Older Person' and the 'Care Skills' modules. The remaining six modules and the complete level 5 QQI award should be obtained within 11 months (HSE 2018a). HCOs are also advised to establish a training plan with HHCAs to ensure outstanding modules are completed. Nonetheless, Conyard et al. (2019) found that training plans were often absent among HHCAs, resulting in many HHCAs working for significant lengths of time with only two modules completed.

Like Conyard et al., Drennan et al. (2018) also found that the current system of providing and supporting education programmes for HHCAs was inadequate, as they do not appropriately prepare the HCA for work and were disconnected from the reality of working as HHCA. Furthermore, an earlier study of HCAs in the UK identified an absence of sufficient training, finding that 40% of HCAs providing home care services were unqualified and often sent to clients' homes without the proper training (Cavendish 2013). Similarly, more recent research among HHCAs in the United States also found that they are often required to carry out tasks for which they had not received training (Sterling et al. 2020). The lack of training expressed in these studies may pose an issue with staff retention, as studies by Sepahvand and Khodashahri 2021 and Dietz and Zwick 2021 found that training and development are essential factors of employee retention.

From an organisation perspective, a study among HHCAs in France found that organisations that invest in and support their staff's personal and academic development experience increased retention rates (Cloutier et al. 2015).

Previous research has shown that HCOs providing HHCAs with formal training and support programmes showed higher retention rates (Feldman et al. 2019). Training has an important role in the retention of HHCAs, but many other factors influence the intention to stay in post, including how the employee experiences their working life.

2.7 Working Life of HHCAs

Examining job performance, Budie et al. (2019) found that employee job satisfaction plays a vital role in the success of the organisation they work for, as employees who are satisfied in their jobs display increased productivity and performance. Self-reported job satisfaction has been described as having a preference for one's current position over another available opportunity (Lévy-Garboua and Montmarquette 2004). Both intrinsic and extrinsic factors influence job satisfaction. Intrinsic factors include a sense of accomplishment and making a difference in the client's life. In a study among Home Care Nurses, Ellenbecker (2004) found that extrinsic factors include wages, work environment, support from peers or supervisors, autonomy and control of one's work hours, and autonomy and control of one's work activities (Ellenbecker 2004).

In a study exploring job satisfaction rates among 4,162 HCAs working in nursing homes in Switzerland, Schwendimann et al. (2016) found that higher rates of job satisfaction were associated with increased reports of support from leadership, teamwork, and safety in the workplace. Work environments that promoted and implemented effective communication strategies between management, employees, and clients also displayed increased teamwork (ibid). Similarly, findings from other studies found managerial support, feeling valued, receiving adequate hourly rates of pay and having sufficient time allocated to complete tasks required have been shown to directly influence the job satisfaction of HCAs working in both nursing homes and home care

settings (McDonald et al. 2019; Berridge et al. 2018; Schwendimann et al. 2016).

A study by Coogle et al. (2007) examined the link between training, job satisfaction and job turnover among 140 home care workers in America and found that the opportunity for progression within one's role increased job satisfaction for the employee and improved company retention rates. Furthermore, a study exploring job satisfaction and intention to leave among nurses in America found that job autonomy and peer support significantly influenced the nurses' intent to remain in post (Han et al. 2015). These findings were echoed among HHCAs in a study evaluating the factors that influenced Swedish home care workers' job satisfaction and linked higher worker autonomy to higher reports of job satisfaction (Ruotsalainen et al. 2020).

HCAs in nursing home residential care settings were also found to have increased job satisfaction when the HCA had the opportunity to provide high-quality PCC, having greater job autonomy and job control (McDonald et al. 2019; Health Service Executive 2018; Cavendish 2013). Furthermore, HCAs who are included in daily decision-making processes, decisions about the client's care, and have opportunities to implement autonomy into their daily practices report being more satisfied in their jobs and more likely to remain working with their current employer (Kusmaul et al. 2020; Berridge et al. 2018).

In a study focusing on HCAs, Drennan et al. 2018 found that satisfied HCAs report less intention to leave their jobs than those with lower job satisfaction. This finding within the current study concurs with Kusmal et al. (2020) as despite the challenges outlined by participants, many of the participants expressed an intent to remain working in their role due to the difference they are making within their client's lives. Furthermore, a study examining the link between employee empowerment, job satisfaction and retention among HHCAs Kusmaul et al. (2020) found that HCAs who are more satisfied in their jobs continue working with the current company for longer, thus maintaining

continuity of care and improving the quality of care provided. Other elements shown to influence job satisfaction among HHCAs specifically include job security, safety at work, low pay, and supervision from management (Maurits et al. 2018; Ruotsalainen et al. 2020; Sterling et al. 2020; Kusmaul et al. 2020; Schwendimann et al. 2016; van Eenoo et al. 2016; Cavendish 2013).

Although the literature on HHCAs in Ireland is scarce, previous literature on job satisfaction of HHCAs in other countries suggests that those with opportunities for progression within their role display greater likelihoods of job satisfaction (Kusmaul et al. 2020; Berridge et al. 2018). Swedberg et al. (2013) also reported that increased healthcare knowledge and empowerment levels among HHCAs are vital to increasing retention and reducing HHCA turnover rates. Ravalier et al. (2019) found that increased experiences of stress associated with one's job decreases job satisfaction. Indeed, increased work-related stress and job demands have been shown to reduce employee retention rates(Möckli et al. 2020). Unsurprisingly, over a decade ago, Fleming and Taylor (2007) reported that HHCAs in Northern Ireland had considered leaving their profession due to unsociable hours, lack of management support, workload, dissatisfaction with their working hours, and lack of financial security and support from the client.

For many years, HHCAs have been reported to be leaving working in HCOs to work in long-term residential facilities to be guaranteed working hours (Delp et al. 2010; Fleming and Taylor 2007). Indeed, it has been over a decade since Fleming and Taylor (2007) suggested that hours must be contracted and guaranteed if retention rates were to be improved among HHCAs. The increasing complexity of care required by older people has also extended the already unsociable working hours expected from HHCAs (Fleming and Taylor 2007).

Participants in Cavendish (2013) also reported that many HHCAs often work on week-to-week, zero hour contracts, meaning they are not guaranteed any

work hours. Mc Donald et al. (2019) found that using zero-hour contracts amongst HHCAs negatively impacted their ability to manage their time effectively. Likewise, Ravalier et al. (2019) completed a study among HHCAS working in the UK and found that HHCAs working on zero-hour contracts are exposed to more stressors than those working contracted hours.

Time pressure has previously been described as one of the most strenuous work factors for HHCAs and is linked to physical and emotional strain (Andersen and Westgaard 2013). Time is a vital component required to build effective relationships between carers and clients, maximizing the quality of PCC provided (Cavendish 2013; McDonald et al. 2019). In turn, HCAs in residential care settings had increased job satisfaction when they had the time to provide high-quality PCC (McDonald et al. 2019; Health Service Executive 2018; Cavendish 2013).

Previous studies have linked lower job satisfaction to lower pay rates among healthcare staff (Drennan et al. 2018; Morgan et al. 2010) with inadequate pay, a frequently cited issue of concern for HHCAs in Ireland (Conyard et al. 2019). Previous research has found that HHCAs' jobs require high levels of responsibility for low and unguaranteed pay due to zero-hour contracts (Ravalier et al. 2019; Cavendish 2013). In addition, HHCAs are required to travel from client to client and are rarely paid for the time it takes to complete the commute or for the expenses associated with travelling, i.e., fuel cost and upkeep of their vehicle (Conyard et al. 2019). Indeed, the study conducted by Morgan et al. (2010) found that HHCAs have reported leaving one agency to work for another, offering higher wages.

HHCAs are often the only HCPs present during their shift and must work independently, using their initiative (Franzosa et al. 2019; Cavendish 2013). Despite the requirement for HHCAs to independently support their clients, Kusmaul et al. 2020 found that HHCAs often do not have the autonomy or control within their working scope to use their initiative. Likewise, HHCAs in

other studies have reported limited control in the use of their time (McDonald et al. 2019), their working schedule (Franzosa et al. 2019), and their working environment (Swedberg et al. 2013).

Those working in acute settings often have access to supervision from their superiors on-site. The nature of home care often requires the HHCA to work on a one-to-one basis with clients, reducing the opportunities for HHCAs to avail of peer support from their co-workers or support from members of management (Coogle et al. 2007). Similarly, Swedberg et al. (2013) found that supervisors are rarely present during a HHCA's shift. Likewise, Cavendish 2013 found that HHCAs can often only contact their supervisors via phone. The absence of supervisors on shift for HHCAs can exacerbate their need to work independently while decreasing their interaction with peers.

2.8 Challenges within the home care service

Recruitment and retention have been identified as one of the most significant challenges faced by HCOs in Ireland (Hunt 2021; NCCN 2017). Sepahvand and Khodashahri (2021) have described retention of employees as preventing good employees from leaving their current work organisations, increasing the organisations' profitability and productivity as a result. Ensuring qualified employees remain working within organisations can benefit organisations in many ways. According to Bakker and Demerouti (2017), when an employee experiences high job demands without access to appropriate job resources, an undesirable outcome occurs, also known as negative organisation outcomes.

For healthcare services to operate effectively and safely, adequate staffing levels must be maintained. The Institute of Public Health in Ireland (2018) has highlighted that current staffing levels and availability of HHCAs indicate home care as a sector under pressure, struggling to meet the demands of the clients they provide care. In healthcare settings, staff shortages have also been

shown to increase the time pressure faced by HHCAs, reducing their ability to provide high-quality PCC (Kusmaul et al. 2020; Fleming and Taylor 2007). Challenges with recruitment, retention and other areas of the HHCA workforce existed before the COVID-19 pandemic. However, as Markkanen et al. (2021) have found, the COVID-19 pandemic also increased the psychosocial demands placed on HHCAs.

In December 2019, a novel human coronavirus (COVID-19) was identified in Wuhan, China. The virus subsequently spread to most countries worldwide, and the WHO characterised the outbreak as a pandemic on March 11th 2020. Many countries, including Ireland, issued stay-at-home orders to reduce the rapid spread of the COVID-19 virus (Galea et al. 2020). Although these recommendations varied between countries, these outlines predominately advocated for individuals, particularly those of older age or with multi-morbidities, to stay at home and only go out for essential purposes such as grocery shopping, obtaining medical supplies, or for essential types of work (Lin and Fisher 2020). In March 2020, the Irish Government introduced 'cocooning' as a measure for those over 70 years of age to minimise interactions with others by not leaving their homes.

The COVID-19 pandemic presented additional challenges to the health and well-being of older adults (Robinson et al. 2020). One of these challenges was due to older adults needing to self-isolate. Lin and Fisher (2020) found that self-isolating or quarantining at home can significantly reduce and alter one’s ability to carry out daily tasks. This reduced ability to complete tasks emphasised the demand and necessity of home care workers as those isolating could no longer care for themselves the way they would have previously. HHCAs were members of a front-line care team involved in supporting older people to negotiate their health and wellbeing during a time when few others could visit to provide support during the early phases of the pandemic (Rowe et al. 2020).

2.9 Conclusions

Recruitment and retention have been identified as one of the most significant challenges HCOs face in Ireland. With the projected demand for home care services to continue to increase, action is required to increase the number of HHCAs working in-home care services, but this requires improving the working conditions and retention rates of HHCAs in Ireland. However, while the literature presented provides some insight into the challenges experienced by HHCAs, little is known about the direct experiences or the resources required by HHCAs to continue working in the sector. This study aims to fill that gap.

Chapter 3 - Theoretical Framework

A Theoretical Framework guides research studies by providing a structure to explore research phenomena. Each theory can provide a different perspective on the research subject. (Bolt et al. 2014). Utilising one theoretical framework throughout a study ensures that continuity is observed. Theoretical frameworks provide a lens through which researchers can evaluate and organise a research study. Theoretical frameworks are based on pre-existing theories and can assist the researcher with study design and evaluation of findings (Bazeley 2020).

When determining a suitable theoretical framework for use within this study, various theoretical frameworks were considered to address the key objectives of this study: to evaluate the working experience of HHCAs, to establish how work demands impact HHCAs, and finally, to establish the resources required by HHCAs as part of their role. To maximise the utility of the findings within this study, a framework that enabled an examination of these objectives from both the workers' and organisations' perspectives was sought.

3.1 Job Demands and Resources (JD-R) Theory

The JD-R theory combines two research concepts, job design traditions and job stress theories (Bakker and Demerouti 2014) and proposes that critical elements of job design, such as job demands and available resources, influence either positive or negative employee outcomes. The JD-R model was first proposed by Demerouti et al. (2001) and initially focused on how job demands and job resources influenced the development of burnout among employees, attributing employee disengagement to high demands and low job resources. This model acknowledged that each occupation has specific job stress factors and classified these factors into two categories: job demands and job resources (Bakker and Demerouti 2007). Over time, the JD-R model has evolved into the JD-R theory (Bakker and Demerouti 2014), recognising

job resources' influence and buffering effect on adverse organisational outcomes (Schaufeli and Taris 2014). Since the first publication of the JD-R model (Demerouti et al. 2001), many studies have confirmed the model's reliability (Bakker and Demerouti 2017; Schaufeli and Taris 2014).

The two processes caused by job demands and job resources are health impairment and motivational processes (Bakker and Demerouti 2017). Negatively viewed job demands are linked with the health impairment process (e.g. time pressure), and positively valued factors of the job are associated with job resources *and* instigate the motivational process (e.g. managerial support) (Bakker and Demerouti 2017; Schaufeli and Taris 2014). Since its publication, The JD-R theory has focused more on work engagement as a positive dimension of job outcomes (Bakker and Demerouti 2017; Bakker and Demerouti 2014). Employees who experience high engagement rates are also more likely to experience high retention rates within organisations (Schaufeli and Bakker 2004).

Adverse organisational outcomes may include employee disengagement, strain or burnout (Schaufeli 2017). Burnout has been described as a stress syndrome in which the individual may experience emotional exhaustion and diminished personal accomplishment, shown to negatively affect retention rates in HCPs (Willard-Grace et al. 2019; Kim et al. 2018; Maslach and Leiter 2016). A list of examples of critical elements of the JD-R theory, as outlined by (Schaufeli and Taris 2014), can be viewed in Appendix A. The health impairment process occurs when employees experience long-term exposure to excessive job demands, from which they do not adequately recover, leading to emotional or physical overexertion and exhaustion (Lesener et al. 2019; Bakker and Demerouti 2017).

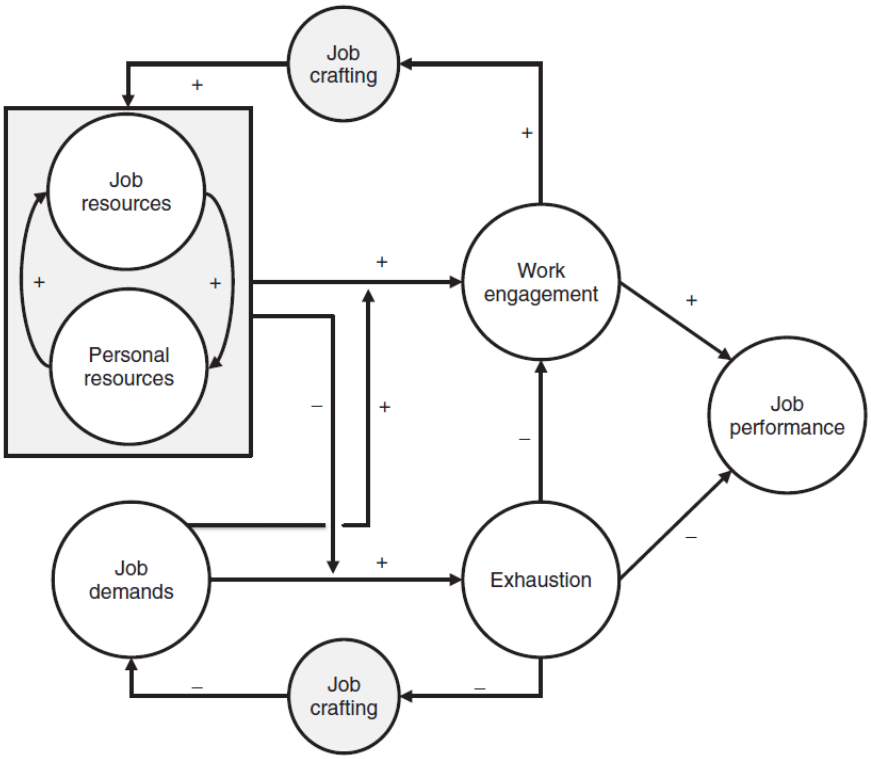

Figure two- Job Demands Resources Theory (Bakker and Demerouti 2017).

3.1.1 Job Demands

Job demands are elements of a job that must be completed to meet work goals and include physical, psychological, social or organisational aspects of the job requiring either physical or emotional effort from the employee (Bakker et al. 2003; Demerouti et al. 2001). Examples of job demands include high workloads and work tasks (Bakker and Demerouti 2017; Bakker et al. 2003).

Job demands can be beneficial if experienced in a short duration or when the employee has access to appropriate resources to meet these demands, as this balance of job demand with appropriate resources can include the motivational process (Lesener et al. 2019). However, when experienced over a long period, job demands that once motivated an employee may eventually cause job stress (Adil and Baig 2018). Furthermore, should the employee not have adequate job resources to buffer the strain of such job demands, the

potential risk of evolution into job stressors increases (Schaufeli and Taris 2014).

Bakker and Demerouti (2014) associate job demands with the stress process, resulting in strain for the employee and playing a crucial role in predicting exhaustion, burnout and health-related issues for employees, which initiates the health impairment process (Lesener et al. 2019; Bakker and Demerouti 2017). When presented with high job demands requiring sustained effort, employees may implement protection strategies, which can present as withdrawal, disengagement, or compromise by reducing the effort exerted, which also reduces the quality of their work (Schaufeli and Bakker 2004).

3.1.2 Job Resources

Resources are job characteristics that support employees in coping with job demands and challenges. Job resources further encourage employees by supporting work and personal goals while alleviating work-related stress (Grover et al. 2017). This, in turn, buffers the negative impact of job demands, such as reducing the stress arising from the demands of the job (Bakker and Demerouti 2014; Bakker et al. 2007).

Job resources refer to any physical, psychological, social or organisational aspects of the job that may do any of the following:

1. be functional to achieve work goals,
2. reduce job demand and the associated physiological and psychological costs that
3. stimulate personal growth and development (Demerouti et al. 2001).

Job resources influence positive organisational outcomes such as work engagement, employee well-being and intent to stay (Schaufeli 2017; Schaufeli and Taris 2014). Work engagement refers to a positive, fulfilling, work-related state of mind defined by high energy levels and mental resilience (Schaufeli and Taris 2014; Schaufeli and Bakker 2004). Work engagement has

been described as the extent to which an employee is engrossed and devoted to their work (Lesener et al. 2019). Employees who are less engaged in their roles have a higher tendency to leave the organisation in which they work (Arora et al. 2015). Job resources significantly impact an employee's experience of work engagement and enjoyment (Bakker and Demerouti 2014). The positive and buffering effect job resources can have on job demands have resulted in recognition of the importance of ample job resources in their own right (Bakker and Demerouti 2014).

Job resources are critical to the motivational process as they stimulate work engagement and positive organisational outcomes such as increased work performance and the employee's intention to stay in their role (Bakker and Demerouti 2017). When an employee works in an environment with abundant job resources, the Motivational process occurs (Schaufeli 2017). The motivational process encourages the willingness and dedication of the employee within their role (Schaufeli and Taris 2014). Job resources can have intrinsic and extrinsic motivational roles as they foster the employees' ability to learn, grow and develop, enabling them to achieve work goals (Schaufeli and Bakker 2004). Employees with many available job resources can cope better with their job demands (Bakker and Demerouti 2017). Compared to disengaged employees, engaged employees are more likely to remain engaged and create their own job resources, a process also known as job crafting (Bakker and Demerouti 2017; Bakker and Demerouti 2014).

The original JD-R model (Demerouti et al. 2001) assumed employees were primarily reactive to the environments and resources provided by managers or human resource departments (Bakker and Demerouti 2017). However, the JD-R theory that Bakker and Demerouti (2014) proposed recognises the proactive response employees may have to job demands. This proactive response is known as job crafting. It has been described by Bakker and Demerouti (2017) as employees changing the job demands or job resources that they experience by, for example, asking for feedback or learning new skills.

Job crafting has been used to explain how different employees who work in the same job and working conditions may experience their work differently (Bakker and Demerouti 2017). The original definition of job crafting was provided by (Wrzesniewski and Dutton 2001) and refers to an approach an employee can take to change either their work tasks (known as task crafting) or the types of relationships in which they engage whilst at work (relationship crafting), such as changing the type or duration of work-related interactions (Bakker and Demerouti 2017).

3.1.3 JD-R Theory Application

Compared to other job demands models, the JD-R theory allows for a more comprehensive, flexible and inclusive approach to considering the many job demands and resources relevant to the work of HHCAs. Most studies implementing the JD-R theory have used methods of self-reported job demands and resources along with self-reported outcomes, which some authors have argued may result in outcome report bias (Schaufeli and Taris 2014). However, this study focused on the resource needs of HHCAs from the viewpoint of the HHCA; therefore, the JD-R model is an appropriate framework to support the self-reporting of resource needs from the HHCAs interviewed. Chapter 3 shall discuss the justification for the methods used.

3.1.4 The flexibility of the JD-R theory

The flexibility of the JD-R theory allows for a comprehensive approach to address a range of job resources and job demands without explaining why particular demands interact with particular resources (Schaufeli and Taris 2014). Although this flexibility of the JD-R theory has been criticised as the Achilles heel of the theory, flexibility can also be seen as the theory's greatest strength (Bakker and Demerouti 2017), particularly in this study. The model's flexibility allows it to be applied to many professions, encapsulating various job demands and resources. As this study is focused on the job experiences of

HHCAs as a whole and is not focused on one specific job demand or resource, this potential limitation does not limit the use of the JD-R theory in this study.

3.2 Models considered but not used

Various theoretical frameworks were considered as part of this study to evaluate the resource needs required by HHCAs. Karasek (1979) initially proposed that the Job Demands-Control (JD-C) model identified job demands and control as essential job characteristics that influence employee well-being. The JD-C model proposed that redesigning work processes to increase job resources and, more specifically, control available to employees could reduce the mental strain on employee experience. The JD-C model focused solely on control as the primary resource of interest. However, as seen in the literature review, a broader range of resources of relevance for HHCAs should be considered.

The Job-Demand-Support-Control (JD-SC) model, introduced by Johnson and Hall (1988), found that although job stressors impact workers' well-being, the amount of social support available to an employee reduces the impacts of job demands. Although recent literature has outlined that HHCAs typically work individually and have limited opportunities for support from their colleagues (Sterling et al. 2020), the exact extent of support available to HHCAs, either from their colleagues or members of management, has yet to be determined. The JD-C and JD-CS models focus on specific job resources, resulting in Bakker and Demerouti (2014) criticising the models for being too simplistic. However, neither the JD-C nor JD-SC models consider the many other factors that may influence employee engagement levels. The JD-C and JD-CS models may be plausible in specific studies among HHCAs after examining the range and variety of resource needs of HHCAs presented in this thesis.

Unlike the JD-C and JD-CR models, the JD-R theory provides a structure to examine the relationships between jobs and resources and positive or

negative organisational outcomes (Schaufeli and Taris 2014). The presence of adequate job resources has been linked with increased employee work engagement and well-being (Bakker and Demerouti 2017). The JD-R theory proposes that engaged employees utilise both job and personal resources to remain engaged (Bakker and Demerouti 2014).

3.3 Conclusion

This chapter presented the Theoretical frame works considered for use within this study. Consideration was afforded to the strengths and weaknesses of these frameworks. The flexibility and extensive opportunities for applying the JD-R theory provide a lens to examine the resource needs of HHCAs. This flexibility also reflects the flexible and chaning nature of the role of the HHCA. To conclude, using the JD-R theory will enable this study to explore (1) the resource needs of HHCAs, (2) how resource availability influences the HHCA working experience and (3) how the relationship between resources may influence positive organisational outcomes, such as engagement and intent to stay in one's role.

Chapter 4 - Methodology

In the context of the increased demands created by the COVID-19 pandemic, the research question of this study is: What are the job resource needs of home healthcare assistants working with older people in Ireland during the COVID-19 pandemic? This chapter presents the methodological approach taken during this study. Justification of the research design chosen is provided, along with an account of the ethical considerations for this study.

4.1 Research Design

Qualitative research is a method focused on studying topics in their natural settings to make sense of phenomena through the meanings that people provide to them (Dezinin and Lincon 2018). Described as an iterative process, qualitative research improves understanding of a new concept or phenomenon by identifying significant distinctions due to getting closer to the phenomenon studied (Aspers and Corte 2019). This can be effectively done by engaging participants in conversations where data collection takes place iteratively or as the conversation progresses. Qualitative research usually asks questions about how people see and experience the world around them, referred to as the lived experience (Ellis 2020b). The lived experience refers to the account provided by the participant of how they navigated and encountered a specific phenomenon and the meanings people form from these experiences (Seidman 2019; Polit and Beck 2018). A qualitative approach involves reporting how people discuss and explain areas relevant to the topic of interest (Creswell and Creswell Báez 2021), in this case, the resource needs of HHCAs, and usually involves using the participants' voices to present the findings in quotes obtained during data collection. This approach is relevant for the current study as it concerns the lived experiences of HHCAs.

Qualitative research works best among individuals or groups not often studied. However, the descriptions gathered from these participants are detailed

(Creswell and Creswell Báez 2021). As previously outlined, the voices and experiences of HHCAs in Ireland are lacking within previous literature. In qualitative research, the researcher's and the participant's connection or involvement can often lead to discussions surrounding emotional or sensitive topics (Creswell and Creswell Báez 2021). These topics may not be as evident within qualitative studies due to the removed role of the researcher in data collection. The work and circumstances surrounding the work of HHCAs in Ireland during COVID-19 were identified as a potentially emotional situation for the participants involved; this was an influential factor in implementing a qualitative approach within this study.

The interview method involves discussing or questioning issues with people (Blaxter et al. 2010). Interviews can be structured, unstructured or semi-structured (Dezinin and Lincon 2018; Polit and Beck 2018). The participant's lived experience is the main focus of qualitative interviews (Bolderston 2012). Traditionally, interviews are carried out face-to-face; however, the evolution of technology and the onset of the COVID-19 pandemic has seen an increase in online interviews (Creswell and Creswell 2018). Effective interviews include the researcher initiating conversation with the participant while ensuring to allow for adequate gaps in speech to allow the participant to provide descriptions of their lived experience (Bolderston 2012). Furthermore, Effective interviews involve the researcher establishing a rapport with the participant, ensuring that the participant feels safe and supported throughout the interview process can aid with information sharing (Kvale and Brinkmann 2009). Another element of conducting effective interviews involves implementing an interview protocol during data collection (Bolderston 2012).

Qualitative data collection methods most often include focus groups or individual interviews. Focus groups involve a researcher and a small group of participants engaging in semi-structured conversations about the research question (Adams 2015). Focus groups can benefit qualitative research as more participants can be reached and involved in the study. Focus group

discussions also allow the participants to expand and build on topics (Creswell and Creswell Báez 2021).

The logistical implications for effective communication under social distancing and infection control measures using face masks were considered when exploring the potential use of focus groups within this study. At this point, it had been decided that any interactions with participants would occur remotely, online. However, given the unpredictable nature of internet connections and potential connectivity issues and the implications this may have had when engaging in group discussions, focus groups were decided against.

The most common form of data collection in qualitative research, the interview method, involves discussing the views and experiences of the participants using questions (Polit and Beck 2018; Blaxter et al. 2010). Enabling participants to respond to questions in their own words was considered necessary within this study to provide a voice to participants who have previously expressed feeling invisible (Jabola-Carolus et al. 2020). For this reason, interviews were the chosen method of data collection. Interviews can be conducted using a structured, semi-structured or unstructured exploratory approach (Dezinin and Lincon 2018; Polit and Beck 2018; Jamshed 2014).

Semi-structured interviews were chosen for this study to gain a broad yet rich understanding of the lived experience of HHCAs working during the COVID-19 pandemic. Semi-structured interviews often include prompts (Adams 2015) and allow the researcher to encourage the participant to elaborate on the information given and involve the researcher in asking open-ended questions that provide a pathway for the interview. Semi-structured interviews are time-efficient (Holloway and Wheeler 2016). Furthermore, semi-structured interviews allow the participants to introduce topics or discussions they feel are relevant to the phenomena.

4.2 Recruitment

In qualitative research, several factors can influence the sample size required, such as the research problem and the context in which it is being investigated, the nature of the research questions, the purpose of the research and the sample population to be investigated (Blaikie 2018).

Purposive sampling is used to identify people with direct and relevant experience with the phenomena under study(Ellis 2020a; Polit and Beck 2018), namely those who have worked as an HHCA in Ireland. Participants were required to meet the following inclusion criteria:

- At the time of recruitment, participants must have been working in a paid role as a home/community HCA,
- Working in a home/community setting for at least three months prior to the beginning of the COVID-19 pandemic,
- Working with older people in the community,
- Fluent in written and verbal English, and
- Aged between 18 and 65 years of age.

Data saturation was the approach to determine the number of participants to include in this study. Data saturation describes repeating the interviewing process until no new information is obtained (Ellis 2020b; Polit and Beck 2018). To reach saturation, the exact number of participants required is a widely debated topic in qualitative research (Ellis 2020b; Cober and Adams 2020; Blaikie 2018; Boddy 2016). Furthermore, Polit and Beck (2018) suggest that data saturation may occur with fewer than 10 participants. Data saturation was identified after ten participants. Those who met the inclusion criteria were considered to have adequate experience working as HHCAs.

Initially, a search was conducted using a web-based search engine (Google.ie) to establish a list of HCOs operating in Ireland. Gatekeepers at HCOs (n=75) were contacted via telephone. An email about the study (Appendix B) and a copy of the recruitment notice (Appendix C) were sent to each gatekeeper, inviting HHCAs to participate by contacting the researcher directly. The

recruitment notice was also posted on the researcher's and research centre's social media platforms: Facebook, Instagram, LinkedIn and Twitter.

Those who met the inclusion criteria were sent a copy of the participant information leaflet (PIL) and data protection statement (Appendix D). Traditional methods of posting a consent form to a participant and requesting they return it via a pre-paid envelope were considered. However, information surrounding the method of coronavirus transmission was limited at the time of recruitment; therefore, considering the potential of virus transmission, consent forms that can be viewed in (Appendix E) were completed online using Microsoft Forms (Microsoft Corporation, Redmond, WA, USA).

As Microsoft Forms stored information on an external cloud server, the ability of the researcher to protect the participants' data was considered and addressed as follows: Prospective participants were provided with a unique identifier code (i.e., PR-123) and requested to use this code when completing the online consent form. This code was then recorded in a password-protected Microsoft Excel file stored on the researcher's laptop. Only the researcher and the related prospective participant had access to this code. Once consented, participants were again invited to complete a demographic questionnaire online (Appendix F) using Microsoft Forms. The questionnaire included age, gender, ethnic background, the highest level of education obtained, the type of home care service worked for, and previous work experience. To complete this form, an additional unique identifier code was provided. The detailed operational procedure regarding participant recruitment is available in (Appendix G).

4.3 Data collection

The literature review guided topics included in the semi-structured interview. Closed-ended questions have pre-specified response options. This method of questioning ensures ease of comparability between participants' answers.

However, a limitation of closed-ended questions is the possibility of important information being omitted (Polit and Beck 2018). Furthermore, as each participant's experience contains similarities and differences to their colleagues and these variations of the HHCA experience constituted the main focus of this study, it was decided that answers to questions should not be pre-specified. By contrast, open-ended questions allow researchers to elicit detailed descriptions from participants of their experiences in their own words, as recommended by (Polit and Beck 2018; Yates and Leggett 2016). A list of the interview questions used can be viewed in (Appendix H).

Interviews were audio-recorded, with the permission of participants. Recording the interview allows the researcher to remain actively engaged in the interview as it takes place, without the need to make notes of the participants' answers (Adams 2015; Jamshed 2014). Recordings were later used to transcribe interviews verbatim.

The COVID-19 pandemic context represented a challenge to traditional in-person interviews since data collection was to occur during the pandemic when guidelines from the Irish Government advised people to refrain from mixing with others outside their households. Face-to-face interviews with a 2-metre social distance between the researcher and participant were considered. Face masks, required at the time, resulted in a muffled sound on audio recordings, risking critical excerpts of information being misheard or unheard during the interview recording. Interviews were facilitated via an online platform such as Zoom (Zoom Video Communications, Inc., San Jose, CA, USA). Conducting interviews online reduced the risk of transmitting the COVID-19 virus for the interviewer and interviewee. However, as with any data collection method, teleconferencing can present some challenges (Tremblay et al. 2021).

4.4 Data Analysis

Thematic analysis, which is described as a relatively straightforward form of qualitative data analysis, can be used to address many types of research questions, such as experiences, perspectives and behaviours, by describing patterns within the data collected (Maguire and Delahunt 2017; Braun and Clarke 2014; Braun and Clarke 2006). Other qualitative research analysis forms include thematic discourse analysis and grounded theory, which also look at patterns or themes across data sets. However, unlike other approaches, including qualitative data analysis, such as grounded theory, thematic analysis is not bound to a specific theoretical perspective (Maguire and Delahunt 2017). The thematic analysis allows the researcher to build and outline the areas of importance from the data.

Inductive thematic analysis produces themes closely connected to the data rather than trying to get the data to fit into a pre-existing coding framework (Braun and Clarke 2006). Unlike deductive thematic analysis, the researcher must examine how closely the study's findings were related to a theoretical framework (ibid). Although thematic analysis is widely used within qualitative research, there are limited guidelines on the recommended processes and details of analysis a researcher should implement (Nowell et al. 2017; Braun and Clarke 2006). The six steps outlined by Braun and Clarke (2006) were followed to guide the thematic analysis of the data. As Maguire and Delahunt (2017) suggest, these steps were not always followed linearly and required the researcher to go back and forth between steps during data analysis.

4.5 Validity and Rigour

Quantitative research is ensured by the measures taken to ensure a study is completed rigorously. Validity refers to the plausibility or appropriateness of a qualitative study's design, tools, methods and findings (Leung 2015). Results from qualitative studies are not intended to be generalised to a larger

population. However, various strategies can be used in qualitative research to maximise the trustworthiness and validity of findings (Creswell and Creswell Báez 2021).

Ensuring that qualitative research findings are not overly affected by confounding influences of context and subjectivity requires ensuring that data analysis is conducted with rigour. The first step of this process includes becoming familiar with the data. Interviews were recorded using a voice recorder and then transcribed verbatim. Transcribing the interviews verbatim allowed the participants' voices to be reflected in the data collected, as their exact words are represented (Creswell and Creswell Báez 2021).

The researcher transcribed two of the interviews. A professional transcriber transcribed the remaining eight interviews. All transcripts were re-read whilst listening to the audio recording of the interview to detect and correct any errors in the transcripts. During this process, the researcher made notes and recorded features of interest within the data. This process supported becoming immersed in the data and gaining an in-depth knowledge of what the data included, as recommended by (Braun and Clarke 2014; Braun and Clarke 2006).

A descriptive coding approach was used during data analysis, as Saldaña (2016) recommends for novice coders, especially those using computer software coding programs. Nvivo12 Pro software (QSR International Pty Ltd. (2018) NVivo (Version 12), https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home) was used to code the data within this study. This coding method organises data at a basic level, allowing the researcher to develop a firm grasp of the data. This process involved selecting a section of the interview transcript to code and applying a short descriptive phrase that reflected the contents of the highlighted section. (Maguire and Delahunt 2017)

The next stage of the Braun and Clarke (2006) guide to thematic analysis is to generate initial codes. Coding supports the researcher with the data analysis process as it structures the data in a way that is easier to retrieve. A pilot coding round was completed, during which the researcher took one transcript and applied codes to sections of interest within the transcript. The research supervisors then reviewed this coded transcript for agreement.

Semantic codes adopt an inductive analytic approach summarising the surface meaning of the data. They are grounded in the data and focus on the meanings provided within the data (Braun and Clarke 2014). The initial coding phase involved the researcher highlighting segments of interest consisting of speech phrases. A broad and descriptive label or code was applied to these segments. Each successive transcript repeated this process, generating new codes as appropriate.

During the second coding round, transcripts were evaluated on a line-by-line basis. This process involved a more detailed analysis of the transcripts to ensure all relevant information was included within a code. Following this step, the researcher's supervisors evaluated the codes for accuracy. Feedback was provided during a supervision meeting, agreement on codes was reached, and necessary changes were made.

After the second coding round, the researcher began to group codes related to similar topics. For example, the codes aprons, masks and gloves were grouped under PPE. These headings became known as parent themes within Nvivo. In order to ensure accuracy, the researcher then read the coded pieces of text within these parent themes to ensure the text bore similarity. Members of the researcher's supervision team also reviewed these theme headings. The headings applied to these parent nodes were discussed and explored in a conversation between the researcher and the supervision team members, and a consensus was reached regarding each theme's names. A copy of the code

book developed during this coding process is available for review in (Appendix I).

Another method to ensure trustworthiness within qualitative research is reflexive writing. Reflexive writing aids trustworthiness within a qualitative study as it improves the transparency of the researcher's role by demonstrating how the researcher interacted with the research process (Johnson et al. 2020). A research diary was maintained during this study and included thoughts and observations during data analysis. The researcher also reflected on how previous experiences may have influenced these thoughts. This record was maintained in the memos section of the Nvivo software, which also made it accessible during the analysis and interpretation of data.

4.6 Role of the Researcher

The researcher's role is vital in thematic analysis as they must define codes for the data, support the analysis discussion, and provide meaning to the identified themes (Maguire and Delahunt 2017). While actively exploring themes within the data set, the researcher must remain aware of the influence and prejudice they may bring to the analysis process (Braun and Clarke 2006). In this case, as a registered nurse who had previously worked as a HHCA within a private home care agency and a HCA within a publicly funded organisation, and during the COVID-19 pandemic, as a nurse providing care to older adults in a nursing home. Acknowledging that these experiences may inform the interpretation of particular accounts, thoughts or observations were recorded following a participant's interview. These diary entries reflected interpretations due to the participant's words or the researcher's previous experiences. These entries were used to separate researcher thoughts or bias from the data contained within transcripts. These field note entries were also used to provide context and reminders of the circumstances surrounding the HHCA’s interview. Thus, providing detail often lost where only transcripts of interview recordings are used in analysis.

4.7 Ethics

Irrespective of the data collection method, the human participant's rights to privacy, dignity and respect must be upheld and maintained. Ethical principles, as outlined in the Declaration of Helsinki, were followed during this study. The Declaration of Helsinki is a set of principles devised in 1964 to protect the welfare of human research participants (Shrestha and Dunn 2020). Since its first publication, the Declaration of Helsinki has been revised several times, the most recent revision in 2019 (ibid). Ethical approval for this study was granted by the School of Health and Science ethics committee at Dundalk Institute of Technology (Appendix J).

Autonomy as an ethical consideration within qualitative research refers to the participant's right to decide if they wish to partake in a study. Informed consent is one of the critical elements of ethical research, and it requires participants to be provided with sufficient information about the study before agreeing to engage in the study (Nijhawan et al. 2013). Informed consent entails a study participant being allowed to evaluate the potential risks and benefits before engaging in the research study (Manti and Licari 2018). Participants were given a participant information leaflet (PIL) before agreeing to participate (Appendix D). This PIL provided information about the justification of the study and the potential risks and benefits of engaging in the study. Participants in this study were informed that they had the right to withdraw from the study at any stage.

Justice is another ethical consideration involved in research. This principle refers to treating all people fairly and equally. As such, all participants were engaged similarly. Beneficence and non-maleficence are also necessary for research. Non-maleficence requires that the research conducted shall not harm those involved, and beneficence dictates that the research is of overall benefit. During data collection, the participants were observed for indications of emotional upset and supported to take a break from the interview if the

situation arose. Participants were informed and reminded that they had the right to withdraw from the study at any time and could also refuse to answer any question they chose. All information relating to participants and potential participants was stored in a password-protected file on the researcher's laptop, which was also password-protected and reviewed with the Data protection officer within DkIT before commencing recruitment. A data protection risk assessment was carried out (Appendix K).

This chapter has presented an overview of the methodology implemented during data collection, the ethical principles and considerations involved in this study, and how the trustworthiness of the data and findings was ensured. The following chapter presents the results obtained from implementing the methodology outlined.

Chapter 5 - Findings

This chapter presents findings from the interviews conducted with HHCAs. Demographic data about the participants are first presented, followed by excerpts from the participant's interview transcripts. The excerpts are presented in themes identified during data analysis. The findings presented in this chapter explore the following themes and sub- themes;

- The job of a HHCA,
  - Variable Work Settings
  - Client-focused Care
  - Adapting Care
- how the COVID-19 pandemic influenced the work of a HHCA,
  - Safety
  - Covid-19 impact on the clients
  - Time
  - Stress
- The coping mechanisms used by participants, and
- Expression of intention to remain working in their role.

5.1 Participants

HHCAs were recruited from an all-Ireland open call via social media and through HCOs. Participants (n=10) were primarily women (n=8, 80%) over 46 years of age (n=6, 60%) who identified as Irish (n=7, 70%). Most participants (n=9, 90%) had completed second-level education or above, and half (n=5, 50%) had obtained a full Healthcare award at Level 5 on the Quality & Qualifications Ireland (QQI) Framework. Two participants (Kate and Liz) were senior carers with the responsibility of care team leaders. Participants were employed in one of three types of HCO: agency-based HCOs (n=6, 60%), employed directly by the HSE (n=2, 20%), and charity-based HCOs (n=2, 20%). More than half of the participants (n=6, 60%) had worked in some capacity as a HCA for six or more years, with most (n=7, 70%) working

specifically in a home setting for at least one year before the study. For a detailed description of all participants, see Table Two. Pseudonyms are used instead of participant ID codes to present the study findings.

Name	Alice	Anne	Jenna	Becky	Frank	Kate	Liz	Vicky	Paul	Beth
Sex	F	F	F	F	M	F	F	F	M	F
Age Range	56-60	46-50	56-60	21-25	60+	36-40	31-35	41-45	51-55	56-60
Highest education †	1	3	2	2	4	4	3	4	4	1
Health care award ‡	No	Yes	Yes	No	Yes	No	Yes	No	No	Yes
HCO type	Agency	HSE	Agency	Agency	Agency	Charity	Charity	Agency	Agency	HSE
Years as a HCA §	1-5	10+	6-10	1-5	1-5	6-10	1-5	6-10	6-10	6-10
Years as a HHCA ‖,	1-5	1-5	1-5	1-5	1-5	1-5	6-10	6-10	1-5	6-10
Ethnicity	White	White/ Irish	Irish	Irish	Asian	White Irish	Irish	Irish	South African	Filipino

Table Two Participant Demographic Information

Table Two Participant demographic information explained

† Education levels: 1- Undergraduate, 2 Some second level education, 3-Leaving Certificate or equivalent, 4- Adult education modules

‡ Health care award signifies a QQI level 5 award in healthcare as per the national framework of education in Ireland (See figure 1 in chapter 2, page 39).

§Years as HCA - the number of years a participant has worked as a Health Care Assistant in any setting

|| Years as HHCA - The number of years the participant has worked as a HCA in a home setting, specifically

5.2 The job of a HHCA

Participants spoke about their jobs and described their various tasks, broadly classified under three main types: personal care, domestic care, and social care. The range of tasks was extensive and often reflected a crossover between task types. As a result, some participants stated that their exact responsibilities were often complicated to determine; *"it* [the job of a HHCA] *is kind of a bit muddily"* (Alice). For example, the requirements of the HHCA job varied between clients. Alice explained how this translated to her everyday working practices;

> I mean, sometimes you could have a cup of [tea] it just depends…. People are so different. Some of the people I go to are very high dependency, like, you know what I mean… and palliative care. Or you go in, and it's a social [call], making sure they're all right and making them a cup of tea and their boiled egg …it's very different, it's very different (Alice).

Participants described personal care as supporting clients with activities of daily living such as washing, dressing and nutritional intake;

> I go in in the morning and they're probably sitting in continence wear all night and I'm bringing them out of that bed and washing them and freshening them and I'm giving them their first meal and I'm the first person they see (Vicky).

For some participants, personal care also included supporting their clients with meal preparation;

> [I] do personal care. Prepare breakfast…. brush his teeth. [I go] into the bathroom and give him a hand. And I'll bring him into his chair, then I sit, and I make him his porridge, and I make sure he eats (Paul).

Domestic care is related to tasks undertaken by participants to support their clients with household duties, such as cleaning; "*I do small, odd jobs for them"* (Paul). Completing cleaning duties were also commonplace; "*We'll change the bedsheets"* (Becky). Recognising that many clients had mobility limitations or physical impairments, participants also reported completing

physical or exerting household tasks; *“You’re lifting bags or you’re lifting buckets of coal” (Vicky).*

Participants saw providing effective social care as establishing a relationship of trust between the participants and clients. Developing rapport through social care tasks was described as a core element of building this relationship. Nurturing client relationships was described as a high-value social care task; *“you can build up a relationship with them, talk to them, get to know them a bit”* (Anne). Creating opportunities to spend time with the clients was viewed as central to providing the social care element of the role; “*Sometimes we'd sit down and we'd have a chat”* (Kate); “*I have a cup of tea with them”* (Paul).

At times, participants viewed clients as family members, citing the length of time they had been supporting clients and the intimate nature of the work as contributing factors to developing this close relationship;

> My very first client I had until, God, I had her for seven years. I used to [feel like] I was going into my nanny's and that's the way it was because I had her every day twice a day for seven years. That was my nanny's. The family and all treated me like family…. We become a family, like, you can't break that (Liz).

“Social care also included tasks designed to support clients to remain living independently at home; “I'm going into the shop to do shopping for them” (Anne); *“I pick up tablets* [medication] *in my car”* (Vicky).

5.2.1 Variable work settings

While some participants reported supporting clients with basic tasks such as food preparation and intake, others provided more complex levels of care. Alice described the multitasking nature of the job, transitioning between tasks such as supporting a client with the intake of food that was texturally modified whilst also helping them with the use of a Continuous Positive Airway Pressure (CPAP) machine to assist with breathing;

> Take off the CPAP, [support the client to use] a big straw, she would suck up as much food as she could, and then you quickly put the CPAP back on again (Alice).

Differences in job tasks were noted between working in an agency-based HCO compared to working as a HHCA within the HSE; *"The HSE staff, they're not allowed to do it. In, wash them, dress them, give them their breakfast and walk out…. No cleaning"* (Vicky). Even between agencies and HCOs, the tasks expected of participants varied. For example, some reported supporting clients with medication administration; "[I] *give them medication" (Vicky).* In contrast, others were not permitted to undertake this same task; "*I'm not allowed to administer medication. We're not insured to do it" (Becky).*

5.2.2 Client-focused care

Participants in this study described providing holistic care in diverse ways, including supporting clients with tasks outside the care plans. Some felt that providing holistic care involved developing a rapport with their client and providing social support. By contrast, for others, holistic care involves enabling clients to live as independently as possible and supporting them with domestic tasks. Paul rationalised completing additional tasks for his clients; *"because that's what we do; we're carers"* (Paul). Beth echoed this sentiment; *"we're carers. We come to care".*

Care plans were identified as task-driven. However, participants felt that, for them, working as a HHCA is driven by their desire to care for their clients; "*Home care is not just doing your care or the breakfast. It's just that they're happy that, you know, someone is there to care for them"* (Beth). The role of a HHCA was seen as extending beyond completing tasks to providing an element of emotional and psychological support for clients whilst completing required tasks;

> From the mental and social welfare of the individual person that you might be going to, flying in, taking as little time as you possibly can and flying out the door again, to me, I miss the point (Alice).

As such, participants saw their tasks as part of their ideal HHCA role and were fuelled by their desire to care for their clients. For some, this included completing additional tasks;

> Home care, I think it's not just to do the job. It's more on there. You do little stuff for them actually beyond your work. We're not meant to do it, but you would see how helpless they are when they're home and when the family is not there (Beth).

The types of extra tasks undertaken varied by the client, such as staying longer with clients to provide social support or engage in conversation; "*I might stick around longer to the end of the call to chat with them"* (Frank). Another participant reported changing their working schedules to suit the needs of their clients;

> I always go to work earlier than I normally get to my client. I go to him at half past seven so that my client can have breakfast with his children in the morning because he won't see them when he wakes up (Paul).

5.2.3 Adapting care

The guidance for HHCAs on the tasks they must complete is often outlined in care plans. In the homecare sector, it is standard practice for clients to have a care plan outlining their care requirements. The type of care description provided in such plans was noted as being general; *"They are basic, kind of, you know? Prompt medication, get out of bed" (Becky); "out of bed, give them breakfast, toilet them, wash them" (Alice).* However, participants explained that a client's care plan does not always accurately reflect the level of care the individual requires, leading to uncertainty regarding the duties HHCAs were expected to complete;

> it could be down [in the care plan] as light household duties, but we've to load dishwashers, unload dishwashers, change the client's bed, clean the bathroom, hoover….. (Vicky).

Differences between client care plans and the exact tasks completed to support clients indicated how participants were required to adapt the provision of care to the immediate context;

> It [the care plan] says. Do personal care. Prepare breakfast. That's it. That's all they do on paper. But to prepare that breakfast, I have an 83-year-old gentleman. He takes 10 minutes to get up in the morning because, you know why? He wants to chat to me... I've been trying to tell the company you cannot give me half an hour with a gentleman because it takes 10 minutes to get him, I check him. I do his eyes, I wipe his eyes in the morning so he can see me. I make sure he's got his specs clean before he gets out of bed so he can see. I put on cream on his feet and I put on his socks and then I make sure he's happy and I said, 'Do you mind if I put some music on?' And we put on music, something, Frank Sinatra playing in the background while having a bath or a wash (Paul).

However, the expectations faced during day-to-day work were to complete tasks that were outside the participants' understanding of the role and job of a HHCA;

> We're home care. We're meant to do personal care. But a lot of people think we're home help, that we're going to go in and start cooking and cleaning, and we do it. I do it, scrub toilets, do washing (Vicky).

In addition to generic care instructions, participants reported inaccuracies within care plans. Becky provided an account of how some care plans were not regularly updated; *"there was one time I got a care plan and it says cared for by her mother and father. Her mam and dad were dead five years".* Generic plans and inaccuracies contributed to a sense of uncertainty among participants about task boundaries and how to respond to inconsistencies between the care plans they were required to follow and the work they felt needed to be carried out to support clients in variable home settings.

Participants routinely encountered a difference between the jobs they were directed to do and the jobs they felt obligated to do to support clients effectively. Assisting clients in taking medication was one such recurring situation. In this regard, the difference between what is expected of a HHCA working in home care compared to a HCA working in residential care was highlighted; "*In a hospital or nursing home, you don't give the medication to them, but when you're in the community, you give* them [client's their medication]*" (Vicky).* The dilemma of working with a client who is unable to self-administer medication without assistance was frequently encountered by participants and required decision-making about how to adapt care to the needs of the client; *"A lot of what we do, we're not meant to do, and a lot of what we do, we're not insured to do, but if we didn't do it, like, there was nobody else"* (Becky). Vicky described how she experienced differences between tasks outlined in the client's care plan and the guidance provided in her training; "*They say you never crush in the safe administration of medication, you never open a capsule and put it in [or] open it because you're releasing the powder it has. I'm doing that in a family home."* Vicky explained her management teams are aware of this conflict; "*My office knows* [in] *my safe administration of medication* [training]*, I'm told not to do that. The office has been told this, and nothing has been done"*.

Care plan inaccuracies and or omissions were concerning for participants, who described feeling a lack of guidance or support to complete additional tasks necessary for clients. The difficulties care plan inaccuracies and discrepancies can pose for HHCAs, mainly those new to the job, was explained;

> I think that does be hard as well for new carers because they come in and they're like, 'But I was told never in a million years to do that [work outside of the care plan]'. And you're like, 'Well, if you don't do it, that person's stuck like that for the day (Becky).

The difference between working for an agency-based HCO compared to working with the HSE was provided as an example of how job expectations

varied not only between client contexts but also within the home healthcare sector as a whole;

> The HSE would have said [the job of a HHCA is] you go in and you do personal care. You wash them, breakfast, you prompt meds, you do that. HSE staff won't do it [housework]. My sister-in-law [who works for the HSE] is not allowed to lift as much as a bucket of coal (Vicky).

Participants reported frequently having to assess and respond to the immediate and changing needs of clients; *"when I go there, I have to assess every time I go there, 'Are you ok?' Like is the family ok? We have to assess and we're kind of conscious of how our next client has been"* (Beth). At times, however, responding to clients' needs resulted in participants completing tasks outside the parameters of the care plan*; "The care plans are very rarely what we do in that house" (Becky).* This required participants to engage in real-time decision-making; "*Well if she needs her pad changed or she hasn't ate all day, what do you do? You can't just leave her sitting there*" (Becky). While participants did not routinely make adaptations to how care was provided without checking with their managers, participants reported their managers did not always offer alternative solutions. Vicky recalled a response she received from her manager when highlighting she was undertaking tasks that she knew she shouldn't be completing and being instructed to continue completing these tasks; *"Oh yes, go ahead. Her* [the client's] *medication has to go into a yoghurt and you're not meant to do that either."*

While real-time decision-making usually involved routine tasks such as changing continence wear, others described how they had to make decisions in response to emergencies. However, they were often unable to make these decisions independently and had to seek approval from their managers before taking action;

> If I walked in and I see someone had banged their head, had a cut and I need them to go to hospital, I would have to ring my

> office. Who would have to ring their next of kin. Who would have to give permission to ring the ambulance, to ring back to my office to give me permission for me to ring the ambulance. Only if it's life-threatening and I can prove it's life-threatening can I ring without permission (Becky).

Despite tacit approval from management, concerns about making care provision changes and undertaking such tasks made participants feel anxious and highly vigilant*; "Nervous* [and] *afraid. You're constantly defending yourself. You're constantly making sure you're doing everything right. You're constantly keeping yourself safe" (Vicky).*

The COVID-19 pandemic impacted the procedure for updating care plans. To reduce virus transmission rates, home visits carried out by managers were reduced; "*They do drop into clients, you know, the care managers, but not as much as they would have because of the Covid" (Anne).* This resulted in care plan assessments being carried out virtually; *"a lot of the time with Covid, it's* [care plan assessments] *done without actually going out to see the client. So, what they will do is, they will ring us and ask us what we need changed on it"* (Becky). However, the added responsibility of guiding care plan adjustments was considered as having implications for participants' confidence about defining the work required in addition to carrying out the tasks required, as explained by Becky;

> The care plan is a failsafe, so it shouldn't be done by the carers who are in the house because it's meant to tell us what to do, not us telling them what to put on it. [there should be] a higher-level staff coming out and assessing the situation and like there's a risk assessment that goes with that, like.

5.3 How COVID-19 influenced the Work of HHCAs

5.3.1 Safety

Maintaining client safety had always been a priority, such as using PPE (i.e., gloves and aprons) for meal preparation and intimate personal care; "*we'd always wear gloves, and we'd have aprons if you wanted to wear them"*

(Alice). In response to the COVID-19 virus, however, new routines were implemented into daily working practices. These routines included the mandatory use of standard PPE (i.e., masks, gloves and aprons); *"Now I have my gloves and a mask, and I've actually started wearing two masks now"* (Jenna). At times, enhanced PPE such as gowns, goggles or face shields were also required. As the pandemic progressed, the type of PPE required changed along with regulations surrounding the use of PPE;

> I think the latest now is when someone, when one of the clients, comes from the hospital. Although the client is not Covid, you have to wear the full PPE and they provide you with the one with the blue gown (Beth).

Providing care during the COVID-19 pandemic required the introduction of additional infection control precautions. Some of these measures included wearing enhanced levels of Personal Protective Equipment and introducing additional disinfection tasks; *"because of the COVID-19, there are more precautions, and more work involved, you know?" (Frank).*

Managing client safety and mitigating fears about virus transmission involved participants monitoring themselves for symptoms of the coronavirus, such as an increased temperature or cough. Requirements by HCOs to take temperature readings varied, with some reporting this was required twice daily;

> We have to take our temperature twice a day before we go to work and when we come home. And if it's above a certain amount, you've to ring them [the HCO] and say I can't go in (Anne).

This requirement to document or report their temperature to their HCO added a new administrative task to the already increased workload of participants;

> We were given thermometers to check ourselves daily. We have to log in daily to record our temperature and say that we feel healthy before we start work (Kate).

An additional type of mask known as an FFP2 mask was included to provide advanced protection to participants;

> FFP2 masks only came out there about two or three weeks ago, saying that we needed to wear them…. we need to wear them only when we have a positive case. We can wear our normal masks when we're doing normal kind of work. But on a positive case, we have to wear the FFP2 mask (Liz).

It also became a requirement for participants to wear advanced PPE for two weeks following a client's discharge from the hospital. Advanced PPE included additional pieces of Personal Protective equipment, such as long surgical gowns, face shields and FFP2 masks;

> If someone coming home from a hospital, we wear the gowns, the white gowns. We would wear them. That's for 14 days because that client is just out of hospital (Vicky).

Most participants viewed the increased level of PPE positively; "*it supports us for the Covid"* (Beth). The protective role of PPE was recognised, "*We have our PPE to protect us and to protect them"* (Kate). Despite this positive attitude, PPE use affected work practices. One consequence of enhanced PPE use was the requirement to complete additional documentation confirming the use of PPE.

> They've added in forms now where we have to say exactly what PPE we use in each call, which adds another five minutes onto every call because you have to sit and fill out the bloody form every time (Becky).

PPE made it difficult for clients to see facial expressions; *"I'm PPE gearing up and my mask, they can't see my face"* (Vicky). Additional PPE, such as the use of facemasks, had an adverse effect on the ability to communicate effectively with clients; *"It definitely caused communication issues"* (Kate); *"Any of them with hearing difficulties, or anything like that, they're really struggling"* (Becky). Other infection control measures, such as opening windows for ventilation, impacted working practices and required additional decision-making on the part of participants; "*you're trying then to rush, like, because you're going oh, I have to open that window, but you can't, it'd be too cold"* (Liz).

An increase in the domestic care tasks required was described due to the COVID-19 pandemic. One such task was preparing large amounts of PPE for disposal; *"Now with the aprons. I need a bigger bag. But now I have a big bag in the car that I need to dispose of" (Frank).* Concerns were highlighted surrounding the facilities available to dispose of this PPE;

> In hospitals, there's setup disposal for it or in nursing homes, whereas, in-home care, there's black bags piled outside the [client's] house. We bag our stuff, double-bag it, and label it with the date. We have to leave it there for three days, then it goes in [the client's] bin (Becky).

Some practices involved tracking how long hazardous waste bags containing PPE were placed outside clients' homes. Others adapted their working practices to dispose of the hazardous waste generated during the pandemic. One participant described additional procedures he had implemented to ensure the safe disposal of hazardous waste from clients' homes; "*After 72 hours, I have a little diary that th*e [client name] *gowns need to be removed. So, I have it in my diary"* (Paul). Paul's HCO implemented this protocol; *"It's the company suggested, but I enforce it. I make sure that it's done"* (Paul).

In addition to PPE, another safety-based recommendation, social distancing, limited the physical touch participants could use to support their clients;

> Now, I have noticed that myself. When I come to my client, I spend as little time with my client in the bedroom, as little time with my client in the bathroom. I get the job done and then I've little time in the lounge and I'll be sitting in the kitchen or sitting in the hallway and talk to him (Paul).

Restricted physical touch was considered to have altered how personal care was provided, particularly limiting the ability to provide emotional support to distressed clients;

> not being able to hug anybody [is] the hardest part. Not being able to sit close to them on the chair. Especially when I think your

> initial instinct is just like, oh, don't cry, you know. Just put your arms around [them], and I'll put the kettle on (Liz).

Sanitisation, always a core practice in the provision of home care, also required additional measures as a result of the pandemic; "*Before* [COVID-19], *when we come to the house, the standard is to wash your hands*" (Beth). Along with PPE, additional sanitisation tasks were part of infection prevention and control measures; *"I make sure that everything is clean. I make sure wherever I touch, I clean. I sanitise, sanitise, sanitise*" (Paul).

Additional sanitisation measures extended beyond the clients' homes as participants completed additional infection control measures before and after their calls; *"I do not go in the same clothes to different people"* (Alice). Participants also implemented infection prevention control measures within their working practices; *"I make sure I sanitise. I clean. I make sure I've got plastic bags all over the car" (Paul).* Mandatory PPE, advanced PPE and additional infection control measures increased the experienced work demands; "*Your infection control is doubled no matter what you're doing, even if you're not in advanced PPE"* (Becky).

5.3.2 COVID-19 impact on clients

Participants spoke about how their clients' lives had changed due to the COVID-19 pandemic. Clients were reported as no longer able to engage in the social activities they had done before the pandemic; *"everything has been stripped from them. Like everything, you know, the little bus trip or…their usual activities or clubs is gone"* (Jenna). The unprecedented nature of the COVID-19 pandemic and the impact it had on older adults was highlighted by one participant; "[my client] *was always complaining that now he is kind of like in prison he can't leave his house, and he would complain that he can no longer go out to the pub"* (Frank). While some clients were no longer able to engage in social activities done before the COVID-19 pandemic, others were reluctant to leave their homes; "*a lot of* [clients]

would go for a walk maybe before. Whereas now, a lot of them are very isolated," (Anne); "*They don't go anywhere, basically, or they're very careful. Obviously the one who's immuno-compromised* [is] *very careful" (Alice)*.

In addition to reducing social interactions with members of their community, participants reported that many clients also significantly reduced interactions with immediate and extended family; "*They were the very people that were being cocooned and* [HHCAs] *were the only people going into them, not even their families were going into them" (*Liz). Many clients were living alone, yet some declined visits from family or friends; "*They haven't let anybody into their home in a year" (*Liz). The isolation experienced by clients was identified, as neighbours and friends had also stopped coming to visit; "*That's a huge problem at the moment, that these people are isolated from their families and their friends" (*Jenna). Although government guidelines encouraged vulnerable adults to continue receiving care from regular caregivers, some participants reported some clients had paused their care packages during the pandemic to reduce social contact; "*They are observing all the protocols of the Covid because they don't want to get it. They're shielding"* (Beth).

During the pandemic, many clients recounted spending extended periods alone in their homes; "*Oh, you're the only soul I saw today'" (Beth).* Participants felt this isolation resulted from clients living on their own; *They were living on their own, and you're sitting having a conversation with them, and they're telling you they haven't seen their daughter for two months"* (Kate). As a result, monitoring and responding to the emotional well-being of clients became an essential part of participants' daily work during the pandemic;

> Before, it was just personal care and light housework…… but now they [clients] have concerns and worries, and they're feeling lonely…. we have to reassure them (Frank).

Participants felt many of their clients were experiencing isolation and loneliness due to restrictions on social contacts and observed that many clients were struggling with mental well-being; *"I can see depression creeping in with a lot of people* [clients]*"* (Jenna). As a result, participants found themselves more mindful of the client's emotional and mental well-being; "W*e have to be more conscious and more conscientious about the mental and emotional state of the clients" (Frank).*

New practices were described that participants had implemented to address concerns about clients becoming socially isolated or lonely. For example, Kate explained how her HCO implemented a new telephone call initiative to support clients who wanted to cocoon or reduce social interactions as per government guidelines;

> It's a monitoring and welfare call because we've a few of them [clients] now that are terrified. They haven't let anybody into their home in a year. So, [it is] the only way of keeping in contact with them (Kate).

Social care calls like these, made by participants to their clients, helped maintain the social connection established with clients before the pandemic. Another practical modification in how social care was provided to clients was described;

> Whereas before, you could go in and just wash your hands, sit down, and have a chat. Now you have to sit at a distance from them, especially dementia patients (Anne).

Further changes in how participants interacted with clients related to ensuring compliance with social distancing rules; *"we had to stand out in the hallway and talk to her with our mask on" (Becky).* These physical distancing measures had a direct impact on how participants communicated with clients;

> When I was sitting beside [clients] or sitting in front of them, yes, it was perfect. They could hear you. Lip movements, they were enjoying the cup of tea, because there was no distance between you. It didn't feel like you were a million miles away (Liz).

5.3.3 Time

Another change in the working practices of HHCAs that impacted clients was time pressure. Increased time-related demands were identified whilst working during the COVID-19 pandemic. Many participants felt that before the pandemic, the time allocated to complete daily duties was already insufficient;

> You could have half an hour to go in and give someone a shower. Thirty minutes to get someone up, washed, dressed, dried, clothed. That's not fair on them, never mind us. Like, you know, they're getting dragged around from pillar to post and now when they add more stuff onto us and still don't change the time, it just gets worse and worse (Becky).

Another participant echoed this experience of not having enough time allocated for their calls;

> We don't get enough support from the HSE for time. There should be a system like this. You have an hour with the client, 45 minutes with the client for personal care and 15 minutes for social care. Not 45 minutes for care, and then you leave without socialising (Paul).

To reduce the risk of transmitting or contracting the virus, some HCOs implemented new guidance to complete care tasks as quickly as possible; *"less time, less exposure, You have to be faster than usual. Less time, the better"* (Beth). The demand to work faster came from multiple sources, including government guidelines, employer guidance, and client's wishes; *"We've been just told... if you can get in and out before the 45 minutes, just get in and out and just don't talk too much" (Alice)*. Another participant spoke about clients also wanting them to work at a faster pace; *"the clients' who also wanted you* [HHCAs] *to only rush in and rush out and do the essentials" (Kate).* Adapting working practices to work faster became one of the demands of the job*; "Now, I'll do everything as swiftly as I possibly can." (Jenna).*

Paul spoke about how increased time pressure manifested during the pandemic, where the required care now took longer despite guidelines to provide care faster;

> Now [during the pandemic], instead of 40 minutes, I'm spending 45 making sure the toilets are clean because my clients are alone and you don't know what they touch when you're not there (Paul).

Although there were additional tasks expected from HHCAs, many reported still having the same time slots allocated for their calls;

> [We've] taken on a lot more responsibility, but the time we have to do it hasn't changed. So you've a lot more to do in, say a half an hour or an hour than you would have had previous, and you also then have to put your gear on, you've to take it off (Becky).

Having to work faster led to increased time pressure being perceived by participants; "*it's just when you have to do extra all of this, oh my God, you're like rushing, rushing all the time and rushing"* (Beth). Another consequence of increased time pressure was reduced opportunities to provide the social care element of the role that had been previously offered; "*Before,* [the clients] *would have liked you to stay for a cup of tea or a bit of a chat"* (Kate).

HHCAs reported the personal impact of having to work under such extreme time; *"You're kind of anxious and stressed. Time-wise, work-wise, go in and out in as little time as possible" (Beth)*. Furthermore, regret was noted about how time pressure influenced how work was sometimes undertaken; "*We don't have the time to be nice" (Becky).*

5.3.4 Stress

The demanding environment of providing home care during the pandemic was acknowledged as highly stressful for participants; "*I find it now I'm getting to the stage where I find it very stressful*" (Anne). COVID-19-related stress was noted as additional to the stress already experienced in the HHCA role; "*They* [the stress levels] *were high before this, but they're even*

higher now" (Vicky). Participants observed fear of the COVID-19 virus in two ways: their fear of transmitting the virus to others; "*I don't want to be going into someone and then I get covid or pass it on"* (Alice), and the fear of contracting the virus among clients; "*You're hyper-conscious if ya cough at all…. because the other person* [the client] *is very nervous, very afraid of picking something up*" (Kate). The Participants also expressed apprehension about being too close to clients due to the risk of virus transmission;

> I used to go in and sit beside a client and talk to them. [Now] I'm constantly running away from them because I'm afraid of if I have it and I give it to them, I couldn't live with my conscience of killing somebody (Vicky).

Another stressor was an increase in absences from work during the pandemic. Some absences were because of typical illnesses; "*I wasn't very well, so I was off, had to be off for the two weeks because I was unwell"* (Alice). Others related to being unable to attend work due to having no childcare because of childcare service closures during the COVID-19 pandemic;

> We had so many people [colleagues] that went out sick or were unable to work because of schools being closed, so they had no childcare in place, because they were unwell themselves and things like that (Kate).

The extent of stress experienced by participants can be found in descriptions of finding it difficult to wind down at night and being consumed by thoughts about their workload; *"Before I even sleep at night, I would be thinking, 'Who is my client the next day?'* (Beth). Poor sleep was related to both mental and physical stress;

> I'm physically and mentally drained. I'm not sleeping at night. I go to bed. I can't knock off. I knock off about half 11 and I'm awake about four, five o'clock with pains all over the bottom half of my body… My body's tired (Vicky).

Stress levels impacted working practices and were identified as an additional daily decision-making struggle;

> I had constant tiredness, no energy, just not wanting to get up some days. There was some days I'd be in bed, and I'd say God, what'll I ring in and say today? So, some days, I was thinking oh God, maybe if I said I had quite a high temperature, then I wouldn't have to go into work and stuff like that (Anne).

The additional challenges of working during the pandemic resulted in feeling exhausted from working as a HHCA; "*I'm just wrecked. Emotionally, I do cry. I have a great cry now and then. When the burden gets too much"* (Paul). Both emotional and physical exhaustion were reported across participants; "*I'm physically and mentally drained"* (Vicky). Descriptions of emotional and physical exhaustion were repeated across participants;

> As the months have gone on, I have found it very tough. There were days I just felt like I couldn't go into work. I was so tired. Just worn out. Constant tiredness, no energy, lack of energy, no motivation, just so tired (Anne).

Some participants were able to temporarily ignore the stress in order to get on with their job. However, over time, the demands of the job had an effect, sometimes not felt until after work shifts were over; "*I think it was only afterwards you came to realise how exhausted you were, and you wonder how you did it" (Kate).* The impact of work on well-being caused concern for participants*;*

> My body's aching. My body's sore. I'm existing in this world, but I'm not living. And now with the lockdown, it's even harder… I'm fed up of my [ill] health. I need to get my health on track. I'm physically and mentally drained….I'm existing in this world, but I'm not living *(Vicky).*

Participants described the effect the exhaustion they experienced had on their personal lives;

> I found like in my home life. I was just kind of shutting down. I was exhausted. The problem is it [working as a HHCA] affects your home life then. I definitely didn't have as much energy at home to do all the things that I needed to do there (Kate).

Participants recounted feeling hopeless and deflated;

> Giving up. Just want to stay at home. Why bother? Cry. Just sit and cry. What am I on earth to live for? What am I here for? To work and care and look after other people, pay bills (Vicky).

Constant exhaustion and stress led to weariness and frustration with being 'on the front line' during the pandemic; "*I'm fed up with this pandemic. I'm fed up of driving. I'm fed up of looking at everybody else staying at home. I'm fed up with being a front liner" (Vicky).* One participant explained the impact these continued feelings of exhaustion had;

> I feel burnt out. I'm just totally burned out. I'm totally wrecked. I'm just drained… just worn out. Just lack of energy, no motivation, just so tired. The least thing, you know, you'd nearly get upset over. Just so tired (Anne).

Nonetheless, all participants continued to attend work and provide client care despite reporting considerable stress levels.

The most reported impact of working during the COVID-19 pandemic was the effect on participants' emotional and mental welfare; "*You're brought down into, you know, this kind of depression. Everybody's getting anxiety"* (Liz).

In addition to general exhaustion, stress and anxiety, participants also faced the emotional impact of supporting clients who died;

> A client died in my arms. I actually had to do CPR on him. He died in my arms, and the only thing the family wanted to know was, 'Paul, did he die alone?' He did not die alone. He died in my arms (Paul).

The impact on Paul was evident during the interview, as he was visibly upset recalling this experience; "*I was crying like a baby. Can you see the trauma?"* (Paul).

Liz, who identified a need for mindfulness training for HHCAs, echoed the need for emotional and mental support to deal with the trauma and stressful impact of working directly with older people during the pandemic;

> We need something, like, uplifting, like, uplifting. Training, like, something for the mind that relaxes them, something, like, that I'd like to see introduced for carers. Something needs to be provided (Liz).

Liz continued to describe the benefit and positive impact she believed this training could have on the work of HHCAs;

> If they could get something, meditation, anything, something that just keeps their spirits up because once their spirits are up, the people out there that need looking after will be looked after 100%. If you have a carer and they're feeling down she's not doing a job to the best ability, she's not enjoying her job (Liz).

5.4 Coping Together

In response to the stresses of working during the pandemic and the absence of support, participants reported turning to familiar coping strategies for support. Describing how they typically worked alone, some participants found it challenging; *"home care on every level is difficult, very, very difficult and umm, you kind of on your own really"* (Alice). Feeling isolated was identified by participants due to typically working alone within their clients' homes; "*we're healthcare workers, and we work very much on our own. You're very, kind of, isolated in that way. You don't meet other colleagues, and stuff like that"* (Anne). Lone working resulted in a lack of connection with colleagues and a desire for opportunities for additional social support and increased interaction with peers; *"I suppose what would be helpful in healthcare settings and stuff like that, there's more linking in with your colleagues"* (Anne). This need for connection included a desire to talk with colleagues about how the work is done to ensure both quality and safety;

> One thing I think is missing. We're very much on our own. It can be difficult when you're particularly like in these people with those that are very difficult. You have to have, you have to have

> somebody for safety, really. You have some way to check in (Alice).

Having an opportunity to speak about complex cases encountered with a colleague, either a member of management or a counselling service, was also considered desirable; "*I think we should be offered counselling. We've watched people die, people, that we've cared for. We were never offered counselling"* (Vicky).

Some clients require the assistance of two HHCAs, referred to as double-up calls. Participants spoke about using these calls as opportunities to interact with other colleagues. Double-up calls were seen as a welcomed opportunity to meet other colleagues or *"we can have a chat, and you'd have a catch-up at the side of the road"* (Liz). However, as not all clients require the assistance of two carers, this opportunity to interact and meet up with colleagues was limited and not always available. Instead, social media platforms like WhatsApp were often used to communicate and share information. Group chats were also used to provide peer-supported learning and work task information;

> Oh, do you not know how to do that? Let me show you. Or if you're at a client you've never been to before, has anyone been here? Does anyone know what I need to do? (Becky).

WhatsApp was also used to counter the isolation experienced in work as a HHCA, particularly during the pandemic;

> They [group chats] are more valuable than anything. They're the only way we function. They're probably the only way we all get through work at the same time (Becky).

In place of organisationally provided support, and despite not being employed as a team leader, Paul described the support he offered his co-workers and his almost familial relationship with them; *"I'm treated like I'm the big brother of the carers here because I'm the only man in the group of ladies".* Taking care of co-workers included sharing information or assisting in any way possible, such as collecting PPE for them;

> I'm looking out for them. I know the importance of protection because of the lungs, and I share that information amongst my carers because it's my responsibility as the older carer to look after my younger carers, to make sure that they're all good (Paul).

Participants explained how they also used group chats to support colleagues in troubleshooting issues that may arise during a call;

> If we don't know what to do [or] they don't know how to use a piece of equipment, the group chat comes in handy when we start ringing each other or texting and saying 'well, this is how I done it or this is how you done it (Becky).

The importance of these group chats, particularly in situations where they lacked information on how to proceed, was also highlighted, with the group chat used to share work-related updates;

> We share all the information. Everything that's warranted. Proper information about work. Our group is not about talking crap. It's about sharing work information. Everybody's on it. The whole group all the way down to the [Northern Ireland] border is on that group (Paul).

When participants spoke about their colleagues and team members, this idea of looking out for and supporting each other was evident. Some of the support provided to colleagues included collecting PPE; "*When the carers need masks or gloves, they would send me. We have a group, our carer group. And they said, 'Paul, you're the dad. Can you get us supplies?'*" (Paul). Other peer support included teaching and learning from each other, and in some circumstances, participants reported providing social and emotional support to their colleagues as part of a self-established HHCA community.

5.5 Intention to stay

Although most participants expressed a desire to remain working as a HHCA, some spoke to the factors they had considered as reasons to leave their role. The HHCA profession was viewed as undesirable, with many

choosing to leave it entirely; *"people are starting to get out of this industry. They don't want to be in it"* (Vicky). Several factors were identified as explanations for this perception. Work hours and pay were linked as being sometimes problematic. Many participants worked for agency HCOs, which meant they were not guaranteed any hours, and the number of hours they worked could vary significantly from one week to the next, as a client may die or go to the hospital;

> It's not guaranteed money because four of your clients could go into hospital and you're down their money. You're not guaranteed set hours. They [HCOs] are not saying you're working 40 hours, and that's what you're going to get paid (Vicky).

Participants explained that remuneration and job benefits were also influential factors in deciding to stay within their current role or leave. In particular, the instability of pay and income was a factor prompting some to consider leaving the job;

> I would go not, sort of, by choice necessarily but because I need to go and get a solid income that is going to come in every week because it's just kind of unnerving (Alice).

In addition to remuneration, the lack of other benefits such as sick pay or pension contributions was also a relevant factor; "*I like home help, but probably not with the company I'm with. Because of* [the lack of] *sick pay, pension"* (Becky). Others described considering moving from the home care sector to alternative settings where income and working conditions are provided with more regularity; "*I think people move from the community to nursing homes for stability in salary because, in a nursing home, you have a rota, and I think that's to do with salary"* (Paul). In addition to unsure income, a lack of control, working under zero-hour contracts, was also cited as problematic;

> I lost two hours yesterday. They had no right to take it without saying, 'Vicky, listen, we're trying to give a girl a couple of hours. Do you mind if we take your Monday calls to give it to them?' No,

> just took it. No explanation. No phoning me. I was expected to give it (Vicky).

However, zero-hour contracts were not always viewed as a negative element of working as a HHCA. Some participants, like Alice and Becky, spoke about their zero-hour contract as a resource to enable them to have control over their work; "*I enjoy it* [the zero-hour contract] *because it gives me a bit of freedom. In some ways, the zero-hours contract gives me a bit of power"* (Alice); "*You can control your own schedule"* (Becky).

Flexibility was described as a positive aspect of the job of a HHCA that led to some participants intending to remain working in their role; "*I could do the school run and all that stuff because you can work your way through that. You just give the time of your availability, and you work around it"* (Beth). For others, the personal nature of home care, in addition to the flexibility provided by being a HHCA, made staying in the profession appealing;

> well, compared to, eh, the hospitals and also the nursing home, the nursing home, I hear, is actually the most difficult right? in home care the one it truly suits me in that my holidays and my time and everything is actually flexible to my own personal life and my family life (Frank).

Another aspect of being a HHCA, that encouraged participants to remain working in their role was the feel-good factor they described that their job provided to them; "*that's the satisfaction I get from my work, that I have done my role. Yes, that I have a good feeling"* (Beth). Other participants shared Beth's experience, stating they felt they made a difference in the lives of their clients; "*I love the job I'm doing. I feel that I am doing some good here"* (Frank). Others also spoke about the feel-good factor in different ways, describing their job as rewarding; *"it's very rewarding in lots of ways"* (Jenna)

Participants spoke about the impact positive relations with their clients and their clients' families had on their lives;

> a lot of my clients are very nice, and they're very appreciative, and you know one family member buys me a bunch of flowers kind of every week. That's so sweet, and they're very nice (Alice).

Relationships with clients and the client's family members were cited as a positive aspect of the work; *"The satisfaction of the good relationship with a client and the family"* (Beth). This attachment formed with clients, rather than job fulfilment per se, was seen as a reason for staying in the HHCA role; "*People often say they stay in a job because of the clients. It's not because of the role necessarily is fulfilling them anymore"*(Kate).

Opportunity to advance was also identified as a factor in the decision to remain with a HCO. For example, Kate reported that the chance to advance from HHCA to team leader influenced her to remain in her current role. Another participant, Liz, reported she progressed from HHCA to senior HHCA and was a care team leader. Liz's current role involves some caring duties and supporting some clients;

> "the job I'm in now came up as a shift team leader. So, I went. I was a shift supervisor then, so I was out on the road, and I was meeting with the girls and just progressed".

Kate also reported the HCO she worked for encouraged her to continue with her training and also offered her financial support to complete the course; *"I've been wanting to do it, and they've always said once I find a course, they'll pay for it"* (Kate).

Jenna expressed a desire to remain working within the home care sector and aims to progress within her career; *"I would like to do a little more learning and see if I can move on a little bit up the ladder" (Jenna).* Kate explained that for some participants, working as a HHCA can feel as if there are no opportunities for progression, change or advancement; *"as a healthcare assistant, it can feel a little bit dead-end. So, once you've done it for a while, you're looking for a new experience" (Kate).* This desire to progress to new experiences was less evident among older participants who

saw their age as the reason to stay working in their current role *“because now I’m kind of older”* (Alice); *“Well, I’m not young. I’m just waiting for my retirement. So yes, I’ll keep it here and stay here as long as I can, you know*” (Beth). The majority of participants in this study reported they intend to remain working in their role as HHCA.

5.6 Conclusion

The purpose of this chapter was to present the findings from this study. This chapter has presented the findings of this study in thematic form using excerpts from the participants' interview transcripts. The themes presented are reflective of the Job demands and job resources description as provided in Appendix A. The correlation of these themes and the JD-R framework shall be elaborated in chapter 6. Excerpts from participants' verbatim interview transcripts presented the findings with an insight into the participants' unique view of their lived experience. The themes identified included the job of HHCAs, changes to the working practices and experiences of HHCAs during the COVID-19 pandemic, the challenges experienced, particularly relating to safety, time, fear, stress, resource needs, and an intention to remain in post. The following chapter provides insight into how findings from this study sits within the current literature.

Chapter 6 – Discussion

Chapter Two presented mainly from the pre-covid literature on the work of HHCAs. The previous chapter has presented findings of this study from the data collected during interviews, which grouped into major themes: the workload experienced by HHCAs and the changes they experienced to their workload during the COVID-19 pandemic, explicitly surrounding the time pressure they faced, the peer support HHCAs engaged in and the HHCA's intent to stay within their current role. Chapter three presented the JD-R theory as the framework used for considering the findings. This final chapter illustrates how the findings of this study are relevant to the previous literature and the theoretical framework. The onset of the COVID-19 pandemic stimulated an increased focus on research surrounding healthcare professionals and the care of older people. As a result, several studies have been conducted since the onset of the pandemic. This chapter discusses the findings from the current research concerning the emerging literature. A summary of the resource needs identified by participants can be viewed in Appendix L.

6.1 The job of a HHCA

The job tasks reported by participants in this study echoed those outlined in (Health Services Executive 2018) and included supporting clients with personal care, meal preparation, and nutritional intake. However, participants recounted completing many additional activities, including routinely undertaking tasks associated with the work of a home help assistant, such as household duties, as was also found by Conyard et al. (2019). The contrast between the reality of tasks completed by HHCAS, such as supporting clients with strenuous household duties such as lifting bags of coal, and official care plans with vague umbrella terms, such as "*prepare breakfast"* or *"do personal care",* resulted in a source of uncertainty

among participants around task boundaries and requirements. This uncertainty, combined with the perceived requirement to address clients' immediate needs as they presented, placed an exceptionally high demand on HHCAs during the pandemic.

Participants in this study described a range of pre-existing challenges before the COVID-19 pandemic and how these increased significantly during the pandemic. Before the pandemic, the job tasks and role of HHCAs included supporting older adults who often lived alone, possibly spending much of their day in solitude. However, the COVID-19 pandemic exacerbated previous issues experienced by HHCAs and created new challenges. Bell et al. (2022) also reported similar experiences with HHCAs completing extra tasks to compensate for the deficit of social or domestic support that may have been available from family members or friends who could no longer visit during the pandemic. Some of these additional tasks included completing the client's grocery shopping or supporting them with household and or care additional tasks. Participants in this study voiced that they felt obligated to support their clients with these additional tasks because no one else could support them.

Similar to HHCAs in a study carried out in the USA by Markkanen et al. (2021), participants feared contracting the COVID-19 virus and transmitting it to those they cared for. Participants described challenges accessing PPE resources, with some reporting having to reuse surgical facemasks when supporting clients. By contrast, HHCAs, in the study by Markkanen et al. (2021), denied having supply issues with PPE and reported that their employers provided them with the necessary amounts of PPE and guidelines on how to use it. Other care environment changes were unprecedented, such as social distancing and supporting older adults who were cocooning or isolated from social support networks, resulting in HHCAs dealing with isolation and loneliness not only among clients but also personally.

6.2 Role Ambiguity

Role ambiguity is described as a situation in which one lacks clear direction about the expectations of their role (Rizzo et al. 1970). Echoing the findings of Brown et al. (2022), participants in this study reported that their client's care plans are sometimes an inaccurate source of information to guide care provision, leaving HHCAs to fill in the gaps. This ambiguity increases the perceived responsibilities of HHCAs, who must establish and determine what additional care the client requires in response to missing information. The impact of this role ambiguity increases the HHCA's requirements to work on their own initiative, completing real-time assessments and care provision with limited support or guidance from managers or peers, a situation exacerbated during the pandemic as most managers also conducted fewer client oversight visits during a time when the client's needs were more significant than ever. The requirement for HHCAs to act on their own initiative, with a feeling of lack of support from members of management, suggests an increase in the job demands experienced as per the JD-R framework.

6.3 Isolation

While it has already been noted that when HHCAs are assigned to clients, families often 'step back' and provide less support (Smith et al. 2019), this was exacerbated during the COVID-19 pandemic. Participants reported that before the pandemic, some family members and friends may have visited or supported clients with tasks such as shopping or doctor visits, reducing the time clients spend alone. However, this changed when older people were advised to significantly reduce their interactions with friends and family to reduce the possibility of virus transmission (Markkanen et al. 2021; von Mohr et al. 2021). Consequently, HHCAs described completing tasks outside their client's care plan to meet their holistic needs and compensate for the absence of support their client may have received before the COVID-

19 pandemic from extended family or friends. This suggests, participants also reported filling the void of the client's family member during the Covid-19 pandemic.

As reported elsewhere, participants observed increased isolation among clients due to cocooning (Markkanen et al. 2021; von Mohr et al. 2021; Ward et al. 2021; Giebel et al. 2021). As family and friends withdrew or were asked to stay away by older relatives, HHCAs became more aware of their client's mental wellbeing. The cessation of social activities, prevalent among participants' clients, was also consistent with other studies where clients were no longer engaging in the social activities they would have had before the pandemic (Markkanen et al. 2021). As elsewhere, Johansson-Pajala et al. (2022) participants in the current study reported older clients experiencing increased levels of anxiety and loneliness during the COVID-19 pandemic. Concerns about the impact of social distancing and the absence of physical touch on HHCAs and their clients were highlighted in this study and by Markkanen et al. (2021). Furthermore, other research found that decreased tactile support opportunities due to the COVID-19 pandemic increased anxiety and loneliness among care recipients (von Mohr et al. 2021), an issue of considerable concern for HHCAs in this study and for which mitigation measures were not forthcoming.

The burden of concern placed on HHCAs was also identified by Markkanen et al. (2021), who found that psychosocial demands experienced by HCAs increased during the pandemic. Concern for clients who *'seemed depressed'* due to increased isolation was exacerbated by anxiety about the limited support HHCAs could provide to address these concerns. Nizzer et al. (2022) also found that a lack of emotional well-being and organisational support were available to support HHCAs. This finding suggests that participants and HHCAs within these studies were experiencing increasingly worrying working conditions with a lack of organisational

support, increasing the likelihood of negative organisational outcomes as per the JD-R framework.

6.4 Challenges to providing person-centred care

A holistic approach to care has been described as acknowledging the care-recipient as a whole person, providing care that shows an understanding of the client's physical, psychological, emotional and spiritual well-being (Jasemi et al. 2017; Zamanzadeh et al. 2015). However, even as PCC and holistic care are widely considered and taught as the cornerstone of modern care provision, HHCAs can experience difficulty reconciling to tight schedule-bound task requirements and the desire to provide PCC. Completing extra tasks and staying longer than scheduled with clients was justified by participants as they explained that being a HHCA is seen as more than just completing tasks assigned on a care plan. Instead, being a HHCA required them to adopt a holistic approach to care. This finding suggests, HHCAs consistently experience challenges between supporting their clients with the tasks required and avoiding emotional connections.

6.4.1 Time Pressure

A HHCA's ability to deliver PCC in the home is frequently challenged by a lack of resources, such as insufficient time allocations and staff continuity due to staff shortages (Höglander et al. 2020). Time has been cited as one of the most crucial components for HCPs to establish meaningful relationships with clients and their extended families (McDonald et al. 2019). Participants in this study shared similar experiences. The time pressure, as shown in the findings, was exponentially increased during the COVID-19 pandemic, as requests to work faster came from clients and managers alike. The request to work faster, paired with additional tasks required during the pandemic, further increased the time pressure experienced by HHCAs.

Höglander et al. (2020) noted how a lack of resources, including insufficient time allocations, often challenged a HHCA's ability to provide PCC.

Participants in this study, similar to HHCAs elsewhere (Orcid et al. 2019), described going the extra mile for their clients as a measure of providing high-quality care. It might be expected that in the absence of resources such as time, HHCAs would not have been able to provide the level of PCC required. However, this was not the case among participants in this study. Instead, self-sufficiency was commonplace, with HHCAs taking matters into their own hands, staying longer than their allocated times, and completing additional tasks outside their client's care plan, all to ensure that they provided the highest level of PCC possible.

6.4.2 Emotional Demands

Emotional demands are already recognised as everyday stressors for healthcare professionals (Grover et al. 2017). Emotional demands in the workplace, while unavoidable in several occupations, such as health and social care, have been described as work that requires sustained emotional effort from employees (Framke et al. 2021). However, the longevity and intimate nature of home care provision lead to increased challenges for participants to remain emotionally detached from their clients. Participants saw building and nurturing a trusting rapport with their clients as vital to providing person-centred and social care. Similarly, Smith et al. (2019) reported that HHCAs in this study often saw their clients as family members.

Despite recognising the importance of creating and nurturing emotional connections with clients, many participants reported being advised against building strong emotional connections. Nonetheless, the emotional relationship with clients is a key component of holistic PCC (Kogan et al. 2016). Yet, developing this relationship is absent from written job descriptions. Similarly, Gazzaroli et al. (2020) spoke about the invisible yet

common emotional relationship HHCAs describe with their clients, stating it was common for the worker to be viewed as an extended family member.

6.4.3 Emotional Suppression

Participants described experiencing various emotional challenges as part of their jobs, including dealing with client bereavement or supporting clients with end-of-life palliative care. Emotional suppression, described as the requirement to hide one's emotions, has been recognised as an emotional demand of home care workers in the USA (Sterling et al. 2020). Likewise, emotional suppression was found in this study, with HHCAs cautioned not to show clients how they were genuinely feeling. In particular, hiding the fear they were experiencing about the COVID-19 virus was essential, placing a significant psychological burden on HHCAs.

Previous research has shown that emotional dissonance is unavoidable in professions and environments, like healthcare, that require emotional involvement from the employee (Emanuel et al. 2020). Emotional dissonance is viewed as a job demand within the JD-R theory (Bakker and Demerouti 2017) and has been described as a difference between the emotions an individual experiences and the work organisation's rules of the emotions they may display (Fiabane et al. 2019). However, participants in this study struggled to provide person-centred care without engaging emotionally with clients, expressing conflict between viewing clients as family members yet being instructed and required to treat clients more emotionally detachedly.

6.5 Role Conflict

Role conflict can be described as an inconsistency between expectations that can affect task performance (Rizzo et al. 1970). Differences between what was taught during training and what was necessary for the real-world

work environment reflect the findings of an Irish report on the educational preparation of HHCAs. Drennan et al. (2018) found that training did not appropriately prepare the HCA to work in the home care setting as a HHCA. However, participants in the current study described the majority of role conflict they experienced centered around emotional demands.

For participants, role conflict was mainly evident within the emotional demands of the job, where training encouraged adopting a person-centred approach to care as the current best practice; however, the time available to the HHCA to provide this care, along with the uncertainty regarding the threshold of how emotionally involved the HHCA should be contrasted with this training. Conflicts between taught best practices and work-setting practices have also been identified by Smith et al. (2019), but no further examination of this phenomenon or how it impacts HHCAs, clients, or care delivery has been undertaken to date. Additional research is required to determine the differences between the education received by HHCAs and the reality of their work settings.

6.6 Resource Needs Identified by HHCAs

It has already been noted that the Home Care sector is facing an issue recruiting HHCAs. As this study evaluated the resource needs of HHCAs supporting community-dwelling older adults, HHCAs identified job resources they required within their working practices. Unsurprisingly, participants identified the absence of some resources as a deterrent to remaining in the HHCA role. These included the lack of guaranteed hours and pay instability. Indeed, Baker and Shaufeli (2014) have identified, job instability and remuneration as job demands with the presence of many of job demands being linked to possible negative organisational outcomes.

Although participants acknowledged zero-hour contracts enabled them to have flexibility and choice within their working hours, some viewed the zero-

hour contract as a negative element of their role. The flexibility participants described echoed the findings of previous studies that reported flexibility within one's role decreases the likelihood of burnout (Hämmig 2018). However, the use of zero-hour contracts among workers has been linked with a negative impact on work satisfaction caused by decreased job security (Gheyoh Ndzi 2021). The contrasting experiences of zero-hour work contracts expressed by participants echo findings by Atkinson et al. (2016), who reported that HHCAs viewed the flexibility of zero-hour contracts as both a benefit and the insecurity of hours as a negative aspect of the job of a HHCA. Furthermore, Bakker and Schaufeli (2014) outlined unfavourable working conditions as a potential job demand and, as previously discussed in Chapter 3, that job demands can have negative organisational outcomes when not balanced with provision of the correct job resources. Although there was a difference of opinion between participants about the merits of current shift patterns, organisations should consider employee preferences when allocating shifts as a move towards improving job resources.

In addition to the irregular working hours described, participants also reported that their rate of pay and zero-hour contracts did not accurately reflect the amount of responsibility their role required. Echoing the findings of a study carried out among HHCAs in Wales, workers expressed they felt their pay rate did not reflect the amount of responsibility their role required (Atkinson et al. 2016). Participants described having to act autonomously, using various skills, and supporting clients who required varying levels of support. Despite possessing and implementing a wide variety of skills, HHCAs remain to be one of the lowest-paid workers within the healthcare system. Participants in this study described that this often made them feel disposable within the health care system, contrasted with knowing they provide essential services and support to their clients. This essential role was highlighted during the COVID-19 pandemic as HHCAs reported filling

the void or absent services. Responsibility and remuneration has been linked with job demands as per the JD-R theory, whilst positive patient interactions has been linked with Job Resources. Participants in this study continually expressed the desire to remain working in their role as they made a difference in their client's lives. However, this opportunity does not appear to be a priority for the HCO nor the task orientated system within which the HHCA works.

6.6.1 Coping with Stress

Both physical and mental health have been linked to work-related stressors (De Cieri et al. 2019). Most participants acknowledged that they experienced stress in their roles before the COVID-19 pandemic. However, similarly to other healthcare providers, the increased demands faced during the COVID-19 pandemic exacerbated stress levels for participants. Participants reported experiencing emotional stress and physical exhaustion. Specifically, participants reported physiological issues with sleep, decreased energy levels, and emotional exhaustion. Psychological stress symptoms included feelings of hopelessness and feeling deflated. Mental and physical exhaustion were also articulated, and some reported a feeling of burnout. Emotional stress and physical exertion have been linked within the JD-R theory as job demands.

Burnout has been described as a stress syndrome in which the individual may experience emotional exhaustion and diminished personal accomplishment (Maslach and Leiter 2016). Burnout has been shown to negatively impact retention rates in HCPs (Willard-Grace et al. 2019; Kim et al. 2018). In a study examining the prevalence of burnout among HHCAs and HCAs in long-term care facilities, high levels of managerial support were associated with decreased reports of burnout, whereas increased reports of co-worker support did not decrease HHCAs presenting with burnout (Boerner et al. 2017).

Similarly, increased managerial support is cited as a job resource within the JD-R theory (Schaufeli and Taris 2014). Another job resource, co-worker support, was prevalent among participants in this study. However, providing such extensive peer-support on an ongoing basis may have placed an additional and unacknowledged job demand on HHCAs. The use of unregulated peer support, as described within this study, may have attributed to expressions of burnout among participants. However, this was not fully explored during this study. Therefore additional research is required to explore the nature of the relationship between burnout and peer support among HHCAs in greater detail.

There is disagreement in the literature about the link between burnout and retention among HCPs. A study among HCAs in UK nursing homes observed no direct links between burnout and staff turnover rates (Costello et al. 2019). As in the Costello et al. (2019) study, participants described experiencing burnout; however, most reported they did not intend to leave their current roles. The findings of Costello et al. (2019) concur with the findings of the current study, where despite an expression of burnout from some participants, intention to remain working within their role was also expressed.

Participants in the current study reported experiences of burnout within their jobs, yet burnout among HHCAs remains absent mainly from existing literature. However, some studies have been completed examining burnout among HCAs working in residential or hospital settings, particularly surrounding the bereavement of a client. Similarly, participants in the current study identified a need for mental well-being support through mindfulness training to support them with work-related stress. Mindfulness involves purposively focusing on the present moment non-judgmentally (Kwee 1994). Coping mechanisms such as mindfulness-based techniques to deal with job-related stresses have been shown to reduce burnout among residential home care workers (Harrad and Sulla 2018). Mindfulness, as a

personal resource within the JD-R framework, has been shown to decrease workplace stress experienced by employees (Grover et al. 2017). Further research must determine if burnout is directly related to peer support.

The need for mental health services for HCPs working during the COVID-19 pandemic has been identified as a critical necessity for maintaining these employees' well-being and welfare (Bender et al. 2021; Cao et al. 2020). Some participants in this study echoed the findings of Bender et al. (2021) and Cao et al. (2020), highlighting the need for additional emotional support. Despite participants in this study briefly accounting for the need for additional services, additional and further exploration of the psychological impact of emotional suppression on HHCAs working during the COVID-19 pandemic is warrented (Framke et al. 2021; Grover et al. 2017).

6.6.2 Support

Previous literature has focused on the experience of loneliness and isolation among the clients HHCAs care for (Von Mohr et al. 2021; D'cruz and Banerjee 2020; Thyrian et al. 2020; Sixsmith and Sixsmith 2008). However, the isolation experienced by HHCAs due to lone working has received less attention to date. HHCAs worked alone before the COVID-19 pandemic and reported experiencing increased isolation and loneliness during the COVID-19 pandemic as they could not meet up with colleagues or members of management (Kelleher et al. 2022). However, participants reported that this isolation was exacerbated during the pandemic.

An exacerbation of loneliness or isolation experienced by workers has been shown to have an increase in the job demands one experiences. As HHCAs typically work alone with their client, they may be predisposed to feeling loneliness. Therefore, efforts should be made by each organisation to promote and facilitate opportunities for staff members to meet and work together. These meetings could be implemented into working policy and

arranged through mandatory staff meetings or through the appropriate scheduling of double-up calls where a client may require the assistance of 2 staff members. Alternatively, as demonstrated during this study, these meetings could also be facilitated via online meeting apps such as Zoom or Microsoft teams.

Alternatively, support and education on emotionally supporting one's co-workers would enable HHCAs to recognise when shared information may be beyond what is acceptable. The relationship between the participant and their colleagues was casual compared to the interactions participants described having with members of management, which were more formal and structured, often occurring during client spot checks. Adding a more informal opportunity for the HHCA and management to meet would be a welcome opportunity for the HHCA to receive support.

6.6.3 Peer Support

Interviews highlighted a lack of sufficient support from managers identified by HHCAs to process these emotional demands, resulting in HHCAs implementing methods of peer support. However, as participants in this study viewed peer support as a crucial element of their role, removing or discouraging HHCAs from engaging in peer support would be unwise or unhelpful. However, additional training on the limitations of engaging in peer support would be beneficial for HHCAs.

Participants reported routinely using group chats on social media platforms to communicate and liaise with each other regarding client care, arranging PPE collections and shift cover. An essential element of these group chats that emerged during data analysis was the sense of community, peer support, and confidence group chats provided to participants. Surprisingly, participants in this study were not alone when using group chats to communicate with colleagues. HHCAs, in a UK-based study, also reported

using social media platforms, such as WhatsApp, to communicate with their colleagues (Kelleher et al. 2022).

Participants in this study described using these group chats to support each other with learning, as did HHCAs in the UK (Kelleher et al. 2022), who also highlighted the benefit and value of learning from their peers in this way. Group chats presented an amalgamation of these two resources, peer support and knowledge and information, as Bakker and Demerouti (2017) outlined, as participants described using the group chat to troubleshoot issues or concerns with colleagues. However, this group chat was established by the HHCAs and did not appear to have been approved by managers.

Multiple HHCAs within different organisations reported using group chats to communicate, provide, and receive peer support. As the learning and conversation within these group chats were not monitored for information quality, GDPR adherence, or potential oversights in advice or learning opportunities provided, it raises areas for concern regarding potential issues with the quality or accuracy of the content provided within these group chats.

However, a positive solution to this concern and implication for future practice, would be a WhatsApp group arranged and monitored by the HHCA's manager or team leader. This would facilitate events of positive feedback from the manager to HHCA, knowledge sharing, and peer support. A further recommendation for a term-of-use policy to accompany and support the use of this group chat. For example, this policy could guide the HHCA on how to ask questions whilst protecting the anonymity of their client.

Contrary to the JD-R, which outlines that additional work effort is influenced by access to adequate resources, participants explained that their motivation to complete additional tasks was influenced by their desire to

positively impact their clients' lives. However, despite participants emphasising the importance of making a difference in their clients' lives, this concept is not a prevalent factor in the policies, procedures or job descriptions of HHCAs. Instead, as participants outlined, their jobs are routinely task-orientated, and their ability to provide PCC is often hindered by time pressures and advice to remain emotionally uninvolved by their clients. The contrast between the reality of the job experience of HHCAs, as noted by the participants as making a difference in the client's life, contrasted with the task-based, time-pressured system HHCAs currently work within, suggests that HCOs are missing an opportunity to encourage and support HHCAs to complete their duties in a way that both meets the organisations' requirements for task completion and the HHCA's desire to make a difference in their client's life. Should HCOs adapt organisational procedures to support the HHCA's ability to make a difference in their client's lives, as the JD-R suggests, positive organisational outcomes should increase.

6.7 Limitations

The qualitative nature of this study equates to an inability to generalise the findings to the broader population of HHCAs. However, this study aimed to explore and capture the lived experience of HHCAs supporting community-dwelling older adults in Ireland during an unprecedented pandemic. As this study was one of the first to examine the lived experience of HHCAs supporting community-dwelling older adults in Ireland during the COVID-19 pandemic, literature on this topic was limited prior to data collection.

Completing the consent form online via Microsoft Forms was associated with strengths and limitations. Online consent forms were perceived as a safer option to reduce virus transmission. However, using technology or internet services may also be considered a limitation of this method as it may present a challenge or an indirect exclusion factor for some

participants. However, in an uncertain and ever-changing environment during the early days of the COVID-19 pandemic, when vital information about the virus remained scarce, this was perceived as the safest and most effective method of communication available at the time of recruitment for both the HHCA and the researchers.

Those uncomfortable using online technology to communicate and needing access to a stable internet connection may have been unintentionally excluded from participating in this study. This limitation was considered in the decision of methodology for this study. Despite the issues and challenges raised during the methodology decision-making process, online interviews were chosen as they presented the least infection control risk to both the researcher and the participants and, indirectly, the clients the HHCA supported. Using online interviews also enabled the study to continue respective of social distancing and infection control measures outlined by the Irish government and health authorities. Despite the limitations outlined, this study provides valuable insight for stakeholders, policymakers, and managers of home care services and HCOs alike into the working experiences of HHCAs during COVID-19.

Finally, the researcher's experience working as a nurse both before and during the pandemic may have posed a potential bias risk to the results. However, as previously discussed, the researcher recorded regular field notes and participated in reflexive writing to mitigate this bias. Particular attention was paid to reflecting on the origin of beliefs throughout the study process.

7.0 Conclusion

This study evaluated the resource needs of HHCAs supporting community-dwelling older adults during the COVID-19 pandemic. The literature presented in chapter two outlined the settings in which HHCAs work and the importance of the role of HHCAs within health care systems both globally and in Ireland. This chapter also presented the challenges HCOs currently face with recruitment and retention of HHCAs, along with the challenges HHCAs experienced in their role before the pandemic. With the demand for HHCAS projected to increase, it is imperative to understand potential factors that may alleviate the impact these challenges have on the work of HHCAs.

7.1 Implications for practice

The onset of the COVID-19 pandemic exacerbated the challenges HHCAS faced before the pandemic. Participants in the current study identified that alongside the challenges faced before the pandemic, the onset of the COVID-19 pandemic introduced additional tasks, such as adhering to additional infection control procedures and using additional PPE and social distancing measures. Additional challenges reported by HHCAs included lack of support, clarity surrounding their role specifically relating to the boundaries of their emotional involvement and ambiguity relating to the required tasks. However, despite the challenges reported by participants, a consensus of going above and beyond for their clients was observed throughout participant interviews.

Participants explained that being a HHCA was more than just a job or completing tasks on a list. Instead, it was the amalgamation of becoming their client's friend, extended family member, advocate, support worker, all whilst completing their job as a HHCA. Participants in this study described a range of instances in which they completed additional tasks outside the clients' care plans despite having available resources such as time.

Participants explained that providing PCC was a crucial element of the role of a HHCA and that they would stay on longer, past their allocated time slot, to ensure the client received the level of care required.

7.2 Implications for Policy

Previous literature has shown that fewer job demands contributed to improved motivational processes of employees. As reported in this study, HHCAs faced many job demands as part of their work before and during the pandemic. Indeed, the onset of the COVID-19 pandemic increased the presence of job demands experienced by HHCAs whilst also creating additional job demands. The JD-R theory outlines that the availability of job resources help to reduce an employee's experience of job demands. However, before this study, the essence of job resources required by HHCAs working in Ireland was unexplored.

The JD-R theory outlines positive organisational outcomes, such as employees going the extra mile when they have access to adequate job resources to mitigate the effects of the job demands they experience. When evaluated with the JD-R framework, extra-role performance is a positive organisational outcome considered to result from the motivational process involved with job resources. However, despite the presence of various job demands identified by participants, this study found that participants used a job resource that had been previously unmentioned to mitigate their experiences of job demands. This previously unmentioned resource was the HHCAs' ability to make a difference in their clients' lives, fuelled by the emotional connections they established by providing PCC to the clients they support.

Given the current recruitment and retention issues faced by HCOs across Ireland, this research offers valuable insight into the resource needs identified by HHCAs, namely the recognition of the value and importance of

HHCAs to establish a positive rapport with their clients through delivering PCC. Furthermore, additional support opportunities are required by HHCAs, such as increased support from HCOs, increased clarity on their tasks and recognition of the emotional involvement required within their role. Furthermore, participants and literature reported HHCAs frequently using social media platforms to communicate and support one another. Further research is required to determine if adding the resource needs identified by participants in this study influences their working practices.

Participants in this study continually expressed the desire to remain working in their role as they made a difference in their client's lives. In order to promote and encourage the ability for the HHCA to provide PCC and build appropriate rapport with their clients, HHCAs must be afforded the opportunity and resources to do so. By encouraging HHCAs to provide PCC, HHCAs will increase the positive overspill from work, a job resource as outlined by Bakker and Schaufeli (2014).

7.3 Contribution

This study highlights the resources identified by HHCAs as necessary to complete their jobs, a previously unexplored topic. This study provides a welcomed discussion surrounding the resource needs of HHCAs supporting community-dwelling older adults in Ireland, addressing previously unexplored phenomena. Furthermore, this study provides insight into the experiences of HHCAs working during an unprecedented global pandemic. This thesis is the first study to provide insight into the job resource needs of HHCAs supporting older adults in Ireland. Additionally, this study is one of the first to examine the job resource needs of HHCAs supporting older people in Ireland while working in an unprecedented pandemic context. It is hoped that the information provided by this study raises awareness among HCOs and policymakers to prove HHCAs with the resources outlined to increase recruitment and retention rates of HHCAs.

7.4 Consideration for further research

This study was one of the first to explore the experiences of HHCAs working in Ireland. Although this study provides welcoming insights into the lived experiences of HHCAs, further studies would be beneficial in exploring some of the findings from this study. For example, examining the correlation between increased availability of work resources and HHCAs intent to reamin working within their role.

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Appendices

Appendix A JD-R Criteria (Schaufeli and Taris 2014).

Job Demands

- Centralization
- Cognitive demands
- Complexity
- Computer problems
- Demanding contacts with patients
- Downsizing
- Emotional demands
- Emotional dissonance
- Interpersonal conflict
- Job insecurity
- Negative spill over from family to work
- Harassment by patients
- Performance demands
- Physical demands
- Problems planning
- Pupils' misbehaviour
- Qualitative workload
- Reorganization
- Remuneration
- Responsibility
- Risks and hazards
- Role ambiguity
- Role conflict
- Sexual harassment
- Time pressure
- Unfavourable shift work schedule
- Unfavourable work conditions
- Work pressure
- Work-home conflict
- Work overload

Appendix A JD-R Criteria (Schaufeli and Taris 2014).

Job resources

- Advancement
- Appreciation
- Autonomy
- Craftsmanship
- Financial rewards
- Goal clarity
- Information
- Innovative climate
- Job challenge
- Knowledge
- Leadership
- Opportunities for professional development
- Participation in decision making
- Performance feedback
- Positive spill over from family to work
- Professional pride
- Procedural fairness
- Positive patient contacts
- Quality of the relationship with the supervisor
- Safety climate
- Safety routine violations
- Social climate
- Social support from colleagues
- Social support from supervisor
- Skill utilization
- Strategic planning
- Supervisory coaching
- Task variety
- Team cohesion
- Team Harmony
- Trust in management

Appendix A JD-R Criteria (Schaufeli and Taris 2014).

Personal resources

- Emotional and mental competencies
- Extraversion
- Hope
- Intrinsic motivation
- Low neuroticism
- Need satisfaction (autonomy, belongingness, competence)
- Optimism
- Organization-based self-esteem
- Regulatory focus (prevention and promotion focus
- Self-efficacy
- Value orientation (intrinsic and extrinsic values)

Outcomes (negative)

- Absenteeism (self-report and company registered)
- Accidents and injuries
- Adverse events
- Depression
- Determination to continue
- Unsafe behaviours
- Negative work-home interference
- Physical ill-health
- Psychosomatic health complaint
- Psychological strain (General Health Questionnaire, GHQ)
- Turnover intention

Outcomes (positive)

- Extra-role performance (self- or other-rated)
- Innovativeness
- In-role performance (self- or other-rated)
- Life satisfaction
- Organizational commitment
- Perceived health
- Positive work-home interference
- Service quality
- Team sales performance

Appendix B –Email to Gatekeepers

Dear _____,

Thank you for taking my call earlier today. I would appreciate if you could forward this email to Health Care Assistants working within (insert organisation name), supporting older people within their own homes during the COVID-19 pandemic in Ireland.

The study has received full ethical approval from the DKIT ethics committee.

Should you need any further information please do not hesitate to contact me.

Thank you in advance,

Kind Regards,
Aoibheann.

Hello,

My name is Aoibheann Mc Keown and I am a Registered Nurse. I am currently studying towards a Master of Science degree through research in Dundalk Institute of Technology (DkIT).

As part of my course, I am required to carry out research and I have chosen to find out more about the experiences of Health Care Assistants, (HCAs), supporting older people who live in their own homes.

As a HCA working in the community, you can provide valuable insight into what it is like to work in home care services in Ireland, during the COVID-19 pandemic.

Taking part in this research will involve completing an interview and a short survey.

If you would like your experiences heard, please email me at Aoibheann.mckeown@dkit.ie with "HCA study" as the email subject title.

Your support and co-operation is greatly appreciated.

Kind Regards,

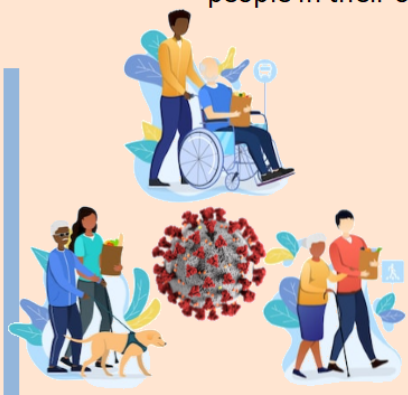
Aoibheann Mc Keown.

Appendix C- Recruitment Notice

DUNDALK INSTITUTE OF TECHNOLOGY

NetwellCASALA

The experience of Health Care Assistants working with older people in their own home, during the Covid-19 pandemic.



Are you:

- Currently working in a paid role, as a Health Care Assistant,
- In the community with an older person

And:

- Have you been working since November 2019?

If yes, we would like to hear from you.

Please contact us by emailing Aoibheann Mc Keown via

Aoibheann.mckeown@dkit.ie using **"HCA study"** as the email subject title.

Appendix D- Participant Information Leaflet

Participant Information Leaflet

Study Title: Resource needs of health care assistants working with community dwelling, older people in Ireland during the global COVID-19 pandemic.

You have been invited to take part in a research study exploring the experiences of home healthcare assistants (HHCAs) during the COVID-19 pandemic. Before you decide about participating, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Should you have any further queries, you can contact the researcher using the contact details below.

WHO I AM AND WHAT THIS STUDY IS ABOUT

My name is Aoibheann Mc Keown and I am a Registered Nurse. I am currently studying towards a Master of Science through research in Dundalk Institute of Technology (DkIT). The aim of this study is to establish what resources health care assistants working with older people living at home during the global COVID-19 pandemic need.

Home health care assistants (HHCAs) provide care to those living at home, and usually this includes providing support with activities of daily living (ADLs) such as; washing, eating and dressing. COVID-19 pandemic advice from the Irish government, directs all members of the population to engage in social distancing. These recommendations represent a challenge for those caring for older people, who are generally in receipt of home care to support difficulties self-managing these ADL tasks and which, by their nature, require close personal contact. Many studies have been completed to examine the experiences of nurses and other healthcare professionals during pandemics, however, very few studies have examined the experiences of HHCAs.

WHAT WILL TAKING PART INVOLVE?

Taking part in this research will involve completing an interview and a short survey.

The interview will cover questions on your background, experience working as a HHCA and your experience of working with clients with community dwelling older adults during the COVID-19 outbreak in Ireland. The interview will take place online (via zoom or skype) or via telephone should you prefer.

The demographic questionnaire will help us describe who has taken part in the study, (i.e. gender, age etc.). The questionnaire should take 10 minutes approximately to complete and the interview should take approximately 40 minutes to complete.

After completing this interview, you will be invited to notify me if you would like to participate in further research into developing supports for HHCAs during the COVID-19 pandemic.

Appendix D- Participant information leaflet

WHY ARE YOU BEING INVITED TO TAKE PART?

As an HCA working in the community, you can provide valuable insight into what it is like to work as an HCA in home care services in Ireland, especially during the challenging circumstances of the COVID-19 pandemic.

DO YOU HAVE TO TAKE PART?

Your participation in this study is voluntary. You are under no obligation to participate or continue with this research should you chose not to.

WHAT ARE THE POSSIBLE RISKS AND BENEFITS OF TAKING PART?

You will not be exposed to any physical harm during the completion of this interview; however, this interview explores topics surrounding COVID-19, which may be distressing for some. Should you become distressed during the interview, you can withdraw from the interview without any consequences and without having to provide a reason. Should you experience distress after completing the interview, you are advised to contact your GP or other support services. A list of support services are outlined below.

Organisation	***Overview***	***Number***
HSE Healthcare Worker Advice Line	A dedicated phone line for all health care workers to give advice during the COVID-19 outbreak.	1850420420 Monday- Friday 09:00hrs to 18:00hrs.
www.Turn2me.org	Free Online-counselling service for residents of Ireland.	Website: www.Turn2me.org

MyMind	Free online counselling service. Counselling is free for those affected by COVID-19. This includes frontline workers, those experiencing bereavement as a result of COVID-19.	www.Mymind.ie
Samaritans	A listening service for anyone who needs it, no matter what you are going through.	Freephone: **116 123**
Pieta House	Provide support for people who are considering harming themselves.	Freephone: 1800247247
In Case of Emergency	National Ambulance or An Garda Síochána	999 or 112.
HSE website: ""Mental health supports and services during coronavirus"	Further details of mental health support available during the corona virus	Website: https://www2.hse.ie/services/mental-health-supports-and-services-during-coronavirus/

While you will not receive a specific benefit in terms of a financial remuneration for participating, this research should contribute to better understanding of the experiences of HCAs working in home care services in Ireland. By conducting research, it is hoped to provide evidence for home care organisations and policy makers to support the work of HHCAs for both during and after the COVID-19 pandemic.

WILL TAKING PART BE CONFIDENTIAL?

When completing this interview, some demographic information such as your age, education and place of work will be requested. All information collected, will be anonymised according to DKIT polices. Your name will not be associated with other information you provide and you will only be identified by an ID code assigned to you. You will not be identified in any report or papers published from this research.

Information collected from you will be stored and processed in line with GDPR legislation and DKIT privacy policy.

As per Nursing and Midwifery Board of Ireland of professional conduct, there may be exceptional circumstances where the researcher must share confidential information. These circumstances may include:

- A disclosure made by a participant which indicates potential harm to the participant
- A disclosure indicating potential harm to the clients cared for by the participant
- A disclosure made which outlines the participation in illegal activities.

Should any of these circumstances arise; the researcher is obliged by law to notify relevant authorities. In such a case, the researcher will disclose the minimal amount of information necessary and only to relevant people.

HOW WILL INFORMATION YOU PROVIDE BE RECORDED, STORED AND PROTECTED?

Information (data) will be stored on an encrypted, password-protected file on an external hard drive. When not in use, the hard drive will be stored in a locked bag in a locked room. Only the researcher and the researcher's supervisors will have access to this data.

Data from this study shall be stored as above for a maximum of 5 years after the completion date of the study (December 2025). Following this term, all data collected shall be destroyed in a confidential manner. Secure shredding shall destroy hard copies of data collected and soft copies shall be permanently erased from all databases as per NetwellCASALA and DKIT procedures.

WHAT WILL HAPPEN TO THE RESULTS OF THE STUDY?

Results of this research may be presented in academic research journal articles, conference presentations, reports to the home care sector or government and/or general publicity such as on the research centre website through news sources. Findings from this study will also be included in the researcher's thesis, which will be submitted for marking as part of the Masters in Science degree.

WHO SHOULD YOU CONTACT FOR FURTHER INFORMATION?

For further information, you can contact me using the contact details below. If you have any concerns about the researcher, this study or how it has been conducted, you should contact my research supervisor: Suzanne Smith MSc, Research Centre Manger at Suzanne.smith@dkit.ie

Thank you for taking the time to read this information. Your support is greatly appreciated.

Aoibheann McKeown

Aoibheann Mc Keown BSc, RNID.

Aoibheann.mckeown@dkit.ie

Appendix E- Consent Form

Consent form

Research Title: Experiences of health care assistants working with community dwelling, older people during the global COVID-19 pandemic.

- I voluntarily agree to participate in the research title as outlined above.
- I understand that even if I agree to participate now, I can withdraw at any time or refuse to answer any question without any consequences.
- I understand refusal to participate will not result in any consequences with my employer.
- I understand that my participation is anonymous and my employer will not be informed whether I participate or not.
- I understand that my employer will not have access to any information I provide as part of my participation.
- I have read and understand the purpose and nature of the study.
- I had the opportunity to ask questions about the study prior to participating.
- I understand that participation involves completing an online or telephone interview that will be recorded for analysis by the researcher.
- I understand that I will be asked questions on my background and experience of working as a healthcare assistant during COVID-19.
- I understand that I will not receive financial or other compensation for participating in this research.
- I understand that all information I provide for this study will be treated confidentially.
- I understand that it will not be possible to identify me in any report on the results of this research.
- I understand that if I inform the researcher that I or someone else is at risk of harm they may have to report this to the relevant authorities - they will discuss this with me first but may be required to report with or without my permission, as outlined in the participant information leaflet.
- I understand that all information collected will be stored in an encrypted, password-protected file on the researcher's password-protected laptop.
- I understand the data collected will be kept for up to 5 years and will then be destroyed in a confidential manner in line with DkIT data management policies. (Please see the participant information leaflet for more).
- I understand the information I provide will only be used for this study by the researchers named on the Participant Information Leaflet and will only be used for further related studies if conducted by the same researcher/s and approved by the DkIT ethics committee.

Please complete the section below (digital signature acceptable):

This form will be completed online via Microsoft forms.

Participant will select yes or no after each question to indicate consent. Signatures will be collected digitally and date will be collected when the person submits the form.

Appendix F- Demographic Questionnaire

Study title: The resource needs of health care assistants working with community dwelling, older people during the global COVID-19 pandemic.

This demographic survey shall be distributed electronically via an online platform e.g. survey monkey or google forms.

To give us an insight into who has answered this interview, please complete the questions below.

1. **What is your sex?**
   Please select one
   - ☐ Male
   - ☐ Female
   - ☐ Non binary

2. **What is your age range?**
   Please select one
   - ☐ 18 - 20 years of age
   - ☐ 21- 25 years of age
   - ☐ 26- 30 years of age
   - ☐ 31 – 35 years of age
   - ☐ 36 - 40 years of age
   - ☐ 41 - 45 years of age
   - ☐ 46- 50 years of age
   - ☐ 51-55 years of age
   - ☐ 56-60 years of age
   - ☐ Over 60 years of age

3. **What is the highest level of education you have achieved?**
   Please select one
   - ☐ Primary
   - ☐ Some second level
   - ☐ Leaving certificate or second level equivalent
   - ☐ Adult education modules
   - ☐ Bachelor's degree
   - ☐ Master's degree or higher

4. **Have you completed a full QQI/Fetac Level 5 award in healthcare?**
   - ☐ Yes
   - ☐ No Due to complete in _____

5. **Please specify the type of home healthcare service you work for**
   Please select one

- ☐ HSE
- ☐ Public funded private
- ☐ Private
- ☐ Charity
- ☐ Agency based (independent contractor)
- ☐ Paid by private arrangement (cash arrangement with client or client's family member)

6. **How long have you worked as a health care assistant?**
   Please select one
   - ☐ Less than a year
   - ☐ 1-5 years
   - ☐ 6-10 years
   - ☐ More than 10 years

7. **How long have you worked as a home health care assistant?**
   Please select one
   - ☐ Less than a year
   - ☐ 1-5 years
   - ☐ 6-10 years
   - ☐ More than 10 years

8. **Are you currently working as a Home Healthcare Assistant?**
   - ☐ **Yes**
   - ☐ **No**

9. **Ethnic background**

How would you describe your ethnic background? (for example: White, settled/Traveller Irish, Black African/Sudanese, Asian/Chinese/Filipino, Polish, Mixed Irish/African etc.) _____

Appendix G- Standard Operational Procedure for Recruitment.

Standard operational procedures

Recruitment

- ☐ Posters shall be circulated on social media platforms i.e. Facebook, twitter etc. (Appendix C for poster)
- ☐ Email attached in Appendix B shall be sent to home care organisations in Ireland asking them to inform the home health care assistants (HHCAs) working for them about the study.
- ☐ Those who are interested in partaking in the study will be asked to contact the researcher via the email address provided using email subject "HCA study".
- ☐ Emails including expression of interest will be moved to separate folder of the researcher's email inbox titled HHCA Study.
- ☐ Those expressing interest in participating in the study will be referred to as **Prospects**.

Prospects

- ☐ Prospects will be sent a response email from the researcher including;
    - Outline of study
    - Participant information leaflet
- ☐ Link to Microsoft forms consent form
- ☐ Prospects will be asked to read the PIL carefully and if they wish to proceed with taking part in the study, to complete the consent form on Microsoft Form using the ID code provided.
- ☐ Prospects will be provided with the researcher's contact details should they have any questions prior to consenting.
- ☐ Email addresses and names of Prospects will be kept on an excel spreadsheet, stored on password protected drive on password protected laptop which will be kept in a locked press when not in use.
- ☐ Prospects will be screened to ensure they meet the selection criteria.
- ☐ Those who meet the selection criteria and complete the consent form will be referred to as **Candidates** and will be included in the study.
- ☐ Those who do not meet the selection criteria will be informed via email that they are unable to be included in this study, as they do not meet the selection criteria.
    - Data (name and contact details) will be erased from the Excel spreadsheet in accordance with GDPR guidelines
    - For other Prospects not progressing, the reason for this non-progression will be noted where possible.

Appendix G- Standard Operational Procedure for Recruitment.

Candidates

- ☐ Candidate details, name and email addresses shall be transferred to an Excel spreadsheet containing information of study participants.
- ☐ On receipt of the completed consent form, an email will be sent to the candidate with the demographic survey to be completed and submitted on Microsoft Forms and requesting a suitable date and time for the interview to take place.
- ☐ Once a completed copy of the demographic survey has been received, the Candidate becomes a **Participant**.
    - Details of candidates and participants will be stored on an excel spreadsheet using the codes P-(number) for participant, C- (number) for candidate.

Participants

- ☐ Participant status change shall be updated in the project excel document.
- ☐ An email will be sent to participants thanking them for completing the consent form and demographic survey. In this email, participants will be asked to arrange a time for the trial call/ consent confirmation call to take place

Interview protocol

- ☐ On receipt of demographic questionnaire the researcher will schedule an interview time slot with the participant
- ☐ Records of interview timeslots shall be kept on password protected calendar.
- ☐ Interviews will take place online via one of the following; skype, zoom.
- ☐ Researcher shall ensure contact details of participants are entered correctly into calling system.
- ☐ The researcher will call participant at a prearranged time.
- ☐ Prior to starting the interview, the researcher will ask participant to confirm verbally that they have read, understood and consented to participating in the study.
- ☐ Researcher/Interviewer will introduce themselves and the co-interviewer, if present.
- ☐ Researcher will give participant brief overview of layout of interview, reminding them of their right to refuse to answer any question they choose
- ☐ Participants will also be reminded they can withdraw from the interview at any stage.

☐ Participants will be offered time to ask researcher questions
☐ Participants will be reminded that their interview will be audio recorded to allow for data processing at a later stage.
☐ Researcher will use questions outlined in Appendix H to guide the interview

Appendix H –Semi-Structured Interview Question Guide

Study Title: Resource needs of healthcare assistants providing care to community dwelling older people during the Covid-10 pandemic.

Interview Questions

Explain to the participant that the interview shall be recorded (Audio/visual recordings method dependent). Remind the participant none of the information they provide will be shared with their employer.

- Has your work changed because of the COVID-19 outbreak in Ireland?
    - *If yes:*
        - How have you dealt with that?
        - Do you think there are things that would help you deal better with it?
        - If you said yes, you needed help, what would be the response?
- What information or resources have you received regarding working as a HHCA during this pandemic? & what have you received?
- What additional information or resources do you feel would be beneficial and why?
    - *If you are lacking resources;*
        - How have you been filling that gap and managing without these resources?
- Has COVID-19 changed how you provide care to your older clients?
    - *If yes;*
        - How have you managed that? What have you been doing?
        - How is this different from what it was like pre-Covid?
- What training or information have you received about working with ***older people*** specifically during the COVID-19 outbreak?
- What do you need to help you work with older people at this time/during the COVID-19 outbreak?

Appendix I- NVivo Code Book

Name	Description
background	
age of clients	
change in clients routines as a result of Covid-19	
Clients haven't left their houses	
Clients need to resume their social life	
Client's social outings cancelled	
changes in HHCAs job since covid	Changes to HHCAs job because of covid
changing their clothes	HHCA now changes their clothes for infection control
Client chose to manage on their own during covid	
client isolated	
Client cocooning	
Client is alone	
client isolated from their families	
Clients haven't seen their families	
Client not letting anyone into their homes	
clients don't go out	
clients isolated from their friends	
Clients want to give HHCA a hug	explained

Clients want to shake HHCA's hand	Client wants to shake HHCA's hand as a greeting
elbow	HHCAs now greeting clients with the covid elbow "hand shake"
fist bump	instead of hand shaking
HHCA's job pre covid	HHCA gives account of what their job was like pre covid
How HHCA has dealt with covid change	How HHCA has dealt with changes to their role since covid
New routines	new working routines
pre-covid managers came to the clients house	to do assessments / spot checks
work is hard	HHCA's work is hard as a result of covid-19
Differences in homecare vs residential or hospital	
no time to sit down and talk to patients in hospitals	
other care settings involve working in one place for entire shift	
government	
Changes from government	Government advice or guidelines that has changed the HHCAs job like social distancing etc.
Home care service	
[Home care service is not properly structured]	
HHCAs sent to clients with no briefing	
clients assigned to HHCAs	

community care	
demand for HHCAs	
No shortage of work for HCAs	
older people want to remain living at home	
Role of HHCA is Essential	
Client is dependent on HHCA	If not the HHCA then who?
HHCA is the only person client sees all day	
Description of home care	
home care is more than just a job	
homecare is relaxed	
not rushing in homecare	
Difference between male vs female HHCAs	
HHCA is the only man working in his area	
Different roles within home care services	
home carers	
Home help	
nurse working within HCO	
home care nurses	
HHCA one of the most exposed members of the community	
members of the community see HHCAs as an increased exposure risk	

home care is different to residential and nursing homes	
home care profession not recognised	
HHCAs have no voice	
Home care experience not recognised	
HSE vs Private HCO- Home care organisation	
HHCA in private HCO working with HHCA from HSE	
Home care services provided by the HSE	
benefits of working with HSE	
HHCA is sub contracted to HSE via company	
HHCA wanting to work in HSE	
HHCA working for HSE	
Home care should be all carried out by the HSE	
HSE look after their staff	
job requirements HSE	
no governance in home care services	
private informal HHCAs	
side of the road	
type of company HHCA works for	
private home care organisation	
no changes with covid	

How HHCA delivers care is still the same	
Nursing homes or acute services (hospital)	
Client goes into hospital	
client goes into nursing home	
hospitals	
client discharged from hospital	
clients don't want to go to hospital with Covid	
long hours in hospitals or nursing homes	
Nursing homes	
clients don’t want to go into nursing homes	
Nursing homes are very routine based and structured	
previously worked in a nursing home	
reason for not working in nursing home	
Wouldn't go back to working in hospitals	
Previously worked in residential care	
Demands	
Communication break down or falling short	
Delay notifying HHCA of close contact status	close contact of covid-19 positive case

delay with office staff informing HHCAs of clients covid status	office staff slow to communicate info with HHCAs
communication breakdown between HHCA and client	examples of this
communication difficulties	
Communication difficulties between family and office	HHCA gives an account of above
English is not HHCAs first language	language barrier
environmental noises	affecting communication and causing difficulties
hearing difficulties	in relation to communication difficulties
HHCA has to raise voice	to combat communication difficulties
HHCA stands closer to client	to rectify communication difficulties
how HHCA deals with communication difficulties	e
Covid 19	Anything relating to Covid-19
Clients don't want to get covid	
covid 19 is a health concern	HHCA expresses concern for health b/c of c-19
Covid 19 awareness	
Client's awareness of covid	HHCA speaks of the client's awareness of c-19
Family's understanding of covid 19	HHCAs account of the family members understanding of c-19
Covid 19 guidelines	New guidelines implemented during the Covid-19 pandemic
Covid 19 Information	

	Covid 19 information is limited	limited info on C-19 available
	Covid 19 information over whelming to HHCA	C-19 getting to HHCA
	Covid 19 information provided to HHCA	account of information provided to the HHCA
	covid 19 MIS-information	
	information for client about covid	HHCA having information for client
HHCA having to explain Covid-19 guidelines to client		HHCA has to explain the Covid-19 guidelines/ rules/ restrictions to client
HHCA having to inforce covid-19 guidelines		HHCA has to enforce covid-19 guidelines i.e. reminding family members to maintain social distancing, coughing etiquette
infection control		HHCA mentions infection control in their work
	hand hygiene	HHCA mentions hand hygiene
	hand washing	
	hand sanitiser	HHCA mentions hand sanitiser
	HHCA disinfecting environment	
	HHCA has to be cleaner in the house	HHCA speaks about having to be cleaner or clean more in the house to reduce infection/ virus transmission
	management don't understand infection control	HHCA speaks about management not understanding infection control procedures

Opening window for ventilation	HHCA opens window in clients house for ventilation as an infection control measure
social distancing	the need to keep distance between people
Can't hug	unable to hug because of Covid-19
can't shake hands	unable to shake hands because of the covid-19 virus
Can't sit close to client	HHCA unable to sit close to the client because of covid -19 or infection control measures
Family not carrying out social distancing	Client's family not carrying out social distancing either from client or from HHCA
HHCA has to go closer than 1m to client	HHCA is required to go closer than 1m distance to client because of covid-19 or infection control measures
HHCA sitting at a distance	HHCa having to sit at a distance away from the client because of Covid-19
no social distancing with personal care	HHCA speaks of being unable to keep distance between them and client during personal care
reminding client's to keep distance between them and HHCA	HHCA having to remind client to maintain social distance between them [client] and HHCA
Standing at a distance	HHCA having to keep a distance between them and the client

	because of Covid-19 or infection control measures
talking from a distance	HHCA having to talk to client from a distance because of covid-19 guidelines
lockdown	HHCA speaks about "lock downs".... when government implemented stay at home orders/ travel radius/ social outings closed
covid 19 hospital wards	HHCA mentions covid-19 in the hospital wards
Covid 19 statistics	
Covid 19 death numbers	HHCA mentions C-19 death numbers
covid 19 infection rate numbers	HHCA mentions C-19 infection rates
covid 19 tests	
client tested positive	HHCA speaks about client testing positive for Covid-19
Office staff or management's response to client testing positive	
HHCA tested for Covid-19	
HHCA tested for Covid-19	HHCA speaks of getting tested for Covid-19
HHCA tested positive	HHCa tested positive for C-19
HHCAs not routinely tested for covid	
negative covid 19 test	
Covid has tested the HHCAs	

essential care only - covid	HHCAs only providing essential care
less time, less exposure	
HHCA working faster	
HHCA conscious of covid 19	
careful	
cautious of covid	HHCA mentions fear of covid
HHCA afraid of giving covid to client	
HHCA coughing	
HHCA touching their face	
precautions	
HHCA has more responsibility no extra time	because of covid or since covid extra responsibility includes extra tasks, PPE
New company protocols	HCO has introduced new policies because of covid
HHCA cannot be in the house when family are there	
when HHCA suspects client may have covid	HHCA speaks about experiences during which they suspected the clients had covid-19
pandemic	HHCA mentions a pandemic
people are sick of Covid	HHCA fed up hearing about C-19
People not believing in Covid	HHCA mentions people not believing in covid
Symptoms	HHCA mentions symptoms of C-19

HHCA monitoring clients for symptoms of covid	explained
HHCA self-monitoring for covid-19 symptoms	
HHCA taking their own temperature	
vaccine	Covid-19 vaccine
HHCA having to travel get the vaccine	HHCA says they had to travel to get their vaccine
Virus transmission	HHCA speaks about transmission of the virus
coming into contact with Covid-19 close contact	HHCA's experience of coming into contact with a covid-19 positive client or case
community transmission	
Covid 19 contact tracing app	HHCA speaks about the Covid-19 app by the HSE
Job demands	
Emotional demands (sch list)	
expected from HHCAs	
expected to get on with it	
put up with it	
Heavy work in hospitals or nursing homes	
HHCA job tasks	HHCA outlines their above
Client Care	
Client Care Plans	
care plan assessments	

care plan not representative of client's needs	
care plans incorrect	
Clients require more care than what is outlined to HHCA	
HHCA only does tasks listed on the care plans	
HHCA printing care plans	
manager's assessment does not reflect what's actually required	
managers do the care plan assessments remotely	
Client refusing care	
Client wouldn't allow HHCA into the room with her	
Having to persuade clients to allow HHCAs to continue working	
HHCA providing social care	HHCA talks about providing social care i.e. communication, companionship
colouring	HHCA colouring with client

HHCA Having a cup of tea with client	e
HHCA is scheduled time to provide social support	
HHCA trying to keep client upbeat	
Client's mental health and well being	
HHCA trying to boost clients mood	
out for walks	HHCA going for walks with client
HHCA takes client out for a walk	e
HHCA supporting client	HHCA supporting client in general
HHCA supporting client with physio exercises	e
HHCA tasks	HHCA's job tasks
Going to the pharmacy	HHCA going to the pharmacy for the client
HHCA advocating for clients' needs	e
HHCA doing assessments	
light domestic work	light house work
changing bed sheets	HHCA changing client's bed sheets
cleaning	HHCA cleaning
cooking	HHCA cooking client's meals
dishwasher	HHCA using the dishwasher with client
hoovering	HHCA hoovers client's house

shopping	HHCA shopping for client
medication	
prompting client to take mediation	
palliative care	HHCA providing palliative care to client
paper work	HHCA completing paper work
personal care	HHCA supporting client with personal care
assisting client with dressing	explained
cutting clients nails	e
incontinence care	explained
shower client	showering personal care
washing	explained
wound care	HHCA carrying out wound care with client
Support with nutritional intake	HHCA supporting client with above
breakfast	HHCA giving client breakfast
HHCA gives client lunch	e
person centred care	
client only likes specific carers	
continuity of care	
Role of HHCA	
HHCA considering needs of the client	
HHCA role is very diverse	
HHCA sitting with client	

Responsibility felt by HHCA	
HHCAs raise issues with management	
HHCA's concerns not addressed	
HHCAs work environment	any codes that the HHCA talks about the people, place of things within their work environment
going into people's homes	
HHCA dealing with client's family during call	
Client living with family	
client lives with off-spring	
Client's family have moved in with them	
family become defensive	
family members complaining	
it's my house	
visitors to clients home	
HHCA not knowing what they're going into	
HHCAs working between multiple settings	
HHCAs can't work in different sections during covid	

Staff levels	
Company took on extra staff	
lone working	
HHCA are on their own	
HHCA is isolated	
HHCAs don't know other people that work in the job	
HHCAs don't meet other colleagues	
staff changeover	
staff shortage	
HHCA off work	
HHCAs work hours	
HHCA's work schedule	e, shift pattern, days on
arranging cover for their shift	HHCA arranging for rather staff member to cover their shift
HHCA covering a team members shifts	explained
other HHCAs have to cover if HHCA is off	alternative staff needed to cover HHCA's shift
Process of arranging cover when HHCA has to self-isolate	explained
breaks	breaks from work
no break	HHCA does not get a break
no lunch break	HHCA does not have a lunch break when working

Changes to HHCAs work schedule	unspecified change
HHCA not notified of roster change	explained
client's allocated hours	Hours client has been allocated in care package
call duration	length of call allocated or time taken to complete the call
time allocated to client not sufficient	care package hours not enough
call time	Time of day call is. or length
contracts	HHCA talks about their contract
don't have the time	HHCAs don’t have the time
HHCA rushing in home care	e
no additional time to put on PPE	amount of time allocated to complete call remains unchanged despite extra task of PPE
flexibility of hours	HHCA mentions flexibility of working as a HHCA
HHCA double booked on calls	HHCA roster asking them to be at 2 calls at once
HHCA is on standby to cover shift	Covering shift for other college
HHCA not wanting to leave clients	at the end of calls
HHCA rostered for hours outside of their stated availability	explained

	carers availability	HHCAs stated hours of availability
HHCA's hours increased		as a result of covid HHCA is working more hours
long working hours as a HHCA		either the shifts are long or time from first call to last call is long
	12 hour shifts	HHCA working 12 hour shifts, HCAs in hospitals working 12 hour shifts
roster or schedule of working hours		heading code to cover discussions relating to the above
	HHCA organises own roster	e
	regular clients missing from HHCAs roster	HHCA observed regular clients they have were not included on their roster
Time off		HHCA talks about time off
	HHCA afraid to ask for time off	e
	HHCA needs time off	HHCA mentions they need time off
	HHCA not able to take time off	reasons HHCA may not be able to take days off
	HHCA requesting time off	HHCA requesting days off work
	HHCAs not taking time off	examples of why HHCA does not take time off or HHCA says they're not taking time off
	influence of taking days off	HHCA mentions the above

no one to replace HHCA if they are off	No other staff to cover HHCA's A/L...
no time off	HHCA does not get time off
Hours not guaranteed	
company giving HHCAs hours to other workers	
HHCa may lose their job	
no contract	
there is no one else	
burden	
Tough job	
heavy work in home care	
travelling between calls	
distance to travel to work	
mode of transport	
car	
taxi	
walking from call to call	
no pay for travelling between calls	
no travel time	
stuck in traffic	
travel time between calls	
Types of clients HHCA works with	
challenging behaviour	
Challenging behaviour training	
Dying Client	
Client died	
HHCA had to do CPR	

HHCA dealing with loneliness in clients	
using technology to improve loneliness in clients	
working with vulnerable people	
bed bound clients	
Client has underlying health conditions	
clients have long term illnesses	
clients with brain tumours	
dementia	
Alzheimer's society have sent out packs	
clients with dementia	
immuno-compromised	
neuro degenerative diseases	
Older client	
safeguarding	
stroke patient	
working expenses	
fuel	
HHCA claiming work expenses	
HHCA buying own hand sanitiser	
HHCA is paid for fuel costs	
HHCA would like contribution towards working expenses	
uniform expenses	

wear and tear of car	
workload	
Work over load	
making conversation with client became hard	because of covid
Personal Demands	
HHCA's family	
Childcare	
HHCA don't get to see their family	
HHCA has vulnerable family members	
HHCA's children	
single parent	
Homework conflict (schaufeli list)	
HHCA's job affected their home life	
leaving everything at the door	
leave it at the door	
Emotions or Feelings	
Client's emotions or feelings	
Client's emotions (negative)	
client becomes distressed	
Client is afraid	
client panicked	
Client was anxious	
Clients becoming stressed	
Clients get annoyed	
depression in Clients	
fear in clients	
gets upsetting for client	

Client's emotions (positive)	
clients happy to see HHCA	
HHCA feelings or emotions	
HHCA emotions (negative)	
afraid	
Annoys HHCA	
Anxiety	
burnout	
HHCA confused	
HHCA emotional	
HHCA felt like they couldn't go to work	
HHCA felt tired	
HHCA fed up	
HHCA Feeling drained	
HHCA has no energy	
HHCA has no motivation	
HHCA worn out	
HHCA felt uncomfortable	
HHCA frustrated	
HHCA hypersensitive emotionally	
HHCA worried	
HHCA worried about clients family in the home	
I can't function	
nervous	
panic	
physical exhaustion	
HHCA finding it tough to deal with changes from covid	within their job

HHCA's emotions (positive)	
HHCA's feelings (negative)	
HHCA feels sad for the client	
HHCA not wanting to get up	
You have to get up and go for the clients	
HHCA's feelings positive	
HHCA feeling more relaxed	
HHCA is proud of themselves	
HHCA passionate	
Negative	
Absence of job resources	
HHCA requires additional resources	
client requires more nursing support	
HHCA requires additional supports	
Office to provide more information to clients	
Changes observed in client	
changes in client's needs	
Changes in client's presentation	
client has regressed	
client feels like they've done something wrong	
clients are struggling	
Client's fear of covid	
Clients don't want to go to their doctor because of fear of getting covid	

Clients feeling like their home is dirty	
HHCA speaks negatively	
company only cares about the money	
HHCA not appreciated	
HHCA not considered	
HHCA not respected	
HHCA not valued	
HHCA treated like a number	
HHCA un happy	
HHCA under strain	
Negative experience of working as a HHCA	
HHCA gets no thanks	
injured at work	
no praise	
problems at work	
negative experience with management	
guilt tripping or blame game	
company using the good of carers	
HHCA getting blamed	
HHCA made feel bad	
Management do not appreciate HHCA	
management or office staff don’t care	
management telling HHCA to sort it out themselves	
no compassion from managers	

only time HHCA's boss knows what they do is when there is a complaint made against HHCA	
negative experience with office staff	
office staff asking HHCA to do tasks they know are unattainable	
Office staff constantly phoning HHCA	
Office staff don't know	
Office staff don't know all that HHCA do	
office staff don't know the clients	
office staff getting covid-19 information from the news	
office staff not accommodating	
office staff not taking responsibility	
Office staff not trained to give training to HHCAs	
office staff slow to know Covid-19 information - guidelines	
Office staff under pressure	
Private company on back foot or behind	
managers reluctant to do home visits	HHCA's manager is reluctant to do home visits for assessments / check-ups now during covid

Training insufficient	HHCA says training is insufficient for them
HHCAs still don't understand after training	HHCA says they still don't understand the topic even after training
Previous training not sufficient	for HHCA
unfair towards HHCA	rushing at call unfair on HHCA
Outcomes	
Negative Outcomes	
Exhaustion (sch list)	
compassion fatigue	
employer disregarding HHCAs symptoms of CF	
fatigue	
HHCA awareness of CF	
How CF affects HHCAs	
Response to - And before Covid, would compassion fatigue have even been considered by yourself	
symptoms of compassion fatigue CF	
compassion fatigue	
fake smile	
HHCA can't relax during time off	
HHCA car crash whilst at work	
HHCA doesn't want to leave their house	
HHCA feels left out	

HHCA forgets to care for themselves	
HHCA not wanting to go to work	
HHCA putting company needs above their own	
HHCA says I can't do it anymore	
HHCA's intended absenteeism	
HHCA's work has been traumatic	
reluctance to return working as a HCA	
stress	
coping with stress	
HHCA job is stressful	
How HHCA job is stressful	
Stress levels have increased during the pandemic	
stress of job causes HHCA to be sick	
HHCA is not completing role to the standard expected	
HHCA left previous home care agency	
HHCA comparing previous and current agencies	
previous agency not organised	

HHCA reason for changing care organisation	
HHCA Sick	
client's response to HHCA being out sick	
HHCA covering shift for colleague that is off sick	
HHCA out sick	
no sick pay	
HHCA phoning in sick	
Manager or office reaction to HHCA phoning in sick	
why HHCA doesn’t phone in sick	
HHCA stopped bothering	
Turn over intention (Sch list)	HHCA expresses intent to leave their current job
HHCA does not see themselves staying in home care	
Do not see themselves staying in their current role	
HHCA having to leave the job	
leaving home care	
HHCA Not wanting to continue with current company	
HHCA threatening to leave	
Positive Outcomes	

HHCA intends to stay working in home care	
HHCA just about staying in homecare	
HHCA stays working because of the clients	
See themselves staying in homecare	
What keeps HHCA working in home care	
HHCA trusting company	
Work Engagement	
Going above and beyond	
HHCA doing more than what's expected of them	
doing more than what's asked	
HHCA spending more time than they should	
HHCAs stop going the extra mile	
HHCA doing something they're not supposed to	
HHCA has to prioritise who gets what amount of time	
HHCA unable to follow the rules in homecare - job doesn’t allow	
HHCA volunteered	

staying for longer than time allotted	
Job satisfaction	HHCA speaks about being satisfied in their job
Enjoying the job as a career- general	
HHCA feels appreciated	
HHCA feels respected	
HHCA not satisfied in job	
If HHCA is down, they don't complete their job as well	
role not fulfilling HHCA	
HHCAs need to enjoy what they do	
ideal company for HHCA to feel valued	
Positive experience of working as HHCA	
enjoying the job as a HHCA	
HHCA happy	
HHCA likes helping people	
HHCA likes the job	
HHCA likes the work	
HHCA likes their clients	
job is rewarding	
love the job	

reason for moving to home care	
When HHCA is in good mindset, they work better	
This job is not about the money	
work life balance as a HHCA	
HHCA wanting to cut down hours	
Suits HHCA's holidays	
Positive	
current company HHCA works for is good	
nice company to work for	
positive experience with management	HHCA has had above
HHCA can phone management with concerns	e
HHCA feels linked in with management	linked/ connected
Management are understanding	HHCA say
management checking up on HHCA	e
management offering support to HHCAs	e
management offering to talk to HHCAs	e
management regularly phone HHCAs	e
management taking careers into consideration	HHCA say
managers consider HHCA's needs	

Private company- look after their staff	
What I like about home care	
meeting people	
spending time with people	
Resources	
Access to resources in nursing homes or hospitals	
access to resources	
Communication	
Communication - HHCA with....	
communication between HHCA and client	
Client lip reading	Client lip reading during communication with HHCa
Clients can understand HHCA	Client can understand HHCA when communicating
Clients can't hear HHCA	explained
Clients can't understand HHCA	explained
HHCA phoning Client to check up	HHCA phoning client to check in on their wellbeing
linking in with client	HHCA keeping up communication with client,
talking to client	HHCA talking to client
communication between HHCA and office	
communication between office staff and HHCA is poor	explained

company slow to give information to HHCAs	When communicating with HHCAs, office staff are too slow/ not forthcoming with info
HHCA communicating with client's family	HHCA communicating with the client's family
Communication with HHCA and family reduced during covid	explained
getting to know the families	HHCA getting to know the client's family
HHCA liaising with family	HHCA liaises with client's family
linking in with family	HHCA communicating with client's family
HHCA interacting with colleagues	
group chat	HHCA's using group chats to communicate with each other
WhatsApp	HHCA using Wats app to communicate with each other
HHCAs communicate with each other	explained
linking in with colleagues	HHCA staying in contact with their employees
Communication- client with....	
client communicating with family	client communicating with their own family
Communication- Client's family	heading
Not communicating effectively with HHCA or office	Client’s family do not communicate effectively with office or HHCA

communication is essential	HHCA outlines necessity for communication
eye contact	Eye contact in relation to communication
facial expressions	in relation to communication
HHCA supporting client to communicate with family members	Explained. May be because of self-isolation or cocooning during covid
phone calls	Communicating with client's family via phone call
text message	HHCAs use text messages to communicate with each other
contact the office	
for clarity	
HHCA does not want any additional information or resources	
Job Resources	
befriending service from ALONE	
Communication Managers or Office staff with...	
Company organise fun tasks	
Company was prepared	
control	
HHCA has control over job	
HHCA avoids working with hoists	
HHCA chooses clients	
HHCA choses hours	
HHCA has choice in their role	

lack of autonomy in HHCA's role	
HHCA feels like they have no choice	
HHCA not allowed to or restricted or limited	
HHCAs in the community do not have the same autonomy as HCAs in residential	
lack of control in HHCAs environment or work	
lack of control	
other home care staff not allowed or limited or restricted	
Education	
course completion requirements of HHCA	
education or information from government	
HHCA wants to do further learning	
training	Training for HHCA
company funding additional training	HCOS funding additional training for HHCA
dementia training	HHCA mentions above
face to face training	in person face to face training
Have not received additional training to	e

	support older people during covid	
	HHCA does not want additional training	e
	HHCA not paid for training	explained
	HHCA says they need training	explained
	HHCAs are not trained in palliative care	HHCA says above
	in-house training	HHCA receives above
	manual handling	manual handling training course
	mental health courses for HHCAs	
	accessible mental health support for HHCAs	
	No additional time for training	HHCA training hours not included in their weekly working hours
	online training courses	e
	previous training WAS sufficient	Previous training HHCA received was sufficient
	Safeguarding training	HHCA discusses above
	team leader training	HHCA speaks about team leader training
	training for clients	HHCA suggests the need for training for clients
	training for HHCA to support client with technology	HHCA gets training on how to support client with technology

training for team leaders	participant mentions training for team leaders
how to support HHCAs during covid	team leaders got training on how to support HHCAs during covid
training office staff have received	HHCA discusses the training office staff have received
Training specifically to support older people	HHCA mentions training as above
training stopped during covid	training courses for HHCAs stopped during covid
training to uplift carers needed	HHCA says above
equipment	
equipment not suited to client's needs	
HHCAs don't know how to use the equipment	
hoist	
hospital bed	
wheelchairs	
Feedback	
appreciation for HHCA	
appreciation for HHCA	
Bonus from company	HHCA speaks about receiving bonus from their company
gift card from company	HHCA speaks about receiving gift card from the company
HHCA worth	
Management do not appreciate HHCA	HHCA does not feel appreciated.....upon review

	this code covers a lot of "management don’t care"
management or office staff don’t care	
managers appreciate HHCA	
Bonus from company	HHCA speaks about receiving bonus from their company
gift card from company	HHCA speaks about receiving gift card from the company
HHCA worth	
Management do not appreciate HHCA	HHCA does not feel appreciated.....upon review this code covers a lot of "management don’t care"
management or office staff don’t care	
managers appreciate HHCA	
Appreciation for HHCA through client or clients family	
Clients look forward to seeing HHCA coming	
HHCA gets praise from client's family	
Client to Management	
clients feedback to management about service	

HHCA is recognised for hard work	
management to HHCA	
Managers give HHCAs feedback	
Praise goes a long way	
praise makes HHCAs feel good	
HHCA communicating with client's family	
How management communicate with Family	
managers communicating with family email	e
managers communicating with family letter	e- client's family
letter	managers communicate with families via letter
managers communicating with family phone	e
managers method of communication with family	client's family
managers communicating with family general	
managers communicating with families about covid-19	e
managers sent guidance on relative quarantining after foreign travel	e

Managers updating the family	methods & contents & frequency
HHCA communicating with clients	
How managers communicate with client	e
HSE HHCA pay	
HSE HHCAs have paid time between calls	
Job security	
Nursing homes and residential jobs are more secure	
MDT	
HHCA interacting with MDT	
HHCA needs more support from members of the MDT	
MDT not going into houses	
MDT staff levels reduced during Covid 19 pandemic	
multi-disciplinary team MDT	
palliative care services	
palliative care nurse	
public health nurses	
Office or management	
company office	
HHCA going into the office	
management	anything relating to management
HHCA tells managers or office staff about what they do	

	information provided to HHCA from management	
	Management monitoring staff for Covid symptoms	
	managers coming to clients house	
	managers don't come to the house as often because of covid	
	team leader or supervisor	
	rapport between team leader and HHCA	
	supervisor is good	
	team leader can advocate from experience on behalf of HHCAs to management	
	team leader duties	
	team leader treating staff well	
Managers communicating with HHCAs general		
	how management communicate Covid-19 exposure risk with HHCAs	methods of communication
	Management using text messages to communicate with HHCA	e
	managers ask has HHCA got any concerns	e

	managers ask how HHCA is	via any device or method of communication
	Managers ask if HHCA has any problems	e
	managers asking has HHCA got enough PPE	e
	managers communicating with HHCAs via email	e
	Managers communicating with HHCAs via letter	e
	managers don't ask HHCA how they are	e
	managers meet up with HHCA to give PPE	e
	managers praise HHCAs	e
	Managers send out survey to see how HHCAs are feeling	e
	managers send weekly email to HHCAs	e
	managers share family feedback with HHCA	e
	managers updating HHCAs	Managers giving HCAs an update
office hours		
office staff		
	office staff are not health care staff	
	office staff not being supported	

office staff working from home	
PPE	personal protective equipment
access to PPE	HHCA's access to PPE
advanced PPE	HHCA mentions advanced PPE- advanced PPE refers to full gowns face shields, FFP2 masks... additional extras to just a mask gloves and apron
aprons	HHCA mentions aprons
changing PPE	HHCA mentions having to change their PPE during a client's call
client asking HHCA to remove PPE	Client asks HHCA to remove PPE during call
Client takes off HHCA's PPE	Client removes HHCA's PPE
client's afraid of PPE	
Clients family not wearing PPE	HHCA says their client's family is not wearing PPE wither when they are in the house or other wise
collecting PPE	HHCA having to collect PPE
Company distributing or delivering PPE	Company distributing PPE to HHCAs
donning and doffing PPE	HHCA donning and doffing PPE
experience of wearing PPE	What is was like for HHCA to wear PPE
heat	wearing PPE gets warm
gloves	HHCA mentions gloves

goggles	Conversation relating to the use of goggles or eyewear as part of PPE
HHCA takes off PPE	
HHCA unclear about PPE guidelines	HHCA expresses confusion about PPE guidelines or uncertainty
Managers reminding HHCAs about PPE	management reminding HHCAs to wear PPE going into houses
mask	HHCA mentions mask
Company stock count masks	company counting mask stock
HHCA moving the mask to speak to the client	HHCA talks about having to move the mask to communicate effectively
Mask impacting communication	
mask communication difficulties increase with foreign nationals	HHCA says communication is altered with mask and language barrier
PPE disposal	
Client has to dispose of the rubbish	Client has to dispose of rubbish caused by PPE
having to leave waste at clients house	HHCA mentions having to leave PPE disposal at the clients house
Hazardous waste	HHCA mentions hazardous waste
PPE has become part of the uniform	HHCA describes PPE as becoming part of their uniform

PPE has not changed how HHCA provides care	self-explanatory
PPE is limited	HHCA recalls limited access to PPE supply
PPE is protecting HHCa	HHCA mentions PPE is protecting them from C-19
PPE shortage	HHCA mentions PPE shortages- struggling to obtain PPE running out of PPE, unable to access adequate supply of PPE
PPE stock balance	HHCa mentions having to keep stock of PPE also mentions HHCA being mindful of the stock balance of PPE
stock counting PPE	HHCA talks about stock counting PPE
types of PPE	types of PPE listed
visor	
Remuneration	
0 hour contract	
gives HHCA power	
income depends on amount worked	
Hazardous pay	
HCAs work for whatever company pays the most	
HHCA low pay	
HHCA not paid for time spent over allocated hours	
HHCA pay	
holiday pay	

HSE staff paid for work expenses	
income reduced	
pension	
no pension	
time off = HHCA down pay	
role progression	
HHCA has progressed within their role in current company	
HHCA wants to progress in their role	
no opportunity for progression as a HCA	
opportunity for progression in HHCA's company	
Safety	
company don't care about HHCA's safety	
dangerous	
HHCA concerned	
HHCA concerned for the safety of their client	
HHCA concerned for their safety	
HHCA is protecting client	
HHCA maintaining client safety	
HHCA reports incident	
no safety at work	
no safety audits following incident	
risk assessments	

HHCA carrying out risk assessments	
safety when we go into the homes	
sense of community among HHCAS	
HHCA is member of community	
HHCA learning from another HHCA	
HHCA learning on the job	
HHCA teaching another HHCA	
HHCAs help each other	
HHCAs supporting each other	
HHCAs work together	
HHCA's team	
meeting other HHCAs	
more than one carer on duty	
Support for HHCA	in general
HHCA needs more guidance	HHCA says they need more guidance
HHCA want's clarification on their role	e
Support for HHCAs	
Additional supports needed	HHCA outlines additional supports needed
HHCA requires more information on the covid-19 virus	explained

	encouragement from managers	as a support system
	HHCA having someone to talk to	as a support method
	HHCAs support network	e
	Home care nurses supporting HHCA	e
	mental health support provided for HHCAs	overview
	24 hour counselling service	HHCA speaks about a 24hr counselling service
	company provided counselling service	HCO provides counselling services for HHCA
	counselling should be offered to HHCAs	HHCA reckons counselling should be provided to HHCAs
	online supports for HHCAs	e
	support for HHCAs essential	e
	Supports separate from work needed for HHCAs	e
	Team leader is HHCAs support contact	Team leader is the HHCAs support contact
Support from families		for HHCA
Support from managers		the support for HHCAs from managers
	24 hr emergency call number for HHCAs to contact management	HHCA has access to above
	Good support from management is...	HHCA outlines what good support from managers is

HHCA having support is good	The influence of support for HHCA
HHCA did not feel supported by management	e
HHCA feels supported by management	e
HHCA not asking office or managers for support	HHCA hadn't rang their office for support
Support from the company	for clients
Supports removed from homecare	during and because of covid
Personal Resources	
building a relationship with the client	HHCA speaks about building a relationship with the client
banter and craic	HHCA speaks about having banter/ crack
Client and HHCA rapport	
Client is like family	
Client trusting HHCA	HHCA talks about client trusting the HHCA
getting to know the client	HHCA talks about getting to know the client
length of time HHCA has been going to client	
Client wants to talk to HHCA	
HHCA becomes emotionally attached to client	
HHCA gets attached to client	
HHCA reassuring client	
older people love building a relationship with HCAs	

HHCA being self sufficient	
HHCA being proactive with clients care	
HHCA looking up information about covid	
HHCA coping mechanisms	
HHCA can't switch off	
HHCA dealing with emotionally challenging situations	
HHCA dealing with exhaustion	
HHCA going for walks	HHCA and client?
HHCA trying to clear their head	
How HHCA copes with Anxiety	
Puts it to the back of their minds	
How HHCAs have been keeping themselves positive	
HHCA looking out for themselves	
HHCA must protect themselves	
HHCA self-advocating	
insurance	
HHCA says we can make a big difference on people's lives	
HHCA self-awareness	
HHCA knowing own strengths	
HHCA knowing own weaknesses	
HHCA Self care	
HHCA reading to switch off	
HHCA switching off	

mindfulness	
meditation	
tai chi classes	
HHCA skill set	
HHCA standing up for themselves	
HHCA raises issues at staff meetings	
HHCAs have unique skill set	
HHCAs need to have patience	
HHCA's skill set is not sufficient	
HHCA's time keeping	
HHCA's age	
HHCA waiting for retirement	
HHCAs views of their age	
HHCA's digital skills	
Older HHCAs not interested in technology	
HHCA's health	
HHCa's illness	
HHCA's physical health	
HHCA not sleeping	
HHCA's body is sore	
HHCA's mental health	
HHCA went to counselling	
mental exhaustion	
life experience of HHCA	
HHCA was unemployed	
Worked as a health care assistant for a long time	

length of time HHCA has been working as a HHCA	
religion	
using humour as coping mechanism	HHCAA using humour to cope
Support for clients	in general
Office staff supporting clients	e
support is essential for client	e
support for client's family	from HHCA
HHCA supporting family	HHCA is a support system for client's family
Technology	
Alexa	
ALONE outreach program	
client comfortable using technology	
client having technology difficulties	
client reluctant to use technology	
client unable to use items of technology	
Client's digital skills	
HHCA supporting client with technology	
pendant alarm for falls	
smart doorbell	
Social media	
Tablets (iPad)	
television	
Using a care app	
using technology to bridge social isolation	

using technology to monitor wellbeing of clients	
video calls	
zoom	
zoom calls communication	
zoom calls social	

Nodes\\Round 2 coding\\Background

Codes within this folder provide a background on the context that HHCAs work in.

age of clients	
change in clients routines as a result of Covid-19	
Clients haven't left their houses	
Clients need to resume their social life	
Client's social outings cancelled	
changes in HHCAs job since covid	Changes to HHCAs job because of covid
changing their clothes	HHCA now changes their clothes for infection control
Client chose to manage on their own during covid	
client isolated	
Client cocooning	
Client is alone	

client isolated from their families	
Clients haven't seen their families	
Client not letting anyone into their homes	
clients don't go out	
clients isolated from their friends	
Clients want to give HHCA a hug	explained
Clients want to shake HHCA's hand	Client wants to shake HHCA's hand as a greeting
elbow	HHCAs now greeting clients with the covid elbow "hand shake"
fist bump	instead of hand shaking
HHCA's job pre covid	HHCA gives account of what their job was like pre covid
How HHCA has dealt with covid change	How HHCA has dealt with changes to their role since covid
New routines	new working routines
pre-covid managers came to the clients house	to do assessments / spot checks
work is hard	HHCA's work is hard as a result of covid-19
Differences in homecare vs residential or hospital	

no time to sit down and talk to patients in hospitals	
other care settings involve working in one place for entire shift	
government	
Changes from government	Government advice or guidelines that has changed the HHCAs job like social distancing etc.
Home care service	
[Home care service is not properly structured]	
HHCAs sent to clients with no briefing	
clients assigned to HHCAs	
community care	
demand for HHCAs	
No shortage of work for HCAs	
older people want to remain living at home	
Role of HHCA is Essential	
Client is dependent on HHCA	If not the HHCA then who?

HHCA is the only person client sees all day	
Description of home care	
home care is more than just a job	
homecare is relaxed	
not rushing in homecare	
Difference between male vs female HHCAs	
HHCA is the only man working in his area	
Different roles within home care services	
home carers	
Home help	
nurse working within HCO	
home care nurses	
HHCA one of the most exposed	

members of the community	
members of the community see HHCAs as an increased exposure risk	
home care is different to residential and nursing homes	
home care profession not recognised	
HHCAs have no voice	
Home care experience not recognised	
HSE vs Private HCO-Home care organisation	
HHCA in private HCO working with HHCA from HSE	
Home care services provided by the HSE	
benefits of working with HSE	

HHCA is sub contracted to HSE via company	
HHCA wanting to work in HSE	
HHCA working for HSE	
Home care should be all carried out by the HSE	
HSE look after their staff	
job requirements HSE	
no governance in home care services	
private informal HHCAs	
side of the road	
type of company HHCA works for	
private home care organisation	
no changes with covid	

How HHCA delivers care is still the same	
Nursing homes or acute services (hospital)	
Client goes into hospital	
client goes into nursing home	
hospitals	
client discharged from hospital	
clients don't want to go to hospital with Covid	
long hours in hospitals or nursing homes	
Nursing homes	
clients don’t want to go into nursing homes	
Nursing homes are very routine based and structured	
previously worked in a nursing home	
reason for not working in nursing home	

Wouldn't go back to working in hospitals	
Previously worked in residential care	

Nodes\\Round 2 coding\\Demands

Something that requires emotional or physical exertion or attention. Check out schaufeli list. DEFN: Job demands are structural, psychological, social or physical aspects of a job that require physical, cognitive and emotional skills to fulfil necessary tasks (Bakker, Demerit, & Eureka, 2005; Demerouti et al., 2001).

Communication break down or falling short	
Delay notifying HHCA of close contact status	close contact of covid-19 positive case
delay with office staff informing HHCAs of clients covid status	office staff slow to communicate info with HHCAs
communication breakdown between HHCA and client	examples of this
communication difficulties	
Communication difficulties between family and office	HHCA gives an account of above
English is not HHCAs first language	language barrier

environmental noises	affecting communication and causing difficulties
hearing difficulties	in relation to communication difficulties
HHCA has to raise voice	to combat communication difficulties
HHCA stands closer to client	to rectify communication difficulties
how HHCA deals with communication difficulties	e
Covid 19	Anything relating to Covid-19
Clients don't want to get covid	
covid 19 is a health concern	HHCA expresses concern for health b/c of c-19
Covid 19 awareness	
Client's awareness of covid	HHCA speaks of the client's awareness of c-19
Family's understanding of covid 19	HHCAs account of the family members understanding of c-19
Covid 19 guidelines	New guidelines implemented during the Covid-19 pandemic
Covid 19 Information	
Covid 19 information is limited	limited info on C-19 available
Covid 19 information over whelming to HHCA	C-19 getting to HHCA

Covid 19 information provided to HHCA	account of information provided to the HHCA
covid 19 MIS-information	
information for client about covid	HHCA having information for client
HHCA having to explain Covid-19 guidelines to client	HHCA has to explain the Covid-19 guidelines/ rules/ restrictions to client
HHCA having to inforce covid-19 guidelines	HHCA has to enforce covid-19 guidelines i.e. reminding family members to maintain social distancing, coughing etiquette
infection control	HHCA mentions infection control in their work
hand hygiene	HHCA mentions hand hygiene
hand washing	
hand sanitiser	HHCA mentions hand sanitiser
HHCA disinfecting environment	
HHCA has to be cleaner in the house	HHCA speaks about having to be cleaner or clean more in the house to reduce infection/ virus transmission
management don't understand infection control	HHCA speaks about management not understanding infection control procedures
Opening window for ventilation	HHCA opens window in clients house for ventilation as an infection control measure
social distancing	the need to keep distance between people
Can't hug	unable to hug because of Covid-19
can't shake hands	unable to shake hands because of the covid-19 virus

Can't sit close to client	HHCA unable to sit close to the client because of covid -19 or infection control measures
Family not carrying out social distancing	Client's family not carrying out social distancing either from client or from HHCA
HHCA has to go closer than 1m to client	HHCA is required to go closer than 1m distance to client because of covid-19 or infection control measures
HHCA sitting at a distance	HHCa having to sit at a distance away from the client because of Covid-19
no social distancing with personal care	HHCA speaks of being unable to keep distance between them and client during personal care
reminding client's to keep distance between them and HHCA	HHCA having to remind client to maintain social distance between them [client] and HHCA
Standing at a distance	HHCA having to keep a distance between them and the client because of Covid-19 or infection control measures
talking from a distance	HHCA having to talk to client from a distance because of covid-19 guidelines
lockdown	HHCA speaks about "lock downs".... when government implemented stay at home orders/ travel radius/ social outings closed
covid 19 hospital wards	HHCA mentions covid-19 in the hospital wards

Covid 19 statistics	
Covid 19 death numbers	HHCA mentions C-19 death numbers
covid 19 infection rate numbers	HHCA mentions C-19 infection rates
covid 19 tests	
client tested positive	HHCA speaks about client testing positive for Covid-19
Office staff or management's response to client testing positive	
HHCA tested for Covid-19	
HHCA tested for Covid-19	HHCA speaks of getting tested for Covid-19
HHCA tested positive	HHCa tested positive for C-19
HHCAs not routinely tested for covid	
negative covid 19 test	
Covid has tested the HHCAs	
essential care only - covid	HHCAs only providing essential care
less time, less exposure	
HHCA working faster	

HHCA conscious of covid 19	
careful	
cautious of covid	HHCA mentions fear of covid
HHCA afraid of giving covid to client	
HHCA coughing	
HHCA touching their face	
precautions	
HHCA has more responsibility no extra time	because of covid or since covid extra responsibility includes extra tasks, PPE
New company protocols	HCO has introduced new policies because of covid
HHCA cannot be in the house when family are there	
when HHCA suspects client may have covid	HHCA speaks about experiences during which they suspected the clients had covid-19
pandemic	HHCA mentions a pandemic
people are sick of Covid	HHCA fed up hearing about C-19
People not believing in Covid	HHCA mentions people not believing in covid
Symptoms	HHCA mentions symptoms of C-19
HHCA monitoring clients for symptoms of covid	explained
HHCA self-monitoring for covid-19 symptoms	

HHCA taking their own temperature	
vaccine	Covid-19 vaccine
HHCA having to travel get the vaccine	HHCA says they had to travel to get their vaccine
Virus transmission	HHCA speaks about transmission of the virus
coming into contact with Covid-19 close contact	HHCA's experience of coming into contact with a covid-19 positive client or case
community transmission	
Covid 19 contact tracing app	HHCA speaks about the Covid-19 app by the HSE
Job demands	
Emotional demands (sch list)	
expected from HHCAs	
expected to get on with it	
put up with it	
Heavy work in hospitals or nursing homes	
HHCA job tasks	HHCA outlines their above
Client Care	
Client Care Plans	
care plan assessments	
care plan not representative of client's needs	

	care plans incorrect	
	Clients require more care than what is outlined to HHCA	
	HHCA only does tasks listed on the care plans	
	HHCA printing care plans	
	manager's assessment does not reflect what's actually required	
	managers do the care plan assessments remotely	
Client refusing care		
	Client wouldn't allow HHCA into the room with her	

Having to persuade clients to allow HHCAs to continue working	
HHCA providing social care	HHCA talks about providing social care i.e. communication, companionship
colouring	HHCA colouring with client
HHCA Having a cup of tea with client	e
HHCA is scheduled time to provide social support	
HHCA trying to keep client upbeat	
Client's mental health and well being	
HHCA trying to boost clients mood	
out for walks	HHCA going for walks with client
HHCA takes client out for a walk	e
HHCA supporting client	HHCA supporting client in general

HHCA supporting client with physio exercises	e
HHCA tasks	HHCA's job tasks
Going to the pharmacy	HHCA going to the pharmacy for the client
HHCA advocating for clients' needs	e
HHCA doing assessments	
light domestic work	light house work
changing bed sheets	HHCA changing client's bed sheets
cleaning	HHCA cleaning
cooking	HHCA cooking client's meals
dishwasher	HHCA using the dishwasher with client
hoovering	HHCA hoovers client's house
shopping	HHCA shopping for client
medication	
prompting client to take mediation	
palliative care	HHCA providing palliative care to client
paper work	HHCA completing paper work
personal care	HHCA supporting client with personal care
assisting client with dressing	explained
cutting clients nails	e

incontinence care	explained
shower client	showering personal care
washing	explained
wound care	HHCA carrying out wound care with client
Support with nutritional intake	HHCA supporting client with above
breakfast	HHCA giving client breakfast
HHCA gives client lunch	e
person centred care	
client only likes specific carers	
continuity of care	
Role of HHCA	
HHCA considering needs of the client	
HHCA role is very diverse	
HHCA sitting with client	
Responsibility felt by HHCA	
HHCAs raise issues with management	
HHCA's concerns not addressed	
HHCAs work environment	any codes that the HHCA talks about the people, place of things within their work environment

going into people's homes	
HHCA dealing with client's family during call	
Client living with family	
client lives with off-spring	
Client's family have moved in with them	
family become defensive	
family members complaining	
it's my house	
visitors to clients home	
HHCA not knowing what they're going into	
HHCAs working between multiple settings	
HHCAs can't work in different	

sections during covid	
Staff levels	
Company took on extra staff	
lone working	
HHCA are on their own	
HHCA is isolated	
HHCAs don't know other people that work in the job	
HHCAs don't meet other colleagues	
staff changeover	
staff shortage	
HHCA off work	
HHCAs work hours	
HHCA's work schedule	e, shift pattern, days on
arranging cover for their shift	HHCA arranging for rather staff member to cover their shift
HHCA covering a team members shifts	explained

other HHCAs have to cover if HHCA is off	alternative staff needed to cover HHCA's shift
Process of arranging cover when HHCA has to self-isolate	explained
breaks	breaks from work
no break	HHCA does not get a break
no lunch break	HHCA does not have a lunch break when working
Changes to HHCAs work schedule	unspecified change
HHCA not notified of roster change	explained
client's allocated hours	Hours client has been allocated in care package
call duration	length of call allocated or time taken to complete the call
time allocated to client not sufficient	care package hours not enough
call time	Time of day call is. or length

contracts	HHCA talks about their contract
don't have the time	HHCAs don’t have the time
HHCA rushing in home care	e
no additional time to put on PPE	amount of time allocated to complete call remains unchanged despite extra task of PPE
flexibility of hours	HHCA mentions flexibility of working as a HHCA
HHCA double booked on calls	HHCA roster asking them to be at 2 calls at once
HHCA is on standby to cover shift	Covering shift for other college
HHCA not wanting to leave clients	at the end of calls
HHCA rostered for hours outside of their stated availability	explained
carers availability	HHCAs stated hours of availability
HHCA's hours increased	as a result of covid HHCA is working more hours
long working hours as a HHCA	either the shifts are long or time from first call to last call is long

12 hour shifts	HHCA working 12 hour shifts, HCAs in hospitals working 12 hour shifts
roster or schedule of working hours	heading code to cover discussions relating to the above
HHCA organises own roster	e
regular clients missing from HHCAs roster	HHCA observed regular clients they have were not included on their roster
Time off	HHCA talks about time off
HHCA afraid to ask for time off	e
HHCA needs time off	HHCA mentions they need time off
HHCA not able to take time off	reasons HHCA may not be able to take days off
HHCA requesting time off	HHCA requesting days off work
HHCAs not taking time off	examples of why HHCA does not take time off or HHCA says they're not taking time off
influence of taking days off	HHCA mentions the above
no one to replace HHCA if they are off	No other staff to cover HHCA's A/L...
no time off	HHCA does not get time off

Hours not guaranteed	
company giving HHCAs hours to other workers	
HHCa may lose their job	
no contract	
there is no one else	
burden	
Tough job	
heavy work in home care	
travelling between calls	
distance to travel to work	
mode of transport	
car	
taxi	
walking from call to call	
no pay for travelling between calls	
no travel time	
stuck in traffic	
travel time between calls	
Types of clients HHCA works with	
challenging behaviour	
Challenging behaviour training	

Dying Client	
Client died	
HHCA had to do CPR	
HHCA dealing with loneliness in clients	
using technology to improve loneliness in clients	
working with vulnerable people	
bed bound clients	
Client has underlying health conditions	
clients have long term illnesses	
clients with brain tumours	
dementia	
Alzheimer's society have sent out packs	
clients with dementia	
immuno-compromised	
neuro degenerative diseases	

Older client	
safeguarding	
stroke patient	
working expenses	
fuel	
HHCA claiming work expenses	
HHCA buying own hand sanitiser	
HHCA is paid for fuel costs	
HHCA would like contribution towards working expenses	
uniform expenses	
wear and tear of car	
workload	
Work over load	
making conversation with client became hard	because of covid
Personal Demands	
HHCA's family	
Childcare	
HHCA don't get to see their family	
HHCA has vulnerable family members	
HHCA's children	
single parent	
Homework conflict (schaufeli list)	

HHCA's job affected their home life	
leaving everything at the door	
leave it at the door	

Nodes\\Round 2 coding\\Emotions or feelings

Anywhere an emotion is expressed by the HHCA. May be the HHCA's emotions or them discussing the client's emotions.

Client's emotions or feelings	
Client's emotions (negative)	
client becomes distressed	
Client is afraid	
client panicked	
Client was anxious	
Clients becoming stressed	
Clients get annoyed	
depression in Clients	
fear in clients	
gets upsetting for client	

Client's emotions (positive)	
clients happy to see HHCA	
HHCA feelings or emotions	
HHCA emotions (negative)	
afraid	
Annoys HHCA	
Anxiety	
burnout	
HHCA confused	
HHCA emotional	
HHCA felt like they couldn't go to work	
HHCA felt tired	
HHCA fed up	
HHCA Feeling drained	
HHCA has no energy	

HHCA has no motivation	
HHCA worn out	
HHCA felt uncomfortable	
HHCA frustrated	
HHCA hypersensitive emotionally	
HHCA worried	
HHCA worried about clients family in the home	
I can't function	
nervous	
panic	
physical exhaustion	
HHCA finding it tough to deal with changes from covid	within their job
HHCA's emotions (positive)	
HHCA's feelings (negative)	

HHCA feels sad for the client	
HHCA not wanting to get up	
You have to get up and go for the clients	
HHCA's feelings positive	
HHCA feeling more relaxed	
HHCA is proud of themselves	
HHCA passionate	

Nodes\\Round 2 coding\\Negative

HHCA speaks about something negatively

Negative	
Absence of job resources	
HHCA requires additional resources	
client requires more nursing support	

HHCA requires additional supports	
Office to provide more information to clients	
Changes observed in client	
changes in client's needs	
Changes in client's presentation	
client has regressed	
client feels like they've done something wrong	
clients are struggling	
Client's fear of covid	
Clients don't want to go to their doctor because of fear of getting covid	
Clients feeling like their home is dirty	
HHCA speaks negatively	
company only cares about the money	
HHCA not appreciated	
HHCA not considered	

HHCA not respected	
HHCA not valued	
HHCA treated like a number	
HHCA un happy	
HHCA under strain	
Negative experience of working as a HHCA	
HHCA gets no thanks	
injured at work	
no praise	
problems at work	
negative experience with management	
guilt tripping or blame game	
company using the good of carers	
HHCA getting blamed	
HHCA made feel bad	
Management do not appreciate HHCA	

management or office staff don’t care	
management telling HHCA to sort it out themselves	
no compassion from managers	
only time HHCA's boss knows what they do is when there is a complaint made against HHCA	
negative experience with office staff	
office staff asking HHCA to do tasks they know are unattainable	
Office staff constantly phoning HHCA	
Office staff don't know	
Office staff don't know all that HHCA do	

office staff don't know the clients	
office staff getting covid-19 information from the news	
office staff not accommodating	
office staff not taking responsibility	
Office staff not trained to give training to HHCAs	
office staff slow to know Covid-19 information - guidelines	
Office staff under pressure	
Private company on back foot or behind	
managers reluctant to do home visits	HHCA's manager is reluctant to do home visits for assessments / check-ups now during covid
Training insufficient	HHCA says training is insufficient for them
HHCAs still don't understand after training	HHCA says they still don't understand the topic even after training

Previous training not sufficient	for HHCA
unfair towards HHCA	rushing at call unfair on HHCA

Nodes\\Round 2 coding\\Outcomes

Negative Outcomes	
Exhaustion (sch list)	
compassion fatigue	
employer disregarding HHCAs symptoms of CF	
fatigue	
HHCA awareness of CF	
How CF affects HHCAs	
Response to - And before Covid, would compassion fatigue have even been considered by yourself	
symptoms of compassion fatigue CF	

compassion fatigue	
fake smile	
HHCA can't relax during time off	
HHCA car crash whilst at work	
HHCA doesn't want to leave their house	
HHCA feels left out	
HHCA forgets to care for themselves	
HHCA not wanting to go to work	
HHCA putting company needs above their own	
HHCA says I can't do it anymore	
HHCA's intended absenteeism	
HHCA's work has been traumatic	
reluctance to return working as a HCA	
stress	
coping with stress	
HHCA job is stressful	

How HHCA job is stressful	
Stress levels have increased during the pandemic	
stress of job causes HHCA to be sick	
HHCA is not completing role to the standard expected	
HHCA left previous home care agency	
HHCA comparing previous and current agencies	
previous agency not organised	
HHCA reason for changing care organisation	
HHCA Sick	
client's response to HHCA being out sick	
HHCA covering shift for colleague that is off sick	
HHCA out sick	

no sick pay	
HHCA phoning in sick	
Manager or office reaction to HHCA phoning in sick	
why HHCA doesn't phone in sick	
HHCA stopped bothering	
Turn over intention (Sch list)	HHCA expresses intent to leave their current job
HHCA does not see themselves staying in home care	
Do not see themselves staying in their current role	
HHCA having to leave the job	
leaving home care	
HHCA Not wanting to continue with current company	
HHCA threatening to leave	

Positive Outcomes	
HHCA intends to stay working in home care	
HHCA just about staying in homecare	
HHCA stays working because of the clients	
See themselves staying in homecare	
What keeps HHCA working in home care	
HHCA trusting company	
Work Engagement	
Going above and beyond	
HHCA doing more than what's expected of them	
doing more than what's asked	
HHCA spending more time than they should	
HHCAs stop going	

the extra mile	
HHCA doing something they're not supposed to	
HHCA has to prioritise who gets what amount of time	
HHCA unable to follow the rules in homecare - job doesn't allow	
HHCA volunteered	
staying for longer than time allotted	
Job satisfaction	HHCA speaks about being satisfied in their job
Enjoying the job as a career-general	
HHCA feels appreciated	

HHCA feels respected	
HHCA not satisfied in job	
If HHCA is down, they don't complete their job as well	
role not fulfilling HHCA	
HHCAs need to enjoy what they do	
ideal company for HHCA to feel valued	
Positive experience of working as HHCA	
enjoying the job as a HHCA	
HHCA happy	
HHCA likes helping people	

HHCA likes the job	
HHCA likes the work	
HHCA likes their clients	
job is rewarding	
love the job	
reason for moving to home care	
When HHCA is in good mindset, they work better	
This job is not about the money	
work life balance as a HHCA	
HHCA wanting to cut down hours	
Suits HHCA's holidays	

Nodes\\Round 2 coding\\Positive

HHCA speaks about something positively

current company HHCA works for is good	
nice company to work for	
positive experience with management	HHCA has had above
HHCA can phone management with concerns	e
HHCA feels linked in with management	linked/ connected
Management are understanding	HHCA say
management checking up on HHCA	e
management offering support to HHCAs	e
management offering to talk to HHCAs	e
management regularly phone HHCAs	e
management taking careers into consideration	HHCA say

managers consider HHCA's needs	
Private company-look after their staff	
What I like about home care	
meeting people	
spending time with people	

Nodes\\Round 2 coding\\Resources

Skills, experiences or physical items used to assist HHCA to achieve job tasks or external requirement DEFN: Job resources r ever t o s structural, p psychological, social or physical aspects of a work environment.

Access to resources in nursing homes or hospitals	
access to resources	
Communication	
Communication - HHCA with....	
communication between HHCA and client	
Client lip reading	Client lip reading during communication with HHCa
Clients can understand HHCA	Client can understand HHCA when communicating
Clients can't hear HHCA	explained
Clients can't understand HHCA	explained

HHCA phoning Client to check up	HHCA phoning client to check in on their wellbeing
linking in with client	HHCA keeping up communication with client,
talking to client	HHCA talking to client
communication between HHCA and office	
communication between office staff and HHCA is poor	explained
company slow to give information to HHCAs	When communicating with HHCAs, office staff are too slow/ not forthcoming with info
HHCA communicating with client's family	HHCA communicating with the client's family
Communication with HHCA and family reduced during covid	explained
getting to know the families	HHCA getting to know the client's family
HHCA liaising with family	HHCA liaises with client's family
linking in with family	HHCA communicating with client's family
HHCA interacting with colleagues	
group chat	HHCA's using group chats to communicate with each other
WhatsApp	HHCA using Wats app to communicate with each other
HHCAs communicate with each other	explained

linking in with colleagues	HHCA staying in contact with their employees
Communication- client with....	
client communicating with family	client communicating with their own family
Communication- Client's family	heading
Not communicating effectively with HHCA or office	Client's family do not communicate effectively with office or HHCA
communication is essential	HHCA outlines necessity for communication
eye contact	Eye contact in relation to communication
facial expressions	in relation to communication
HHCA supporting client to communicate with family members	Explained. May be because of self-isolation or cocooning during covid
phone calls	Communicating with client's family via phone call
text message	HHCAs use text messages to communicate with each other
contact the office	
for clarity	
HHCA does not want any additional information or resources	
Job Resources	
befriending service from ALONE	
Communication Managers or Office staff with...	
Company organise fun tasks	

Company was prepared	
control	
HHCA has control over job	
HHCA avoids working with hoists	
HHCA chooses clients	
HHCA choses hours	
HHCA has choice in their role	
lack of autonomy in HHCA's role	
HHCA feels like they have no choice	
HHCA not allowed to or restricted or limited	
HHCAs in the community do not have the same autonomy as HCAs in residential	
lack of control in HHCAs environment or work	
lack of control	
other home care staff not allowed or limited or restricted	
Education	

course completion requirements of HHCA	
education or information from government	
HHCA wants to do further learning	
training	Training for HHCA
company funding additional training	HCOS funding additional training for HHCA
dementia training	HHCA mentions above
face to face training	in person face to face training
Have not received additional training to support older people during covid	e
HHCA does not want additional training	e
HHCA not paid for training	explained
HHCA says they need training	explained
HHCAs are not trained in palliative care	HHCA says above
in-house training	HHCA receives above
manual handling	manual handling training course
mental health courses for HHCAs	
accessible mental health	

	support for HHCAs	
	No additional time for training	HHCA training hours not included in their weekly working hours
	online training courses	e
	previous training WAS sufficient	Previous training HHCA received was sufficient
	Safeguarding training	HHCA discusses above
	team leader training	HHCA speaks about team leader training
	training for clients	HHCA suggests the need for training for clients
	training for HHCA to support client with technology	HHCA gets training on how to support client with technology
	training for team leaders	participant mentions training for team leaders
	how to support HHCAs during covid	team leaders got training on how to support HHCAs during covid
	training office staff have received	HHCA discusses the training office staff have received
	Training specifically to support older people	HHCA mentions training as above
	training stopped during covid	training courses for HHCAs stopped during covid
	training to uplift carers needed	HHCA says above
equipment		

equipment not suited to client's needs	
HHCAs don't know how to use the equipment	
hoist	
hospital bed	
wheelchairs	
Feedback	
appreciation for HHCA	
appreciation for HHCA	
Bonus from company	HHCA speaks about receiving bonus from their company
gift card from company	HHCA speaks about receiving gift card from the company
HHCA worth	
Management do not appreciate HHCA	HHCA does not feel appreciated.....upon review this code covers a lot of "management don't care"
management or office staff don't care	
managers appreciate HHCA	
Bonus from company	HHCA speaks about receiving bonus from their company
gift card from company	HHCA speaks about receiving gift card from the company
HHCA worth	

Management do not appreciate HHCA	HHCA does not feel appreciated.....upon review this code covers a lot of "management don't care"
management or office staff don't care	
managers appreciate HHCA	
Appreciation for HHCA through client or clients family	
Clients look forward to seeing HHCA coming	
HHCA gets praise from client's family	
Client to Management	
clients feedback to management about service	
HHCA is recognised for hard work	
management to HHCA	
Managers give HHCAs feedback	
Praise goes a long way	
praise makes HHCAs feel good	
HHCA communicating with client's family	

How management communicate with Family	
managers communicating with family email	e
managers communicating with family letter	e- client's family
letter	managers communicate with families via letter
managers communicating with family phone	e
managers method of communication with family	client's family
managers communicating with family general	
managers communicating with families about covid-19	e
managers sent guidance on relative quarantining after foreign travel	e
Managers updating the family	methods & contents & frequency
HHCA communicating with clients	

How managers communicate with client	e
HSE HHCA pay	
HSE HHCAs have paid time between calls	
Job security	
Nursing homes and residential jobs are more secure	
MDT	
HHCA interacting with MDT	
HHCA needs more support from members of the MDT	
MDT not going into houses	
MDT staff levels reduced during Covid 19 pandemic	
multi-disciplinary team MDT	
palliative care services	
palliative care nurse	
public health nurses	
Office or management	
company office	
HHCA going into the office	
management	anything relating to management

HHCA tells managers or office staff about what they do	
information provided to HHCA from management	
Management monitoring staff for Covid symptoms	
managers coming to clients house	
managers don't come to the house as often because of covid	
team leader or supervisor	
rapport between team leader and HHCA	
supervisor is good	
team leader can advocate from experience on behalf of HHCAs to management	
team leader duties	
team leader treating staff well	

Managers communicating with HHCAs general	
how management communicate Covid-19 exposure risk with HHCAs	methods of communication
Management using text messages to communicate with HHCA	e
managers ask has HHCA got any concerns	e
managers ask how HHCA is	via any device or method of communication
Managers ask if HHCA has any problems	e
managers asking has HHCA got enough PPE	e
managers communicating with HHCAs via email	e
Managers communicating with HHCAs via letter	e
managers don't ask HHCA how they are	e

managers meet up with HHCA to give PPE	e
managers praise HHCAs	e
Managers send out survey to see how HHCAs are feeling	e
managers send weekly email to HHCAs	e
managers share family feedback with HHCA	e
managers updating HHCAs	Managers giving HCAs an update
office hours	
office staff	
office staff are not health care staff	
office staff not being supported	
office staff working from home	
PPE	personal protective equipment
access to PPE	HHCA's access to PPE
advanced PPE	HHCA mentions advanced PPE- advanced PPE refers to full gowns face shields, FFP2 masks... additional extras to just a mask gloves and apron
aprons	HHCA mentions aprons

changing PPE	HHCA mentions having to change their PPE during a client's call
client asking HHCA to remove PPE	Client asks HHCA to remove PPE during call
Client takes off HHCA's PPE	Client removes HHCA's PPE
client's afraid of PPE	
Clients family not wearing PPE	HHCA says their client's family is not wearing PPE wither when they are in the house or other wise
collecting PPE	HHCA having to collect PPE
Company distributing or delivering PPE	Company distributing PPE to HHCAs
donning and doffing PPE	HHCA donning and doffing PPE
experience of wearing PPE	What is was like for HHCA to wear PPE
heat	wearing PPE gets warm
gloves	HHCA mentions gloves
goggles	Conversation relating to the use of goggles or eyewear as part of PPE
HHCA takes off PPE	
HHCA unclear about PPE guidelines	HHCA expresses confusion about PPE guidelines or uncertainty
Managers reminding HHCAs about PPE	management reminding HHCAs to wear PPE going into houses
mask	HHCA mentions mask
Company stock count masks	company counting mask stock
HHCA moving the mask to speak to the client	HHCA talks about having to move the mask to communicate effectively

Mask impacting communication	
mask communication difficulties increase with foreign nationals	HHCA says communication is altered with mask and language barrier
PPE disposal	
Client has to dispose of the rubbish	Client has to dispose of rubbish caused by PPE
having to leave waste at clients house	HHCA mentions having to leave PPE disposal at the clients house
Hazardous waste	HHCA mentions hazardous waste
PPE has become part of the uniform	HHCA describes PPE as becoming part of their uniform
PPE has not changed how HHCA provides care	self-explanatory
PPE is limited	HHCA recalls limited access to PPE supply
PPE is protecting HHCa	HHCA mentions PPE is protecting them from C-19
PPE shortage	HHCA mentions PPE shortages- struggling to obtain PPE running out of PPE, unable to access adequate supply of PPE
PPE stock balance	HHCa mentions having to keep stock of PPE also mentions HHCA being mindful of the stock balance of PPE
stock counting PPE	HHCA talks about stock counting PPE
types of PPE	types of PPE listed
visor	

Remuneration	
0 hour contract	
gives HHCA power	
income depends on amount worked	
Hazardous pay	
HCAs work for whatever company pays the most	
HHCA low pay	
HHCA not paid for time spent over allocated hours	
HHCA pay	
holiday pay	
HSE staff paid for work expenses	
income reduced	
pension	
no pension	
time off = HHCA down pay	
role progression	
HHCA has progressed within their role in current company	
HHCA wants to progress in their role	
no opportunity for progression as a HCA	

opportunity for progression in HHCA's company	
Safety	
company don't care about HHCA's safety	
dangerous	
HHCA concerned	
HHCA concerned for the safety of their client	
HHCA concerned for their safety	
HHCA is protecting client	
HHCA maintaining client safety	
HHCA reports incident	
no safety at work	
no safety audits following incident	
risk assessments	
HHCA carrying out risk assessments	
safety when we go into the homes	
sense of community among HHCAS	
HHCA is member of community	
HHCA learning from another HHCA	

HHCA learning on the job	
HHCA teaching another HHCA	
HHCAs help each other	
HHCAs supporting each other	
HHCAs work together	
HHCA's team	
meeting other HHCAs	
more than one carer on duty	
Support for HHCA	in general
HHCA needs more guidance	HHCA says they need more guidance
HHCA want's clarification on their role	e
Support for HHCAs	
Additional supports needed	HHCA outlines additional supports needed
HHCA requires more information on the covid-19 virus	explained
encouragement from managers	as a support system
HHCA having someone to talk to	as a support method
HHCAs support network	e

Home care nurses supporting HHCA	e
mental health support provided for HHCAs	overview
24 hour counselling service	HHCA speaks about a 24hr counselling service
company provided counselling service	HCO provides counselling services for HHCA
counselling should be offered to HHCAs	HHCA reckons counselling should be provided to HHCAs
online supports for HHCAs	e
support for HHCAs essential	e
Supports separate from work needed for HHCAs	e
Team leader is HHCAs support contact	Team leader is the HHCAs support contact
Support from families	for HHCA
Support from managers	the support for HHCAs from managers
24 hr emergency call number for HHCAs to contact management	HHCA has access to above
Good support from management is...	HHCA outlines what good support from managers is

HHCA having support is good	The influence of support for HHCA
HHCA did not feel supported by management	e
HHCA feels supported by management	e
HHCA not asking office or managers for support	HHCA hadn't rang their office for support
Support from the company	for clients
Supports removed from homecare	during and because of covid
Personal Resources	
building a relationship with the client	HHCA speaks about building a relationship with the client
banter and craic	HHCA speaks about having banter/ crack
Client and HHCA rapport	
Client is like family	
Client trusting HHCA	HHCA talks about client trusting the HHCA
getting to know the client	HHCA talks about getting to know the client
length of time HHCA has been going to client	
Client wants to talk to HHCA	

HHCA becomes emotionally attached to client	
HHCA gets attached to client	
HHCA reassuring client	
older people love building a relationship with HCAs	
HHCA being self sufficient	
HHCA being proactive with clients care	
HHCA looking up information about covid	
HHCA coping mechanisms	
HHCA can't switch off	
HHCA dealing with emotionally challenging situations	
HHCA dealing with exhaustion	
HHCA going for walks	HHCA and client?
HHCA trying to clear their head	
How HHCA copes with Anxiety	
Puts it to the back of their minds	
How HHCAs have been keeping themselves positive	

HHCA looking out for themselves	
HHCA must protect themselves	
HHCA self-advocating	
insurance	
HHCA says we can make a big difference on people's lives	
HHCA self-awareness	
HHCA knowing own strengths	
HHCA knowing own weaknesses	
HHCA Self care	
HHCA reading to switch off	
HHCA switching off	
mindfulness	
meditation	
tai chi classes	
HHCA skill set	
HHCA standing up for themselves	
HHCA raises issues at staff meetings	
HHCAs have unique skill set	
HHCAs need to have patience	

HHCA's skill set is not sufficient	
HHCA's time keeping	
HHCA's age	
HHCA waiting for retirement	
HHCAs views of their age	
HHCA's digital skills	
Older HHCAs not interested in technology	
HHCA's health	
HHCa's illness	
HHCA's physical health	
HHCA not sleeping	
HHCA's body is sore	
HHCA's mental health	
HHCA went to counselling	
mental exhaustion	
life experience of HHCA	
HHCA was unemployed	
Worked as a health care assistant for a long time	
length of time HHCA has been working as a HHCA	
religion	
using humour as coping mechanism	HHCAA using humour to cope
Support for clients	in general
Office staff supporting clients	e
support is essential for client	e

support for client's family	from HHCA
HHCA supporting family	HHCA is a support system for client's family
Technology	
Alexa	
ALONE outreach program	
client comfortable using technology	
client having technology difficulties	
client reluctant to use technology	
client unable to use items of technology	
Client's digital skills	
HHCA supporting client with technology	
pendant alarm for falls	
smart doorbell	
Social media	
Tablets (iPad)	
television	
Using a care app	
using technology to bridge social isolation	
using technology to monitor wellbeing of clients	
video calls	
zoom	
zoom calls communication	

zoom calls social	

Appendix J- Ethics Approval Letter

DKIT
An Scoil Sláinte & Eolaíochta
School of Health and Science

9th July 2020

Ms. Aoibheann McKeown,
NetwellCASALA Research Centre,
School of Health and Science,
Dundalk Institute of Technology,
Dundalk,
Co. Louth

Re: The resource needs of health care assistants working with community dwelling, older people during the global COVID-19 pandemic.

Dear Aoibheann,

The School Ethics Committee reviewed the above study at its meeting dated 9th June 2020. I acknowledge receipt of amendments which you sent dated 25th June and the 9th July 2020. This application is now approved.

Wishing you the best of luck in your Research.

Yours Sincerely,

Dr.Edel Healy
Chair of School of Health & Science Ethics Committee
cc. Ms Suzanne Smith, Netwell CASALA & Dr. Kevin McKenna, Department NMEY

Appendix K – Data Protection risk assessment

Processing Risks - Table

Describe the source of risk and nature of potential impact on individuals. Include associated Compliance and Corporate risks as necessary.

Risk detail	Risk rating (High, medium, low)	Solutions/Mitigating Actions	Effect	Outcome	Measure approved
Hacking into computers where project data is stored.	Low	All computers storing data are password protected. The external hard drive and remotely accessible computer are also encrypted and locked in an office (on DKIT campus). Access is restricted to designated staff only.	Reduced	*Low*	*Yes/No*
Hardcopy data accessed by unintended parties	Low	All hardcopy data will be stored in a locked press within a locked office on the DKIT campus grounds. Only the researcher and supervisor shall have access to the contents of the press.	Reduced	Low	
Data being accessible from an unlocked computer.	Low	All computers are locked with password-protect before the researcher leaves them unattended. Automatic setting also implemented where researcher's laptop self-locks if it remains idle for a set period.	Reduced	Low	

Emails containing personal data of participants are not encrypted	Low	All documents sent via email will be password protected. The password to unlock these documents will never be sent in the same email as the documents.	Reduced	Low	
Emails containing sensitive data of the participant's being sent to the wrong person	Low	All recipients of emails will be checked before sending. Emails containing sensitive information will only be sent when necessary and files will be password protected.	*Reduced*	*Low*	
Data provided by the participant will not remain confidential	Low	Information provided by the participant will only be discussed with researcher and supervisor and at this stage; participants will have been provided a code via a prearranged key. Reducing the likelihood of confidentiality breech occurring.	Reduced	Low	

Appendix L - Resource needs identified by participants:

Employment resources	Task completion resources	Employee support resources
• Clarification surrounding care plans, tasks boundaries • Task descriptors i.e. extent of tasks to be completed. • More regulated and guaranteed working hours • Pay stability • Addition of job benefits such as maternity or sick leave when working with agency HCOs • Opportunities for career advancement	• Training needs • Real time access to managers or supervisors Time allocation flexibility	• The need for additional mental health and mindfulness supports for HHCAS • Formal or monitored opportunities for group chats to be used among participants to facilitate this colleague interaction and guidance opportunities. • Ability to make a difference in their client's lives • Ability to make a difference in the lives of their client's family •