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Personal Assistants' role in infection prevention and control: Their experiences during the Covid-19 pandemic

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Abstract

Personal Assistants (PA) or client-hired workers are directly employed by people needing care and support, often making use of government funding. In the context of Covid-19, questions emerged about how this workforce is supported to practice safely.

This paper reports PAs' understanding and views of infection control during the early months of the Covid-19 pandemic in England. Telephone interviews were undertaken with 41 PAs between 16th April and 21st May 2020. PAs were recruited from a sample that had participated in a previous study in 2014–16. Interview questions focused on changes arising from the pandemic. Data were transcribed and analysed using Framework analysis.

This paper focuses on PAs' perceptions of their role and responsibilities in preventing and managing infection. Arising themes were identified about barriers and facilitators affecting infection control in five areas: accessing information, social isolation, handwashing, hygiene, personal protective equipment and potential attitude to vaccines.

Infection prevention and control are under-researched in the home care sector generally and efforts are needed to develop knowledge of how to manage infection risks in home settings by non-clinically trained staff such as PAs and how to engage home care users with these efforts, especially when they are the direct employers.

KEYWORDS
hygiene, infection control, isolation, Personal Assistants, social care, vaccine

1 | INTRODUCTION AND BACKGROUND

The coronavirus (Covid-19) pandemic has taken a grim toll on people providing and receiving social care internationally. At the time of writing (January 2020), England had experienced more than 30,500 excess deaths among care home residents, with social care staff being twice as likely to die as other adults (Dunn et al., 2020). Deaths of home care recipients were 2.7 times the three-year average for the period 10 April–8 May 2020 (Care Quality Commission (CQC), 2020; Glynn et al., 2020). These figures likely omit the growing numbers of people receiving care from self-employed care workers such as Personal Assistants (PAs) and the workforce supporting them has largely been overlooked in the Covid-19 response.

PAs, also referred to as directly employed or client-hired care workers, are a small, but numerically stable segment of the English care workforce, being an alternative to using home care agencies (home health services). They are favoured by many as potentially providing a more personalised service because they are directly

employed by employers exercising choice and control (Shakespeare et al., 2017) or family members on the care users' behalf (Wilcock et al., 2021). Studies of PAs have often observed how the role gives more autonomy and is more psychologically rewarding than agency care work in which the task-centred pressure of the work often undermines relationship building (Shakespeare et al., 2017; Woolham et al., 2019). PAs may choose self-employed status or be directly employed by the person requiring their services (in the UK using their own or local authority (state) funding). In contrast to home care providers who must register with the Care Quality Commission (CQC), PAs are unregulated and largely invisible to local health and care authorities. Small numbers of PAs have contact with local disabled people's organisations or brokerage agencies who may provide payroll or other services to the disabled person who is the employer or to PAs.

An estimated 70,000 people of the 230,000 adults receiving Direct Payments from English local authorities employed their own care worker(s) in 2019; it was further estimated that there are 134,000 PAs in England (Skills for Care, 2020). The effectiveness of this approach in promoting good quality care, part of an international trend towards 'consumer-directed care' (Fitzgerald Murphy and Kelly, 2019; O'Shea & Bindman, 2016), is of particular interest during the Covid-19 pandemic, although others have previously argued that the safety of a home care client and home care worker is always closely inter-linked (Markkanen et al., 2014).

Although most social care workers in England undertake a small amount of online or in-person training (the Care Certificate) which includes hygiene and infection control, this is not a requirement. However, prior to Covid-19 evidence was emerging from the United States (US) that infections among clients of Home Health Care services are substantially underestimated (Shang et al., 2014, 2018) and that more complex client needs combined with the emergence of new infections require better understanding of how to address infections in home settings. These authors (ibid) noted that infection control guidelines are based on expert opinion and evidence from in-patient settings and so are hard to operationalise in domestic locations. Quinn et al.'s (2016) US survey of 1,249 Home Care aides/home care workers (634 agency-employed, 615 client-employed) reported on 3,484 home visits. They found both staff groups encountered hazards related to musculoskeletal strain, exposure to potentially infectious agents and cleaning chemicals, and experience of violence. However, those who were client-employed (similar to PAs) had fewer experiences of verbal violence but were more likely to have contact with sharps (needles) and with faeces than agency-employed home care workers.

A US survey (pre-Covid-19) completed by 1,204 home care agencies (Rowe et al., 2020) found a lack of guidelines for the sector, inadequate supplies such as thermometers, personal protective equipment (PPE), and insufficient cleaning and disinfectant products. However, their staff had received instruction, training, education and support about infection prevention from their employers although protocols varied. The authors noted that while home care workers and their agencies were the 'front-line' for millions of older people, they were largely excluded from federal, state and health strategies for reducing Covid-19 spread.

What is known about this subject

- Infection control has been an important part of the response to Covid-19.
- Little is known about Personal Assistants or directly employed care workers during Covid-19.
- Research on infection control when care is delivered at home is limited; guidance does not always support untrained care workers working in domestic settings.

What this paper adds

- This study provides new information about Personal Assistants' activity in infection control and prevention efforts during the Covid-19 pandemic.
- It provides an analysis of Personal Assistants' reports of isolating, handwashing, hygiene, access to and use of personal protective equipment and views of potential vaccines.
- It suggests the value of Personal Assistants being included in contingency planning and emergency response initiatives.

As internationally reported (Giebel et al., 2020; Rowe et al., 2020), many home care workers were 'stood down' from their jobs during the Covid-19 pandemic by family members and clients who feared infection. This also applied to PAs. A very small sample of those employing PAs in Scotland (just 18% of 93 respondents) found a few reported care stopping completely, with slightly more reporting care reducing (Scottish Parliament, 2020, p. 7).

This present paper reports a study which is built on an earlier, large interview-based study of PAs conducted in 2014–2016 (Woolham et al., 2019), both studies being commissioned by the Department of Health and Social Care. The first study found that PAs were largely unsupported, many felt occupationally isolated, many lacked employment contracts, they received little training, were unregistered and unregulated, and expected to work flexibly (many worked for more than one client). Within this context, some PAs chose not to use protective clothing or gloves, feeling this 'medicalised' relationship (Woolham et al., 2019, p. 77):

> Me, personally, I don't use gloves. When I'm, like, toileting, I don't use gloves because I'm not actually touching her (client). I'm wiping and then washing my hands, like I would do myself. I don't wipe myself with gloves on, do I? PA550210

Not all PAs felt this way; some were interested in taking on more health-focused roles (Norrie et al., 2019).

Data in this present paper come from a study of PAs undertaken in Spring 2020 during the first UK Covid-19 lockdown in England

(see Woolham et al., 2020). It investigated what steps, including infection control procedures, PAs were taking to protect themselves, their families, and their clients and how the pandemic was impacting on their work relationships with employers but also their families (Manthorpe et al., 2021). This present paper focuses on an arising theme; PAs' knowledge, understanding and views of their part in infection control in these early months of Covid-19. It highlights barriers and facilitators to effective infection prevention and control in five areas: accessing information, social isolation, handwashing, hygiene, PPE and attitudes to vaccination.

2 | METHODS

This was a qualitative study consisting of telephone interviews with 41 PAs.

2.1 | Recruitment

In April 2020, we re-contacted the sample obtained for a previous study (Woolham et al., 2019) that had interviewed 105 PAs from across England. Recruitment had largely been undertaken through disability organisations some of which assist with PA recruitment and payroll management. An information sheet was attached to the 2020 email and PAs were invited to return a consent form if they wished to participate. The email also included details of potential support organisations. Another two PAs who had not been part of the original study were invited to participate. Fifty PAs agreed to be interviewed in the new study and 41 were able to be interviewed within the study's time period. Non-respondents were followed up twice. Two from the original study proved uncontactable, and 48 did not respond. Several (14 of the original sample) replied to say they were no longer working as PAs.

2.2 | Data collection

All interviews were conducted by telephone by one team member (JW) between 16th April and 21st May 2020. A semi-structured interview schedule was devised consisting of 27 questions focusing on Covid-19's impact on PA work. All interviews were audio-recorded with consent and fully transcribed. Interviews lasted from 20 to 60 min duration. Each participant was mailed a note of thanks and £20 in appreciation of their time. Transcribed data were pseudo-anonymised before being entered into NVivo data analysis software (Woolf & Silver, 2017).

2.3 | Data analysis

The main research question was: What is the impact of COVID-19 on the working relationship of PAs and their employers (clients)? This included a focus on isolation, safety, work practices, accessing information, multi-agency working, and their working terms and conditions. Data were analysed using Framework analysis (Ritchie & Spencer, 1994) based on the interview questions. Emerging themes were coded inductively throughout the analysis and added to the coding scheme. Full team discussions ensured new codes were checked, validated by the team and consistency of coding was maintained. The research team (with backgrounds in gerontology, health services research, family care and local authority research) was working from home and met online regularly to discuss study progress and emerging findings, as well as sharing relevant information about social care guidance as this emerged in the early weeks of the pandemic. Data were further analysed for this present paper using key word automated text searches within NVivo to interrogate aspects of infection prevention and control, e.g. handwashing, virus and cleaning.

A favourable ethical opinion was obtained from King's College London before interviewing (ref. HR-19/20-18212). Attention was paid to ensuring procedures were in place if PAs became distressed, or disclosures were made about PAs or clients being at risk. All documents were reviewed by a member of the NIHR Policy Research Unit in Health and Social Care's Public and Patient Advisory Group.

3 | THE SAMPLE

A total of 41 respondents participated. Respondents were overwhelmingly female (95%) and white (83%) with 93% of British nationality. Their mean age was 48.5 years (ranging from 21 to 71 years). Nearly half (49%) were caring for another family member, and a similar proportion was caring for their children in addition to their paid care work (see Table 1).

3.1 | Findings

Barriers and facilitators to effective infection prevention and control at the start of the Covid-19 pandemic are presented from the PAs' accounts with reference to accessing information, social isolation, handwashing, hygiene, PPE and attitude to vaccines.

3.2 | Accessing information, knowledge and training about infection control

Most PAs reported receiving little if any targeted information about infection control and Covid-19 at the start of the pandemic. PAs were effectively left out of early government pandemic guidance for professionals in health and social care (Hodgson et al., 2020). Like the general population, most PAs received information about infection control and protecting themselves and their clients from the general media. Some felt they needed to decide for themselves which sources were more factual or credible than others. Most PAs referred to BBC news and daily government briefings and updates, as key sources of information.

TABLE 1 Participants' demographic details ($n = 41$)

Ethnic background	No.	%
White	34	83
Multiple/dual heritage	3	7
Asian	2	5
Black	1	2
Total	41	100
Age		Yrs
Minimum		21
Maximum		71
Mean		48.5
Gender	No.	%
Male	2	5
Female	39	95
Total	41	100
Caring for member of own family	No.	%
Yes	19	49
No	20	51
Total	39	100
Missing	2	
	41	
Caring for children/students in own family		
Yes	15	49
No	20	51
Total	39	100
Missing	2	
	41	
Nationality		
British	38	93
Polish	1	2
Hungarian	1	2
Jamaican	1	2
Total	41	100

As government guidance was changing, there was a need to keep up to date. Most participants used their own initiative:

> PA: So every day I look at www.gov.uk and update myself, every day
>
> Int: Because the guidance is changing, isn't it?
>
> PA: Yeah, so just to make sure that I'm up to date with everything, I check it every day before I go out…
>
> PA550285

Those PAs with links with a disabled people's organisation were the exception as they reported receiving useful information, including advice about socially isolating (if experiencing symptoms or had had contact with symptomatic others). A small minority received regular updates from their Local Authority (council) via their contacts with these disabled people's organisations. These were considered invaluable, as they offered role-specific advice about accessing PPE or more information about protocols:

> … but certainly (named) County Council and their team, I just feel… because as a PA you're very solitary, you make your own decisions, you haven't got a boss, you don't answer to anybody really, except yourself, and so at times like this you want to say, help, you know, where do I get that glove, or what's the protocol for this, and you've got this little invisible body, if I want to pick up the phone, I can phone them, but it's there and that's a valuable resource and they've really stepped up to the mark, so I feel fully supported, if I need it. PA550310

Most (79%) PAs in the original study had experience of working in a care setting before becoming a PA and so had some knowledge of infection control. Many (58%) had experience of caring for someone in their family. In the Covid-19 context, some drew on their experience and related this to the current situation:

> I worked ten years for (local authority) social services and ten years for [Agency] both agencies, very red hot about everything.... and I'm quite hot on all of that because I've had very good training, and also because I tend to be that way personally.... With regard to Covid-19, if I wanted any information, (disabled people's organisation) do send it but, to be honest, I understand about silo infections and cross-contamination, all kinds, yeah. PA550288.

3.3 | Social isolation measures

Most PA interviewed had stopped or reduced care work during the early stages of the pandemic to control the spread of the infection to their clients and their own families (not working, $n = 15$; reduced hours $n = 13$; no impact = 10; more/slightly more work $n = 3$). Some could rely on a spouse/partner to maintain the family income and so were less affected by not working. However, one PA felt that worry about loss of income might result hypothetically in a PA discounting how unwell they felt and continuing working.

For those who chose to give up working, they reported that the care tasks the PAs had formerly undertaken were now being undertaken by family members, a smaller number of other PAs (where a team of PAs was employed) or by agency care workers who had been previously working alongside PAs. Some PAs continued to carry out tasks at a physical distance, such as delivering

shopping and telephoning clients to check on safety and wellbeing, while choosing not to enter their clients' homes and risk passing on infection.

Of those who were still working in clients' homes, some described great efforts, including putting themselves or family members at risk, to ensure their client continued receiving their support:

> So we were actually talking about the scenario of my employer going to hospital, thinking about it … he would need at least one of the PAs to stay with him, which happened in the past. I think we would probably consider someone either living with him, we have a few PAs who have no families and they're single that would possibly cover, but if… I would cover as well probably, I would consider moving to him for a meantime to stay away from my family. PA550302

Some PAs continued to work alongside clients' families, and described abiding by reduced contact rules:

> We don't go for a walk, we don't go to the park. We go for a drive, which we've been authorised to do, so we've got an amendment to his care plan where we are allowed out for three short trips a day; originally that was one, but this week we've had that extended to three. We don't have any visits from any of the other workers that were working with [client], we don't sit in the garden, we obviously don't have any visitors, but we don't do any outdoor activity that we did before, so yeah, he finds all that strange. We were always probably a little bit over the top in terms of cleaning and infection control, but we've ramped all of that up. PA550312

> I'm a lot more aware of [] the physical contact and how close I go to the clients. That's obviously all changed now… Obviously, when it comes to personal care, you don't want to be… when it comes to washing the upper body you're constantly trying to position yourself so you're not facing each other. PA550315

3.4 | Hand washing

Hand washing was frequently mentioned as part of infection control. The following PA described doing this with rigorously with other PAs:

> Well, we have to be very careful, we basically had to transfer everything we
>
> do into a safe environment, so we had to come down with a lot of restrictions
>
> in our workplace about things like, for example, when we enter the house,
>
> leave the shoes by the door, we have to wash hands straightaway and we
>
> wash hands in a way that nurses do in the hospital, so it's like almost before
>
> surgery, washing hands. PA550302

However, these changes required negotiations with those clients who found it hard to adjust to new infection control measures:

> Trying to instil in [employer] the practices that she should have been carrying out to keep herself safe and people entering her property safe, that [] we wouldn't normally ask her to do, like wiping down door handles, you know, washing her hands more often, all those sorts of things which became obvious that they weren't the norm for her, she was struggling to carry out those extra practices to keep herself safe. PA550316

3.5 | Hygiene

The importance of cleaning, sterilisation and disinfection was mentioned by several PAs who recounted their efforts to access products during shortages (at the pandemic's start) and their use:

> As soon as Covid was around, I was washing down, I was using hand gels to go in and occasionally I was using plastic aprons, where appropriate, which is a must when I was getting a bit more intimate with her, or changing her bed [] And then, as Covid got more and more serious, I was not only cleaning my hands and cleaning myself and making sure I didn't take anything in or out, I was actually cleaning all the doorknobs as I went in, I was cleaning the car doorknobs, I was doing the steering wheel and I was being very careful that anything from her didn't go into my car, therefore could infect my family, or the next person I went on to. PA550293

Most PAs reporting feeling safe, or safe enough, at work, and gave examples of how some clients ensured that cleaning products were available and that other PAs rallied round:

> …the lady who we support, her Mum said if we need any extra money, if we need to order things online, and our families know the job that we do; our friends know the job that we do. My Mum, she's also a PA

> and she had a neighbour drop off two bottles of hand wash on her doorstep, and said, take that into work; she really has been amazing, I can't fault her…I do feel like everybody's pulled together. PA550296

> …one of my friends who is now a PA…she got a massive, 50 litre thing of medical-grade sanitizer and what she's done is she's bought individual bottles from a well-known store online and we each have bought individual bottles from her to help pay for that chunk, because it was about £150 she had to pay for it. PA550310

However, many PAs reported problems in obtaining hand sanitiser, anti-bacterial wipes and other household products, though some considered hot soapy water an effective alternative. A very small number of PAs felt that their client's home was so insanitary prior to Covid-19 that everyday cleaning would make little difference:

> …. (client's) a hoarder, and you would be horrified if you walked into her accommodation, absolutely horrified. It's filthy dirty, she's even got mice, and I'm onto the council, I'm onto her social workers all the time. It's terrible that she's allowed to live like it, but there's not much I can do about that… One of my son in laws said to me, 'I don't know whether you should be going to her with all this going on' I said, 'I'm not going to get Covid-19, I'm more likely to go down with the bubonic plague'. PA55029

3.6 | Personal protective equipment

Given our interviews were undertaken in the early months of the pandemic when there were severe problems accessing PPE in the UK and internationally (McFadden et al., 2021; Rowe et al., 2020), this was much discussed. PAs reported feeling overlooked by the authorities in relation to PPE which caused worry about infecting themselves, their clients and their own families. A few PAs in contact with disabled people's organisations had been given information about PPE regional distribution centres but reported being unable to access them because they had no CQC registration number. Sourcing PPE was difficult for many at this time, but PAs were also concerned about the expense:

> Gloves and masks you have to buy; they're very difficult to get hold of. This woman who's making them, a friend of a friend who's a carer, and they're £4 each and they're patterned so they look alright as well and they're £4 each but I can wash them, so I'm not wasting money that I ain't got. I can actually put it on, take it off, wash – put it into a bag, take it home – wash it and put another one on. PA550320

Self-employed PAs generally accepted their responsibility for providing their own PPE, but those who were directly employed were unclear about whose responsibility it was to provide it:

> … to be honest, to perhaps expect people that perhaps have disabilities and things like that to be able to organise getting PPE isn't perhaps the best idea, especially some people might have learning disabilities and things and be supported with their family, but families are just ordinary people, and trying to source government supplies from an ordinary person when even the frontline staff haven't got enough supplies is obviously a major issue. PA550295

As noted earlier, in our previous study, many PAs stated that they did not use PPE (such as gloves or an apron during personal care). This situation had changed; all PAs in the present study stated that they now wore PPE if they could get it and most said they would continue to do so. Only one PA reported the cost of PPE as being a reason for sub-optimal infection control:

> On the bus I do wear it, but when I get to the client's house I don't, I have to take it off. I prefer not to wear it [mask] because I have to buy it. I told her (client) I bought two face masks for £3.50, she said that's not fair, and yet still she's not providing it. [] By the time I wear it on the street, I have to throw that one when I get there. PA550321

3.7 | Vaccines

PAs discussed their attitudes to annual flu vaccines (recommended for UK health and care staff) and those of their clients. PAs' attitudes to annual flu vaccinations were mixed; many PAs had not 'got around to it', with some preferring not to have this vaccination—either because of concerns that it would make them ill, not feeling they were in a vulnerable category, because they said that they had a 'needle phobia', because when they had asked to be vaccinated, they had been told they were not eligible, or that they felt they had had a reaction:

> [Doctor] just said I couldn't have it done because I wasn't… I think she said I wasn't a member of the family looking after the person, I was like a private carer and I should have to pay for it. PA550305

> I did have a reaction once and I said, never again. … I was poorly for two weeks and it's the only time in my life I've ever had two weeks off work sick. PA550314.

Some PAs confessed a lack of trust in 'official' information and suspicion of side effects. Most said their clients (particularly older clients) had been vaccinated, but not always themselves:

> I just feel it should be for more… the vulnerable. My Mum's diabetic, I always make sure she has it; my Dad has COPD, I make sure he has it, I make sure my clients have it. I don't have it. PA550296

Such views may be helpful in providing the backcloth to attitudes to Covid-19 vaccination which at the time of the interviews was not widely envisaged.

4 | DISCUSSION

Findings revealed several concerns about PAs' role in infection control which have policy and practice implications. Although Covid-19 may have amplified interest in this subject, it highlights the lack of knowledge previously and in wider home care services. As noted, interviews took place in the early months of the pandemic and some more specific guidance for Employers and PAs was issued in November 2020 (Department of Health and Social Care, November 2020) confirming their eligibility for PPE and free flu vaccines. However, in June 2020, Public Health England (2020) reported finding no studies at that time of the risk of transmission of Covid-19 when delivering or receiving home care and no studies of the effectiveness of interventions that aim to reduce the virus' spread when delivering home care. New research could inform our understanding of the risks of virus transmission in this context such as the impact of working in confined spaces or where air is mechanically circulated (Colburn, 2020).

PAs felt and were 'unknown' to health and care services, despite their work income coming from public money in the main. Infection prevention for themselves and for their clients was jeopardised as PAs and home care staff were unable to access PPE in the early months of the pandemic as widely reported (Cook, 2020; Department of Health Northern Ireland, 2020; Home and Community Care Ireland, 2020; McFadden et al., 2021; Scottish Parliament, 2020), amplified by PAs having no 'proof' of their care worker status or managerial oversight and support. Consideration is needed about whether, given these are largely publicly funded workers, their details should be collected by LAs, for example, in the setting up, review and monitoring of care plans. PAs could then be contacted in emergencies and best use made of their resource since they would have access to information about infection control and lines of assistance.

During the early months of the pandemic in England CQC registered home care providers were asked to submit various data to a Home Care Tracker including numbers of service users, numbers of Covid-19 cases, workforce absences and PPE levels. The Tracker however only covers regulated organisations, prompting a call (Hodgson et al., 2020) for improved data across different social care settings to enable local public health teams to identify high risk areas, to put in place infection control measures and improve local co-ordination. Again, PAs would seem to be left out of such data collection proposals since they are unknown to authorities and the regulator, and they are unregistered workers.

PAs were generally not included in information or guidance at the time of the study. They had to source information and products themselves and make their own decisions in these early stages of the pandemic. Most of this study's PAs had background, experience and some training in care work and were generally aware of infection control practices. However, about a fifth had no experience in the sector and, for them, decision-making around best practices would seem less straightforward. Access to training for those new to the sector may therefore be needed by this group as well as more general updating. Standardised training for all health and care support workers was recommended in the Cavendish report (Department of Health, 2013) but in this, and more generally, PAs are not included. Indeed, the Care Certificate provides a minimum standard, transferable, qualification, but is strongly criticised for not being mandatory (Gilding, 2015, 2017; Peate, 2015; Pile, 2015; Willis, 2015). This means that even those joining the PA workforce from the regulated sector do not necessarily bring any knowledge from previous training. It is moreover important not to over-emphasise training, since a recent observational study of US home nurses reported their average hand hygiene adherence rate was 45.6% (similar to rates in hospital and long-term care facilities) and suggested a need to highlight the connection between poor hand hygiene and infection transmission (McDonald et al., 2020).

There is a longstanding debate about which if any social care staff should undertake more complex healthcare activities in community services some of which involve procedures which risk infection transmission (England & Alcorn, 2018; Shang et al., 2014). In this present study, some participants reported considering changing jobs, due to the insecurity, poor remuneration and lack of training opportunities of PA work. However, the care sector as a whole needs reinforcing; research with other care workers during Covid-19 in England suggested a key factor affecting their mental health was the feeling of being under-appreciated compared to NHS staff (Nyashanu et al., 2020) and Watterson (2020) concluded that the care sector had been abjectly neglected when compared to the health sector.

In this present study, family members had taken over much of PAs' work, with some PAs considering this would be unsustainable (Manthorpe et al., 2021). This confirms others' findings (Department of Health Northern Ireland, 2020; Giebel et al., 2020; Scottish Parliament, 2020) of the extra work for family carers during Covid-19. Information collected by LAs about PAs would also enable contingency plans to be put in place to ensure the safety and prevention of infection among clients should a PA or family carer becomes seriously ill and family cover cannot be arranged.

Finally, the views of PAs, and their clients, about vaccines are important to consider. Reluctance to have flu vaccines, despite government guidance stressing their importance (NHS, 2020), suggests wider public health messaging about vaccines for people who are at substantial risk of contagion and those working for them may need to be developed. This reticence was reported early on in relation to care home workers being offered Covid-19 vaccines (Pyman, 2020), suggesting that encouragement for care workers needs to be sector specific.

4.1 | Strengths and limitations

This study was undertaken during national lockdown; thus, telephone interviewing was the only option. Other studies of PAs have similarly done so by telephone or virtually prior to the pandemic, e.g. Shakespeare et al. (2017) interviewed 19/27 PAs by telephone and Skills for Care's (2020) survey was online. As with all such studies, those committed to care work and secure in their immigration and tax status may have been more likely to agree to participate. We made efforts to recruit a range of PAs although the survey of PAs accessed through two support agencies by Skills for Care (2020) found far higher percentages of PAs were their clients' family members.

5 | CONCLUSIONS

Interviews with PAs during the start of the Covid-19 pandemic highlighted their role in infection prevention and control but also underline how they are disconnected from other services and networks. Dickinson et al. (2020) suggested, 'The main challenge posed by personalisation is that it makes it difficult to identify the workforce, train them in infection control, mobilise supplies to all who need these and upscale the workforce in face of shortages in care workers'. Our study provides some confirmatory data of this and further shows how contingency planning and formal risk assessments did not feature in their employment but depended on their personal networks or their clients' resources. This study also flagged up potential dilemmas within the PA role; workers are expected to act under their client's instructions without the wider support of health and social care systems that could help them to do this optimally around infection control and beyond.

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CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

AUTHORS CONTRIBUTION

CN: Undertook data analysis, revision of report and articles and drafted this current article; JW: Led the study, gained ethical approval, project management, conducted interviews, data analysis and drafted the study report, drafted articles and revised current article; KS: Led on undertaking data coding and analysis, and revision of articles including current article; JM: Advised on the study, undertook data analysis, revision of report and article writing including revising current article.

DATA AVAILABILITY STATEMENT

Some data that support the findings of this study may be made available on request from the corresponding author. The data are not publicly available due to privacy restrictions.

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