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Exploring the Impact of COVID-19 on Home Care Workers: A Qualitative Study

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Abstract

This qualitative study aimed to gain insight into the impact of COVID-19 on Home Care Workers (HCWs). During COVID-19 HCWs provided a lifeline for home care clients to support older people remaining living in their own homes. With a high-risk client base, HCWs were one of the few (Health and Social Care Professional) HSCPs to continue providing home-based care throughout COVID-19. Despite these contributions HCWs provided for aging in place during COVID-19, a paucity of research exists in relation to the challenges and impact of the pandemic on HCWs. Three in-person focus groups were conducted ($n = 23$). Two main themes were produced guided by a Reflexive Thematic Analysis approach to enable the researchers to best represent the participants experiences: Challenges and concerns to the personal and private lives of HCWs and Navigating home-based complexities of HCWs workplace during COVID-19. health care challenges to minimize impact to HCWs issues to create a safe workplace for HCWs.

Keywords

health services research, labor force, qualitative research, aging

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What This Paper Adds

- HCWs provide care to a high-risk client base and were one of the few HSCPs to continue providing home-based care throughout COVID-19.
- Despite these contributions HCWs provided for aging in place during COVID-19, a paucity of research exists in relation to the challenges and impact of the pandemic on HCWs.
- Results indicate the need for clearer guidance from practice and policy levels on managing complex domiciliary health care challenges to minimize impact to HCWs issues to create a safe workplace for HCWs.

Applications of Study Findings

- HCWs faced significant challenges and concerns encompassing their personal and private lives during COVID-19.
- The domiciliary nature of HCWs presents a unique set of challenges to navigate.
- Greater recognition is warranted for HCWs need to be implemented to support this group continued to support older people to live at home.

Introduction

Reflecting health policy orientation toward supporting a growing older population toward aging in place, Home Care Workers (HCW) play a key role in supporting older people to live in their own homes, yet their contribution to such aging in place is often overlooked (Pani-Harreman et al., 2021). While COVID-19 saw significant disruptions and reduced capacity across broader health systems, HCWs were one of the few healthcare groups to continue to provide support in the homes of older people. The profile of home care clients added an additional layer of complexity to the HCW sector during COVID-19; frail older people with co-morbidities of care placed this client group at high risk of contracting COVID-19 and becoming unwell or dying as a result (Steinman et al., 2020).

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HCWs Quality of Life pre-COVID-19

Pre-pandemic, the HCW sector faced challenges relating to poor recruitment, retention, low pay, and poor morale (Manthorpe et al., 2022) with the pandemic exacerbating these difficulties. Having been defined as an under-supported, undervalued and undertrained, faced with emotional and practical challenges (Leverton et al., 2021), HCWs pre-Covid-19 were facing challenges relating to poor recruitment, retention, low pay and low morale.

The HCW work profile was undefined prior to the pandemic, with gaps in areas such as training and education of this workforce which impacted HCWs safeguarding and career expansion (Gazzaroli et al., 2020). Largely comprised of HCWs from the female workforce in receipt of lower salaries when compared to other HSCPs with similar roles and responsibilities (Şahin & Kulakaç, 2022), financial security and career progression opportunities are limited within the sector, with recruitment and retention posing ongoing challenges. Additional challenges with the HCW role include difficult working conditions, with HCWs under time constraints due to management, funding and staff issues, resulting in increased stress, low sense of well-being and overall dissatisfaction with their role (Ruotsalainen et al., 2020).

HCWs Quality of Life Post-COVID-19

The workload of HCWs saw significant change during COVID-19, shifting from managing increased client cases to a sudden reduction in their workload due to staff illness and isolation adherence, as well as changing client preferences due to COVID-19 client concerns during the first wave where some clients declined HCWs duties due to COVID-19 transmission concerns. Within this fluctuating workload, HCWs experienced a greater need to provide emotional support for their clients when they were so isolated from others, particularly for clients who had experienced a bereavement during the pandemic (Ness et al., 2021), often providing the main source of social contact for clients (Alnazly et al., 2021; Xu et al., 2023). Navigating HCW tasks was made more challenging with the use of PPE creating communication difficulties, particularly for clients with hearing and cognitive impairments (Moreland et al., 2021).

A paucity of research exists that explores the impact of COVID-19 from the perspective of HCWs. Existing research focuses predominantly on the experiences of health and social care professionals (HSCP) in the acute setting (Alnazly et al., 2021; Emmesjö et al., 2022; Rücker et al., 2021; Urooj et al., 2020). Limited existing home care research has primary been conducted with nursing professionals as opposed to HCWs (Şahin & Kulakaç, 2022; Shoja et al., 2020). HSCPs experiences during COVID-19 in the acute setting as opposed to the domiciliary nature of HCWs in itself presents a unique set of challenges. Existing research which has included HCWs' perspective on working through COVID-19 restrictions is limited to three key studies conducted in the US (Sterling et al., 2020), Italy (Simeone et al., 2022) and more recently in the UK (Nyashanu et al., 2022). The research gap is clear, signaling a greater need for consideration and incorporation from HCWs to inform practice.

Research conducted with HSCPs working in acute and primary health settings showed the emotional and mental health impact of COVID-19, with HSCPs experiencing increased anxiety, anger, and loneliness (Greenberg et al., 2020; Lai et al., 2020; Sahin et al., 2022; Shoja et al., 2020; Xiang et al., 2020). An increased responsibility to respond to complex client needs during the pandemic, necessitating a high level of emotional support and reassurance for clients, created enhanced emotional demands for HCWs (Arble et al., 2021). Despite the contributions and challenges faced by HCWs during COVID-19 working at the frontline throughout the pandemic, HCWs expressed feeling a lack of government recognition and felt undervalued (D'Astous et al., 2019; Grasmo et al., 2021; Manthorpe et al., 2022). Given the historic challenges faced by this sector, and in addition to the pressure faced during COVID-19, it is important explore, acknowledge, and understand the impact of COVID-19 challenges to support this key group in delivering care to older people in an environment that is supportive, responsive, and safe as well as improve the conditions and retention of this vital workforce.

Materials and Methods

This explorative qualitative approach comprised of focus group with data analyzed using Reflexive Thematic Analysis (RFA). RFA was best suited to this study given it is an easily accessible and theoretically flexible interpretative approach to qualitative data analysis which enables the identification and analysis of patterns or themes (Braun & Clarke, 2012).

Recruitment

Participants were recruited through a gatekeeper who was involved in the provision of home care services in Ireland and had access to mailing lists for all registered HCWs in a home care service. A purposive sampling approach was utilized, whereby the research team developed inclusion and exclusion criteria, which was adhered to by the gatekeeper.

The following inclusion criteria were applied: (A) Adults aged ≥18 years; (B) HCW willingness to provide informed consent; (C) HCW working with older adults ≥65 years. Potential participants were excluded if they:

(A) HCW exclusively working with younger populations (<65 years); (B) Limited English language proficiency to participate in the focus groups.

An expression of interest invitation was shared to all HCWs on the gatekeeper HCW mailing list—all current registered HCWs, with information on the study. Interested individuals contacted the research team where an overview of the research was provided. HCWs interested in taking part were sent a study information sheet and consent form in advance of the focus group. Participants had the opportunity to seek further information from the research team on the study.

Data Collection

Three focus groups were conducted, with a total of 23 HCWs taking part (group 1 = 6, group 2 = 7, group 3 = 10). Focus groups were held in person, located in premises used by the service provider for staff training. Each focus group was held in different geographic locations in the Mid-West of Ireland to capture perspectives across a broad geographic area of HCWs. Two focus groups were held in suburban areas while one focus group was held in a rural area in order to provide a broader range of participation areas for HCWs across different geographic areas to elicit elements specific to each area pertaining to access, transport, and geographic specific insights. Offering focus groups in three different areas also was chosen to make participation in the research process easier for participants. Demographically, characteristics of HCWs included all female Irish participants providing home care to older adults. The research team had no prior awareness or existing relationships with participants.

The question guide for the focus groups was developed using Krueger's (1997) framework to model question composition. The guide was piloted prior to use, with revisions made to provide greater clarity to questions and a more open flow to group discussions. The guide explored the impact of COVID-19 for HCWs.

Two female members of the research team CF & EM facilitated the group discussions and EM moderated the group discussions. CF and EM have experience conducting qualitative research. CF has previous experience as a Registered Nurse. [EM] is a Physiotherapist. All participants provided informed written consent at the start of each group. Each focus group lasted approximately 60 min. The same question schedule was used in all three of the focus groups. The participants did not see the questions prior to the focus groups to eliminate the risk of predetermined responses. All focus groups were digitally audio recorded and transcribed by EM. Participants were not paid to take part in the Focus Groups by the research team, however the service provider supported HCWs to attend Focus Groups by holding these during working hours, which meant that participants were not financially impacted during their participation in data collection.

Ethical Approval

This study received Ethical approval from the Faculty of Education and Health Sciences Ethics Committee at the University of Limerick. Consideration was given throughout the study to ethical concerns including participant anonymity and confidentially. Participants consented to the recording of focus groups, which were stored securely on the researchers' password-protected computer and filed to maintain participant anonymity.

Data Analysis

Given the reflexive nature of RFA whereby the researcher has an active role in knowledge production (Braun & Clarke, 2019), each focus group was transcribed [EM] and reviewed by members of the research team (CF and RG). A reflexive thematic analysis approach was utilized (Braun & Clarke, 2021), following the six steps of thematic analysis framework (Braun & Clarke, 2006). One research team member [CF] undertook data analysis which was supported with NVivo 12 software to assist in data management. An inductive approach of coding as outlined by Braun and Clarke was followed to develop themes (Braun & Clarke, 2021). Two members of the research team ([CF] and [EM]) had regular scheduled meetings throughout the data analysis phase to adhere to ensure consistency in both the coding process and the development of preliminary themes. Authors ([CL], [CON], [PB], [KR] and [PM]) provided input to defining and naming themes. SRQR standardized reporting guidelines were adhered to standardize conducting and reporting of the research (O'Brien et al., 2014).

Results

Two main themes were produced: (1) Challenges and concerns to the personal and private lives of HCWs (Emotional Impact, Impact on own family, Financial Impact) and (2) Navigating home-based complexities of HCWs workplace during COVID-19.

Theme 1: Challenges and Concerns to the Personal and Private Lives of HCWs

Emotional Impact. Participants discussed how COVID-19 had both a professional and personal impact, highlighting how the challenges, stress and risk associated with their role as a HCW had significant cross over on their personal life. Participants spoke openly about the impact that fulfilling their role as a HCW had on their mental health, with many talking about a sense of loneliness they felt from a lack of support from the broader health system due to curtailment and reduction of services, as well as reduced contact with colleagues:

"I think sometimes mentally you're going I can't do this anymore its mental and the emotional aspect too" (G1, P3).

A sense of responsibility and guilt toward continuing to provide care to clients during COVID-19 was evident across the groups. This duty of care for their clients appeared to take precedence above their personal wellbeing:

"Even if you weren't feeling great on a certain day you had to put a smile on your face and go in and do what you had to do" (G2, P5).

This sense of responsibility toward clients coupled with a strong empathic duty of care saw many participants put the needs of their clients above their own concerns:

"It was fear more giving it to the clients than it was ourselves really wasn't it" (G2, P1).

"I had a cancer patient as well when I just went back to work it was tough going because when you sneeze or cough you were afraid" (G1, P4).

Participants expressed fear and anxiety around the risk of transmission of COVID-19 to their vulnerable clients. Several participants across each group spoke of the considerable stress and concerns this caused for HCWs, with the concerns primarily related to transmission fears for clients as opposed to the HCW:

"We carry that responsibility. . . that's what I was afraid of giving your client COVID-19 and killing them.. that's the fear" (G1, P3).

Impact on HCWs Family and Personal Life. Many participants expressed concerns about bringing COVID-19 into their own homes, several whom had family members with underlying health conditions placing them at greater risk. One particular example captured the ripple effect the role as a HCW had on HCWs family circumstances, illustrating the wide-reaching impact working as a HCW during COVID-19 had for HCWs and their families:

"I had my daughter living with me and she was expecting twins. My husband had to move out of the room, and it was hard. There were no vaccinations at the time because it was at the very beginning, I couldn't come out of the room" (G1, P6).

"You have to think of yourself too, my mother's 94, if I go in there [to work] I can't go into her, she's not well either so you have to think both ways" (G3, P2).

The knock-on effect into the home life of HCWs was discussed, highlighting the added layers of impact working as a HCW had on their families lives and how they conducted their lives during COVID-19, with this example illustrating the sense of restriction, fear and accountability that was felt from HCWs who had younger family members:

"Even at home, I said [to my son], you can't be going down to friends because you're coming back to me" (G1, P6).

This sense of duty of care could be linked to a lack of additional sources of support and care for clients, in many cases, the HCWs were the only source of social contact during COVID-19:

"They have nobody else, they don't have anybody else, we were the only human contact that they saw" (G1, P5).

Financial Impact. Participants spoke about how challenges such as clients declining HCWs coming into their homes during the first COVID-19 wave, as well as COVID-19 public health measures particularly around varying self-isolation guidance resulting in staff unable to work, were strongly felt from a financial perspective:

"Some clients didn't want us in because they were worried, we would bring it in. Then we were down that client 10 hours, you have 2 clients then that's 20 hours. Over the month you know it could be anything from 80 to 100 hours then, it was very unfair you can't sign on social welfare" (G1, P5).

For HCWs this financial element was an additional source of stress, bringing increased financial uncertainty for staff who were already under strain:

"You barely get by for the amount of hours you put in at the end of the month you're struggling" (G3, P2).

In addition to the specific COVID-19 financial challenges, increased fuel costs were an issue for staff. Given the nature of their role, particularly in rural and remote client locations, this was seen as an additional element of worry for HCWs:

"I think the biggest thing there is the car because you're in the car in the morning to the evening and that's running all day long and as you say the tyres, our costs have gone up at least double for petrol since it was last done" (G2, P1).

Theme 2: Unique Challenges of Home-Based Nature of HCWs Workplace During COVID-19

The domiciliary nature of HCWs role brought a unique set of challenges to the provision of care during COVID-19. Changes in the home environment for clients saw, in some instance, increased numbers of family members in the home, something which was a challenge for

HCWs to navigate, particularly when family members who were present in the clients home during HCWs hours of work may not have adhered to public health measures, particularly the use of PPE and the impact this could have on not only the HCW but on the client, creating a challenging work environment for HCWs:

> *"Some of the families didn't believe in COVID-19, vaccinations, masks or anything" (G1, P4).*

> *"They [family] could ask you if you were vaccinated and if you weren't they could ask you to leave but you couldn't ask them were they vaccinated, so you were walking into the unknown and I felt like the respect wasn't given to . . . I thought this very unfair. . . why shouldn't it be the same both ways" (G2, P2).*

HCWs role took on a greater element of social and emotional support for clients to support clients who had experienced bereavement during COVID-19 and required support to grieve and process difficult life events:

> *"I had one experience it was very sad, he was a man on his own, his last family member passed away, I felt sorry for him, so back then you would have the funeral you would have the masses on the phone so I had him listening to the mass on my phone" (G1, P3).*

In addition to supporting grieving clients, the social interaction element of their role was often the only source of social contact clients had. Understandably, some clients became dependent on HCWs, which was challenging for HCWs to manage:

> *"[Clients were] overdependent if you like. If you had started something extra it continues because they're not inclined to, they're so used to you doing what you've been doing" (G3, P6).*

The lack of recognition was a central feature of HCWs experience while working throughout the pandemic, participants spoke of a sense of lack of recognition for their contribution from the Government:

> *"The government giving us no recognition you know for all of our hard work, you know we were not really recognised at all, the government they don't really want to know us, and they didn't care" (G2, P6).*

This lack of recognition was also expressed within the broader health system whereby HCWs spoke of feeling treated unfairly compared to HSCPs who worked in acute settings. Given the domiciliary nature of HCWs roles they felt the specific challenges and risk they faced were not recognized by Government and broader level health services:

> *"I think we're all chasing our tails really, we were cast aside, we were not classed as frontline workers, it was all nursing home staff, doctors, nurses" (G1, P2).*

> *"The doctors and nurses all had a number of days off a week we didn't get that regardless of COVID-19. . . we were just not thought of . . . we were in the dredges" (G2, P4).*

Discussion

While findings from this study reflected the emotional impact similar to HSCPs in acute settings during COVID-19 including stress, fear, and anxiety (Emmesjö et al., 2022; Hall, 2020; Ornell et al., 2020), the findings from this study speak more clearly to how encompassing the impact for the personal and family lives of HCWs due to the personal nature of the work and exposure to clients COVID-19 challenges and fears. The wide-reaching effect of working as a HCW during COVID-19 was shown to not only impact the working lives of HCWs, but fears of transmission were carried by HCWs in relation to their own families. Participants spoke openly about concerns for vulnerable family members of transmissio with underlying health conditions and the fears they had n risks due to the nature of their employment as HCWs, which had been shown previously in research with HSCPs as opposed to HCWs both post and pre-COVID-19 (Ardebili et al., 2021; Manthorpe et al., 2022; Ness et al., 2021; Ornell et al., 2020).

The sense of responsibility felt by HCWs toward their vulnerable clients was shown to impact social interactions in the personal and family lives of HCWs. Even outside of the workplace, HCWs had concerns for the number of social interactions of their family members during COVID-19, showing how their role as HCW was influencing the decisions and lives of their own families creating an additional layer of stress for this group. Findings highlighted the strong sense of duty of care felt by HCWs, putting the needs of their clients above their own fears and concerns, reflecting similar themes found in research with HSPCs and some HCWs (Shoja et al., 2020; Simeone et al., 2022). This duty of care could be linked to the sense of responsibility and guilt expressed by HCWs as the HCW was often the sole source of social interaction for their clients during COVID-19.

The domiciliary nature of HCWs created a unique set of challenges during COVID-19, which have largely been absent in research until this study. Issues in terms of challenges navigating the domiciliary nature of their role were highlighted, illustrating the complex working environment HCWs faced. Particularly stressful points were shown to be linked to clients' family members moving back into the family home and the challenges this presented in terms of family members adherence to public health measures, in particular the use of PPE, and the fear and uncertainty posed by family members who would not comply with PPE measures and the risks this posed for HCWs. In comparison to HSCPs working in acute settings during COVID-19, HCWs faced greater risk and adversity in this regard. To date, previous research has not fully explored the challenges of client families for HCWs, an area which featured strongly in this study. However pre-COVID-19 research had explored this area highlighting the stress caused for HCWs in navigating client-family

relationships (Ris et al., 2019), something which is likely to have been exacerbated during COVID-19.

In terms of the geographical based experiences, the themes that were produced were consistent across all three sites, showing that the impact on HCWs was similar in both rural and suburban contexts. Factors such as the challenges of increasing fuel costs for HCWs in an area that was shown to be a significant concern for this group, which given the range of travel at the core of this role, consideration is required as to better support HCWs in this regard.

A lack of recognition was evident across the three groups, with participants feeling undervalued and not recognized from government during COVID-19, speaking to the Department of Health's once off pandemic recognition payment for certain frontline public sector healthcare workers to recognize their role during the pandemic. This reflects a lack of recognition amongst HCWs during COVID-19 as previously identified (Sterling et al., 2020), however it contrasts with an Italian study which found the largely migrant HCW workforce had a greater sense of value during the pandemic (Simeone et al., 2022). HCWs expressed dissatisfaction with the challenges and risks they faced when compared to HSCPs in acute settings who had a greater sense of collective support available. HCWs in the home spoke about a sense of isolation in terms of support and back up from broader health services (Nyashanu et al., 2022).

Findings from this study mirror previous COVID-19 HSCPs studies which have highlighted the emotional impact on HSCPs, with transmission concerns a key cause of fear and stress amongst HSCPs (Apisarnthanarak et al., 2020). While this fear has been shown to be multifactorial from a broader HSCP perspective (Taylor et al., 2020), the HCWs in this study were afraid of potential transmission of COVID-19 to their older vulnerable client group as well as to their own family. Little consideration was given for the HCWs themselves and the risk of them becoming unwell because of COVID-19.

Conclusion

With a growing older population, coupled with a policy focus on community and integrated care, the role of HCWs will become increasingly important in supporting health policy and aging in place. This study offers contributions to represent and recognize the impact of COVID-19 on HCWs. Findings highlight the wide-reaching impact faced by HCWs given the domiciliary nature of their work; navigating challenging client-family relationships and PPE compliance that led to a heightened sense of fear. The wide-reaching impact of providing care to an older vulnerable group appeared to impact not alone the personal lives of HCWs, but also the lives of HCWs family members who made social interaction decisions that reduced their social contacts because of the nature of the HCWs work.

Findings from this study highlight the wide-reaching impact of COVID-19 in terms of impact on HCWs professional and personal lives highlighting the need for clearer guidance from practice and policy levels on how to manage such complex domiciliary issues. Operational policies must reflect such challenges for the HCWs groups who are isolated in terms of the support available in the client's home. Measures to support both staff and the client are important to address this issue to create a safe workspace for HCWs.

It is important to note that while the insights captured are important for policy and practice measures, the demographic profile of participants were female Irish HCWs. To capture experiences of a broader diverse demographic, the authors will conduct a National survey, informed by this qualitative phase, to ensure greater representation from diverse HCWs, reflecting the current HCW workforce. Taking into consideration the pre-COVID-19 challenges in the HCW sector it is key that the experiences of HCWs during COVID-19 are explored and understood to help support this key group continue to support older people live in their own homes in a safe, respectful, and valued way. Insights from this study assist in better supporting and equipping the HCW sector with valuable information to guide the development and implementation of relevant support strategies and operational guidelines to deliver care to older people in an environment that is supportive and recognizes the challenges faced during COVID-19.

Declaration of Conflicting Interests and License Type

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Ethical Approval

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