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A thesis submitted for the Degree of Doctor of Philosophy

Older people and homecare in Ireland: How much do we care?

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Declaration

I Lhara Mullins confirm that this work is my own, and not based on any other award or degree.

Lhara Mullins 11/09/21

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Abstract

Homecare is instrumental in enabling older people to remain living at home and avoid long-term stay settings, particularly for those without family members or friends to provide care informally. Homecare was initially provided by religious and voluntary orders in Ireland, prior to the establishment of the home-help department by the health board (now the HSE) in the 1970s. At its inception, homecare addressed the needs of the older person based on personal care tasks, domestic duties and companionship. However, as this service evolved, it became much more succinct and currently addresses very specific tasks such as washing, dressing and getting in and out of bed. Homecare in Ireland is now delivered via a quasi-market system consisting of both the HSE and private homecare providers. However little research to date has been undertaken in Ireland pertaining to homecare and both older people and homecare workers are considered a hard to reach groups, and consequently are underrepresented within research.

The aim of this study is to examine the experiences and perspectives of both older people and homecare workers, in order to establish the key factors they identify as significant in impacting homecare. The methodology employed was qualitative and consisted of both focus groups and interviews with older people, and interviews with homecare workers.

Findings suggest that the homecare worker role is unique and often involves the development of a caring relationship between older people and homecare workers. Results suggest that older people want and need continuity of care in terms of their homecare provision and this is a factor they deem to be significant in impacting their experiences of homecare. The issue of isolation as experienced by older people is a notable factor within the findings which effects homecare workers in their provision of homecare. Results suggest that homecare workers often provide additional care in an unpaid capacity, in an effort to meet their social and companionship needs of older people.

The results of this study are significant as they highlight the distinct role of the homecare worker in the lives of older people, and further the impact of isolation on homecare provision. The issue of continuity of care is notable within the broader legislative context of homecare in Ireland, which to date remains unregulated. The findings of this study demonstrate the longevity of factors such as the need for continuity of care and the isolation experienced by older people, as identified within previous literature. Such findings reiterate the urgency of enacting the Homecare Bill (2020) which

will include the companionship needs of older people, within the remit of the homecare worker and will be underpinned as a stipulation within the legislation. The Homecare Bill (2020) will further place homecare provision on a statutory footing and consequently present consistency and clarity, to both older people and homecare workers in terms of continuity of care.

List of Abbreviations

ASCOT: Adult Social Care Outcome Toolkit

BGS: British Geriatrics Society

CSO: Central Statistics Office

CQC: Care Quality Commission

DCYA: Department of Children and Youth Affairs

DOH: Department of Health

DOHC: Department of Health and Children

DSSPS: Department of Social Services and Public Safety

DQHF: Donabedian of Quality Healthcare Framework

EU: European Union

HCCI: Home and Community Care Ireland

HCPC: Health and Care Professions Council

HIQA: Health Information and Quality Authority

HSE: Health Service Executive

IPC: institute of Public Care

IPH: Institute of Public Health

MCRI: Migrants Rights Council of Ireland

NESF: National Economic and Social Forum

NESC: National Economic and Social Council

NHS: National Health Service

PCAT: The Primary Care Assessment Tool

PPI: Public and Patient Involvement

SCQol: Social Care Related Quality of Life

UK: United Kingdom

UN: United Nations

WHO: World Health Organisation

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Chapter 1: Introduction

This chapter will provide context and background to the topic of study and demonstrate the rationale for undertaking this research. Homecare enables older people to remain at home as they age, via the provision of tailored support aimed to assist them with tasks associated with essential personal care and domestic duties (HSE, 2018; Kiersey & Coleman, 2017; IPH, 2018). The homecare market in Ireland has been increasingly privatised and has expanded exponentially within the past 10 years (Metclaf, 2017; Mercille, 2017). Yet it is widely documented that the lack of regulation of the homecare sector in Ireland is problematic (Dail Eireann, 2019; Timonen, Doyle & O' Dwyer, 2012; Kiersey & Coleman, 2017). The projected growth in the number of older people in Ireland further accentuates the importance of regulating the homecare sector and planning appropriately for the future cared needs of this group (May et al. 2022: Kenny & Mc Garrigle, 2020). A lack of previous research on the topic of homecare maintains uncertainty concerning exactly what homecare provision entails and its impact on the lives of older people (Kiersey & Coleman, 2017; Boyle, 2011; Mayo-Wilson et al. 2014). This study aims to ascertain the key factors which both older people and homecare workers deem significant, in impacting their respective experiences and perspectives of homecare in Ireland.

An overview of the development of homecare in Ireland to date will be provided, followed by a detailed rationale for the current study, via identification of the gaps within the existing literature. Finally, this chapter will present the research question, aims and objectives.

1.1 - Background

Historically homecare provision in Ireland was provided by voluntary groups within the remit Catholic Church and further undertaken by family carers, neighbours and friends (Timonen, 2008). The Health Act of 1970 identified the Health Board (now the Health Service Executive, HSE) as having key responsibility for providing care which would enable older people to age at home (Government of Ireland, 1970). In the 1970's the home-help service of the Health Board was established, to provide more structured and formal care provision to older people within their own homes (Murphy, Whealan & Normand, 2015; Haslett, Ruddle & Hennessy, 1998). Initially the remit of the homecare service was to provide companionship and a listening ear to older people ageing alone (Deevy, 1983). The homecare service provided by the HSE continued to develop and in 2018, the HSE established the homecare support service which replaced the previous home-help service (HSE,

2022). The remit of the current homecare support service is quite specific and is described as providing older people assistance with: washing, dressing and personal care (HSE, 2022).

1.1 (1) - Population growth

In the 2016 Census, 637, 567 people aged over 65 were resident in Ireland (CSO-a, 2016). Of these, 26.7% or 156, 799 lived alone (CSO-a, 2016). The 2016 census data further highlighted the increase in age dependency, with people aged over 65 having increased two-fold, compared to the growth in population of people aged 64 years and younger. Sheehan and O'Sullivan (2020) estimated the number of people aged 65 and older in Ireland in 2019 as 696,300. This illustrates an increase of over 50, 000 in the 3 years since the 2016 census (CSO-a, 2016; Sheehan & O'Sullivan. 2020).

Estimations of population growth for older people aged over 65 in Ireland are expected to reach 1.6 million by the year 2051. Currently in Ireland the age dependency rate is 4-1, or 4 working aged people to every 1 person aged over 65 (Dept. of Finance, 2021). The Department of Finance (2021) estimate that by the year 2050, the age dependency rate will decrease to just 2-1.
The increase in longevity has been described by Sheehan and O'Sullivan (2020) as the greatest success of public health. The Department of Finance (2021) contend that life expectancy has increased across Europe and that by 2070, people will live on average for 20 years longer than compared to 1950. Such increases in life expectances have culminated due to better standards of living, sanitation and advances in medicine (Dept. of Finance, 2021).

May at al. (2022) based on the Irish Longitudinal Data on Ageing (TILDA) surmise that this seismic growth in the population of people aged over 65 expected in Ireland, combined with the estimated dependency ratio, will create never seen before challenges concerning the distribution of healthcare need and usage. Kenny and Mc Garrigle (2020) contend that such increases in longevity will further see a much greater number of people requiring care and support due to functional disability, from both formal and informal care providers. Aspell et al. (2019) describe creating a system of care provision which will support and enable older people to remain at home and avoid long term stay settings, as a major issue for many countries grappling with the increasing population of older people. Yet such planning for this increase in long-term care needs, must be informed by the experiences of older people in receipt of care within their own homes and communities (Aspell et al. 2019). The Migrants Rights Council of Ireland, (MRCI, 2013) concur and argue that the rise in the population of older people and the corresponding increase in the need for homecare, presents significant challenges for the state.

1.2 - Definition of homecare/homecare worker

In 2021, 3543 homecare workers were employed by the HSE homecare support service (HSE, 2021). Home and Community Care Ireland (HCCI, 2019) represent 80 private homecare providers and employed approximately 14,000 homecare workers in Ireland in 2019 (Mercille & O'Neill, 2020). Yet ambiguity exists concerning exactly what homecare entails (MCRI, 2013). Walsh and Lyons (2021) in their Economic and Social Research Institute report (ESRI), define homecare as professional care and support delivered to people in their own homes. The Institute of Public Health (IPH, 2018) contend that homecare in Ireland largely relates to the provision of home-help services such as personal care and domestic duties. Publicly funded home support consists of assistance with personal hygiene, cleaning and cooking, according to Aspell et al. (2019).

The IPH (2018) acknowledge the myriad of additional services provided within the home such as nursing, GP and physiotherapy, yet identify homecare as distinctive in its own right. SIPTU, within their employment guidelines for homecare workers (2015), argue that homecare work is individual based on the needs of the recipient of care, yet often encompasses domestic duties. However, SIPTU (2015) further contend that homecare workers employed by private and not for profit providers, may have different titles.

Indeed within the Homecare Bill of 2020, the definition of homecare encompasses any health or social care provision within the home, which enables a person aged over 18 years to remain living independently at home (Government of Ireland, 2020). The Homecare Bill specifies that this may include but is not limited to: nurses, staff providing therapies, home-helps, homecare attendants and staff providing palliative care (Government of Ireland, 2020).

However, the current study relates specifically to homecare staff employed as homecare workers either directly by the HSE Home Support Service, or a private homecare provider. Based on the author's experience within this sector, and the specific aims and objectives of this study, data will relate to a homecare worker or home-help, who provides personal, social and domestic care in the home to older people (Aspell et al. 2019; IPH, 2018).

1.3 - Privatisation and financing

Mercille and O'Neill (2020) argue that the 1990's marked a notable shift in the provision of care to older people in Ireland, with care being increasingly outsourced to private homecare providers. The return of women to the workforce who perhaps historically would have provided informal care at

home to ageing family members, alongside the growth in the older population, presented increased demand for care which the HSE was unable to meet (Klaiss, 2014; Houses of the Oireachtas, 2019). This culminated into the current quasi-market system of both public and private providers, where the HSE outsources homecare hours to private homecare companies (Aspell et al. 2019; HSE, 2020). Mercille and O'Neill (2020) contend that such outsourcing reduced Governmental responsibility concerning the homecare sector and further enabled the development of increased competition within the market. This impact of neoliberalism in evident within the astronomical growth of the private homecare market via outsourcing from the HSE, which rose from €3 million in 2006, to €176 million in 2019 (Mercille & O'Neill, 2020).

1.4 - Rationale for the research

Care Alliance Ireland (2022) describe the homecare service in Ireland as dysfunctional and inconsistent and argue that regulation of this sector should be implemented as a priority of Government. They further describe the ambiguity concerning access to homecare services in Ireland as an "arbitrary eircode lottery" (Care Alliance Ireland, 2022, p. 5). Yet the research undertaken concerning homecare in Ireland to date accentuates the value older people place on this service and the significance of homecare in enabling older people to remain living in the own homes and communities (Kiersey & Coleman, 2017; Lundstrom & Mc Keown, 1994; Donnelly et al. 2016). The role of family members in the medley of care provision to older people in their homes has further been identified within the literature as momentous (Donnelly et al. 2016; O'Shea & Monaghan, 2017).

The homecare market in Ireland is evolving continually to meet the growing demand for this service (Kenny & Mc Garrigle, 2020). Policy created to inform the care of older people in Ireland has been identified as ineffective to date and not fit for purpose (O'Shea, 2017; Law Reform Commission, 2011, Ruddle, Donoghue & Mulvihill, 1997). The regulation of the homecare sector in Ireland has been repeatedly recommended within both the previous literature and policy to date (Dept. of Health and Children, DOHC, 2001; Kiersey & Coleman, 2017; Lundstrom & Mc Keown, 1994; The Working Party on Services for the Elderly, 1988). This regulation of the homecare sector in Ireland via the enactment of the Professional Homecare Bill, will provide clarity in terms of care provision and afford greater protection for older people in receipt of homecare (Government of Ireland, 2020). Yet the Professional Homecare Bill initially drafted in 2012, and presented before the Dail again in 2014, were both unsuccessful in being enacted into law (Care Alliance Ireland, 2014. The

Professional Homecare Bill (2020) has been redrafted and is currently being debated within the Seanad, with no further updates at the time of writing (Houses of the Oireachtas, 2020).
A lack of research pertaining to homecare overall, can distort knowledge or perceived knowledge within this sector of care provision (Newquist, DeLiema & Wilber 2015). Kiersey and Colemen (2017) alongside Mayo-Wilson et al. (2014), contend that there is a distinct dearth in the evidence base concerning homecare for older people in Ireland.

It is hoped that the findings from this study will contribute to and enhance the limited evidence base to date concerning homecare and further illuminate the issues which older people and homecare workers deem most significant pertaining to homecare. Furthermore, findings may identify specific practice or societal issues which have not been previously identified as relevant to homecare provision, which may be useful for future policy and service planning.

1.4 (1) - Gaps in the literature

The homecare research undertaken to date in Ireland has largely addressed specific issues such as time, working conditions and the impact of policy on practice (MCRI, 2015; Timonen & Doyle, 2008; Dempsey, Normand & Timonen, 2016). Yet little of the existing literature concerning homecare in Ireland has sought to examine the views and perspectives of homecare workers and older people. There appears to be a dearth in literature which really encapsulates the experiences and perceptions of the two parties at the coal face of service delivery.

Much of the existing literature reports on specific issues such as access to homecare and in relation to the planning and feasibility of the regulation of the homecare sector (Donnelly, O'Brien, Begley & Brennan 2016; Kiersey & Coleman, 2017; Haslett et al. 1998). Lundstrom and McKeown in their cornerstone 1994 study did examine service user satisfaction concerning homecare provision. However this research was undertaken almost 30 years ago, and the evolution of the homecare sector in Ireland since then has been substantial (Lundstrom & McKeown, 1994).

The current study is seeking a much more intimate and personal insight into what homecare means to those most directly impacted by it. This study will illuminate the voices of both homecare workers and older people, as hard to reach groups who are often underrepresented within research (Sydor, 2013; Cortese, Trusscot, Nikidehaghani & Chapple, 2019). This research will address the gap in the existing literature and aim to gauge the opinions, experiences and perspectives of both parties

within the homecare relationship concerning what matters most to them, and what factors they deem impact homecare.

1.5 - Research question, aim and objectives

Aim: To examine the current delivery of homecare to older people in Ireland, from the perspectives and experiences of both older people and homecare workers.

Objectives:

- Ascertain the views of older people relating to both positive and negative experiences of homecare provision, based on their individual perspectives.

- Explore homecare worker's experiences of delivering homecare to older people and examine the factors which impact this care.

1.6 - Summary

This introductory chapter has provided an overview of how homecare has developed in Ireland to date and identified the challenges of Government in responding to the care needs of Ireland's fast expanding ageing population. The role of homecare in enabling older people to remain at home as they age was discussed within this chapter. An in-depth description of the role and remit of the homecare workers was outlined, with clarity concerning the specific meaning of homecare as it relates to the current study.

This chapter provided rationale for the current research aim and objectives, within the broader context of the existing evidence base. The justification and reasoning for this study were demonstrating via identifying gaps within the previous literature and by considering the continually evolving nature of homecare currently in Ireland. The following chapter will provide a review of the literature pertaining to older people and homecare.

Chapter 2: Literature Review

2.1 Introduction

This chapter will review the literature pertinent to the research question and provide context to the fundamental issues concerning older people and homecare provision. This key aim of this literature review is to explore the multitude of factors which impact the provision of homecare to older people.

Due to the volume and breadth of the phenomenon of homecare, this literature review chapter will be divided into 6 parts. Each part will identify and discuss an area of practice, theory, research or policy deemed particularly relevant to the topic of older people and homecare. Part 1 will present the key ideas and concepts surrounding ageing and homecare for older people. This will include cornerstone ideas such as ageing in place, isolation and loneliness and health promotion, within the context of homecare need and provision. Part 2 of the literature review will examine homecare work more generally within the international literature and discuss the main ideas which inform understanding of what this means. Issues such as gender and caregiving, alongside motivation to choose homecare as employment, will be considered. Part 3 will examine key gerontological theories with the aim of illuminating the primary ideas which may inform the current study. Part 4 of this chapter will explore policy and legislative developments concerning homecare both internationally and within the Irish context. Policy development pertaining to older people and homecare in Ireland to date will be mapped, while an overview of policy in England will further be provided in order to highlight the contrasting approaches to the regulation of homecare evident between both countries. Part 5 of this chapter will examine key research studies undertaken in Ireland to date, deemed to be particularly relevant to the current study. Finally part 6 of the literature review will consider evaluation frameworks used within health and social care research, and determine if any one may be appropriate from which to draw upon within the methodology of the current study.

Homecare plays a vital role in supporting older people to remain in their own homes and communities as they age (Kiersey & Coleman, 2017). Policy in Ireland has long sustained the idea that older people should be supported to remain living at home for as long as possible (The Working Party on Services for the Elderly, 1988; DOH, 1994; DOHC, 1998; DOHC, 2001; Government of Ireland, 2006). International policy further advocates the role of governments in meeting the health

and social care needs of people as they age (UN, 2002; EU, 2012; European Commission, 2011). Yet Mayo-Wilson et al. (2014) highlight the lack of documented home visit data at an international level, which presents challenges for both policy makers and homecare providers, in establishing methods of best practice. This literature review aims to identify any gaps within the literature concerning homecare and the factors which impact this.

The vast majority of older people want to remain living in their own homes and communities as they age (Ahn, 2017; Cutchins, 2003; Donnelly et al. 2016). However ageing in place is often dependent on the availability of homecare services locally (Calahan & Towers, 2018; Oireachtas, 2018). The substantial role of family carers is further essential for many older people in enabling them to remain living at home (WHO, 2020; McGarrigle & Kenny, 2020). Previous research on this topic has identified the substantial positive impact of the social opportunity provided by the homecare visit for older people, and the development of caring relationships between both older people and homecare workers (Delp et al. 2010; Ivanova & Dykstra, 2015). However Age Action report that older people are remaining in their homes with unmet needs, due to a lack of accountability and transparency concerning homecare in Ireland (Oireachtas, 2018). The availability of the service appears ambiguous, with Alone in 2019 reporting that some regions of Ireland have no homecare service available whatsoever.

This chapter will examine the literature relevant to answering the research question more broadly based on internationally data, and specifically within the Irish context. A comprehensive review of gerontological theory, policy and legislative developments and the evolution of homecare provision to date, will be provided.

Part 1

2.2 - Key Concepts and Ideas Regarding Older People and Homecare

Key concepts which offer explanation regarding the multitude of issues which affect older people as they age at home, will be examined within this part of the literature review. The concept of ageing in place will be discussed, relating to how this affects and impacts older people and their need for homecare provision. The related idea of continuity of care within the context of ageing in place will further be considered. The distinctive yet interrelated concepts of isolation and loneliness will be critically discussed within this section, pertaining to homecare provision for older people. The significance of health promotion for older people will further be examined, with specific focus on the

key issues of choice and control. Finally, ageism and the effect of neoliberalism on the homecare market will be considered. How such ideas culminate to impact both older people and homecare workers, will further be critically explored.

2.3 Ageing in Place

Most older people, wish to remain in their own homes as they age (Cutchin, 2003; Stones & Gullifer, 2014). Cutchin (2003) describes ageing in place as the older person remaining in their place of familiarity, usually their own home. Remaining at home enables the older person to maintain a sense of continuity, safety and familiarity (Barrett, Hale & Gauld, 2011, p. 362). The term itself is unfamiliar to older people and is language more typical of policy makers and planners (Wiles et al. 2012). Yet ageing in place is a concept solely based upon the experiences of older people and their unique perspectives concerning the place where they live (Horsefall et al. 2017; Wiles et al. 2012). Ageing in place is not merely about remaining in one's home, but remaining within the network of neighbours, friends and communities within which older people feel safe (Wiles at al. 2012). Harreman, Bours, Zander, Kempen and Van Duren (2020) suggest that for older people ageing in place is more closely associated with feelings, rather than a physical structure with boundaries. Harreman et al. (2020) argue that older people ascribe characteristics of independence, good mental and physical health and resilience, to their perceptions of ageing in place.

A sense of place according to Gesler (1991, p. 164) is described as "transference of moral and aesthetic judgements to particular sites". Horsfall, Leonard, Rosenberg, and Noonan (2017) propose that the concept of home as a place and the meaning older people attribute to this, is complex. Their study found that older people identified home as: "a place of belonging and comfort, a place of social connection and a place of achievement and triumph" (Horsfall et al. 2017, p. 58). Anton and Lawrence (2014) describe the idea of place attachment as beneficial for older people, relating to overall health and wellbeing. The key components of place attachment relate to place identity and place dependence (Anton & Lawrence, 2014). Place identity is concerned with the activities and rituals undertaken within the place or home (Lengen & Kistemann, 2012). The place provokes emotions, memories and experiences, which result in happiness and satisfaction for older people who have a positive place identity (Lengen & Kistemann, 2012). Place attachment refers to the "positive emotional connections to a place or location" which are based upon both physical experiences and social interactions (Clarke, Murphy & Lorenzoni, 2018, p. 82). Place attachment results in similar emotional responses to those associated with social attachments according to

Scannell and Gifford (2016). For older people, disruption in this place attachment and connection often results negatively on wellbeing (Scannell & Gifford, 2016).

Older people perceive ageing in place as important for enabling them to retain control over their own lives (Stones & Gullifer, 2014). Gilleard, Hyde and Higgs (2007) contend that older people feel a connectedness to not only their home, but also the geographical location of their town or city and the community attached to this. Browne (2016) found via public consultation concerning the care of older people in Ireland, that homecare afforded greater choice for older people and enabled them to remain at home as opposed to long term stay facilities. Yet ageing in place is profoundly impacted by the environment within which the older person is ageing, namely, the impact of policy and resources on their lives as they age (Cutchin, 2003). Hence, although ageing in place is presented as a choice of the individual or an outcome of their preference for care, this may not always be possible. The ability to age is place is largely dependent upon the availability and effectiveness of homecare services, within the locality where the older person lives (Cutchin, 2003). Such findings are pertinent to the current study, as homecare availability can directly impact the older person's ability to age in place as a preference.

Statistically, the percentage of older people ageing in place varies from country to country throughout Europe. In Finland, France and Germany, 90% of people aged over 65 remain at home living independently (Harreman et al. 2020). However, the WHO (2020) argue that long term care statistics are often limited. Though statistics identify bed usage for older people in residential settings, they do not acknowledge that in some countries, such figures depict the maximum capacity. Consequently, this can deflect from identifying and acknowledging the level of unmet need for long term care (WHO, 2020).

In Ireland trends of nursing home usage over time have decreased, as greater emphasis is shifting towards supporting older people to age in place. In 2006, 6.8% of people aged over 65 were residing in nursing homes, with the remaining 93.2% residing in the community. Of those 93.2% of community dwelling older people, 26.7% were living alone (CSO, 2007). However, in 2016, 94.7% of older people in Ireland were ageing in place and living in their own homes and communities. Of those 26% were living alone, according to the CSO (2019). In 2016, 5.3% of people aged over 65 were residing in nursing homes in Ireland. This illustrated a decrease in nursing home usage among older people in Ireland, by 1.5% over this 10 year period (CSO, 2019). This is consistent with other

European countries such as Denmark and the Czech Republic. In contrast, Italy reported that just 1.5% of their elder population were resident in a nursing home in 2009 (HSE, 2014).

In comparison to ageing at home, Nakrem et al. (2013) found that although most participants felt they received quality care, many expressed ambiguity in relation to considering the nursing home, as their actual home. Nakrem et al. (2013) interviewed 15 nursing home residents in Norway, with the aim of establishing the quality of care participants felt they were provided with. Although all participants acknowledged this residential facility is where they live, participants were reluctant to give the meaning of home to their current living arrangements (Nakrem et al. 2013). Moore and Ryan (2017) found through their qualitative study in Ireland, that although most older people living in nursing homes felt safe, supported and less socially isolated, they often don't view the nursing home as their actual home. This research involving 48 nursing home residents and 44 nursing home staff, concluded that the nursing home residents felt they had choice in relation to their care and that staff facilitated this individualised care delivery (Moore & Ryan, 2017). Such findings appear to contrast the ideas presented by the concept of ageing in place and describe older people ageing well in nursing homes and being satisfied with the level of choice this affords them.

Gilleard et al. (2007, p. 600) in their longitudinal study of older people in England, found that only a "modest increase" in wellbeing was reported from participants who were ageing in place, compared to those who had moved house or resided in a nursing home. However, Barrett et al. (2011) argue that the development of dependency requiring the need for care in one's home, can in itself, be disempowering for older people. Stones and Gullifer (2014) found with their qualitative research pertaining to 23 older people in receipt of homecare in Australia, that participants relinquished control somewhat strategically, in order to remain at home and maintain the perceived autonomy associated with this. As health and ability to perform self-care tasks declined, older people felt their control decreasing, yet still found that they could refuse homecare if they wished, a choice some feared they may not have within a residential setting (Stones & Gullifer, 2014).

Boyle (2004) surmised that perceived control may be greater for older people living in residential care facilities, as they have more choices concerning activities they may participate in, or options to attend religious services. Whereas in contrast, older people residing at home may not have such choices due to issues such as: access, support or ability (Boyle, 2004). Such findings illustrate both the complexity of choice and control and highlight the importance older people place on the maintenance of perceived control, as they age. Such findings equally suggest that older people are

often afforded choice by other people, whether they are ageing in place or within a residential setting, and perhaps not truly exercising choice and control over their own lives. This literature will be significant in informing the current study, as ageing in place may be relevant to older people and their need for homecare, in addition to their unique experiences in receiving this care.

The home as a setting for care provision is significant when exploring the concept of ageing in place. Herber and Johnston (2012) suggest that homecare workers often find themselves developing emotional attachments as they meet the needs of older people, within the confines as their homes. Parks (2003) contends that the intimacy of the home as a setting presents unique moral challenges for both homecare workers and older people, as they can develop close and meaningful relationships with one another. The closeness of both parties creates a space where reciprocity in care can become expected and indistinct boundaries between the personal and professional can manifest (Parks 2003). Abrams et al. (2019) argue that the uniqueness of the home as a setting, requires homecare workers to be flexible in addressing boundaries within this context. Homecare workers find themselves "at the intersection between informal and professional care" (Herber & Johnston, 2012, p. 234).

2.3 (1) *Informal carers*

The role of informal carers impacts significantly the enablement of older people to age in place (IPH, 2018; Ambrugo et al. 2020). Based on analysis of the longitudinal data collected via TILDA, family or informal carers are instrumental in supporting older people in Ireland to age in place (McGarrigle & Kenny, 2020). McGarrigle and Kenny (2020) found that between wave 1 in 2009 and wave 5 in 2018, the increase in people requiring support when undertaking activities of daily living (ADL) increased significantly for both men and women. TILDA (2020) conclude that informal carers (comprised of family members, neighbours and friends) play a momentous role in the enabling older people to remain at home, by assisting them with ADL. The data demonstrates growth within the levels of support in the home for older people as they age and functional ability declines (Mc Garrigle & Kenny, 2020). Donnelly et al. (2016) found that informal care often delivered by family members, is instrumental in the myriad of care services which enable older people to stay at home.

Kuzuya et al. (2011) found that informal care is a distinctive marker in reducing the likelihood of an older person entering a hospital or long-term stay facility. Their longitudinal data in Japan surveyed 1582 community dwelling older people and concluded that a lack of informal care, increased the likelihood of participants being unable to continue living in their own homes (Kuzuya, 2011).

Ambrugo et al. (2021) alongside O'Shea and Monaghan (2017) reiterate such sentiments regarding the significant role of informal carers in the lives of older people across Europe. Informal care benefits both the older person they are providing care to and society more broadly, as they reduce the level of more formal care and support required (Ambrugo et al. 2021). In fact the Social Protection Committee and the European Commission (2014), argue that the economic benefit of informal carers is substantial and presents significant savings on the alternative cost associated with long term residential care.

O'Shea and Monaghan (2017) conducted research in Ireland on older people living with dementia who were on the boundary of admission to residential care settings, yet were residing at home. This study had 181 participants and the aim was to measure the true cost of care in the community, in comparison to care in a long-term stay facility. A quantitative methodology was employed and findings indicate that only 47% of participants were in receipt of home-help services, while informal care was the most widely used method of care across respondents (O'Shea & Monaghan, 2017). Interestingly, O'Shea and Monaghan (2017) concluded that when the opportunity cost of informal care and household consumption costs are considered, that this type of homecare arrangement for people living with dementia is actually substantially more expensive, than a place within a residential care setting. Such findings prompt one to critically consider the cost of care in the community, and who is responsible for paying this bill? Certainly based upon the approach undertaken by O'Shea and Monaghan, informal care givers and older people themselves bear the weight of the financial burden associated with homecare. In contrast the government in Ireland bears the cost should the individual move into a residential setting (O'Shea & Monaghan, 2017).

2.3 (2) *Continuity of Care*

Closely linked to the notion of ageing in place, is the idea of continuity of care for older people ageing in their own homes and communities. According to Gulliford, Nathani and Morgan (2006), continuity of care is concerned with the older person's ability to develop a caring relationship with their care provider. Gulliford et al. (2006) contend that continuity of care is further associated with seamless care which is consistent in delivery and which results in older person's satisfaction with the interpersonal aspect of this care delivery. Aspinal et al. (2012) contend that longitudinal continuity, is care that is delivered by as few professionals as possible and is consistent with needs of the care recipient.

Guthrie, Saultz, Freeman and Haggerty, (2008) propose that continuity of care can be considered within 3 specific domains:

1. Informational continuity: a good understanding of the older person's values and preferences, in addition to the more formal information contained in case notes or medical files.
2. Management continuity: clear follow up responsibility and understanding of tasks needed to be undertaken, when and by whom.
3. Relationship continuity: built over time through consistency in care provision. The care provider knows the older person and their needs, and a positive expectation of ongoing and future care is established (Guthrie et al. 2006).

Guthrie et al. (2006) argue that continuity of care is changing as society evolves into an often paperless environment, where telehealth is becoming more common. They further contend that continuity of personnel in particular, result in greater satisfaction from care recipients (Guthrie et al. 2006). A systematic review by Facchinetti et al. (2020) examined hospital readmission for older people and concluded that in the short-term, continuity of care which contained the 3 core domains identified by Guthrie et al. (2006), effectively reduced readmission. Ostman, Back-Pettersson, Sundler and Sandvik, (2021) conducted a small-scale qualitative research project to examined nurses experiences of continuity of care, pertaining to patients with heart failure. Focus groups were conducted with a purposive sample of 14 nurses, and findings suggest that nurses view their ability to collaborate and communicate with patients, their families and other health care professionals, as fundamental to their role in promoting continuity of care (Ostman et al. 2021). Participants expressed that trustful and caring relationships with patients, are a vital prerequisite for continuity of care. This involved getting to know the patient, about their life and background, and being in a position to be able to recall information previously shared, or plans for care agreed (Ostman et al. 2021).

Other scholars argue that longitudinal continuity of care is crucial when supporting people with long-term or chronic health conditions (Aspinal, Gridley, Bernard & Parker, 2012). Individuals having to share their medical history frequently, as they see multiple different medical professionals, can become burdensome. Having 1 key contact person who would be responsible for care co-ordination, was considered to be much more beneficial to the person in receipt of care and resulted in greater levels of satisfaction (Aspinal et al. 2012).

In the context of older people in the community, a study by Ohta, Ryu, Kitayuguchi, Gomi and Katsube, (2020) aimed to examine the factors which impact continuity of care. Ohta et al. (2020) found that good relationships between older people and care providers, enables faster identification of a health decline for the older person, and consequently a more prompt medical intervention response. Equally, Ohta et al (2020) argue that for rural dwelling older people, continuity of care is even more significant given the social exclusion presented by sparsely populated geographical areas. Research specific to homecare for older people further identifies the need for having the same member/s of staff as a key component of continuity of care (Dostálová, Bártová, Bláhová, & Holmerová, 2022). Dostalova et al. (2022) argue that continuity of personnel, culminates into continuity of care. Older people then know what to expect of their homecare visit and have a greater sense of certainty pertaining to their care (Dostalova et al. 2022). It is realistic to surmise that in order to support an older person to age in place, continuity of care is fundamental (Aspinal et al, 2012; O'Shea, 2017; Dempsey et al. 2016). Continuity of care will likely be even more significant for older people without the support of family members to provide informal care, who may be wholly dependent on formal homecare provision to remain living at home (Donnelly et al. 2016; Timonen & Doyle, 2008). For one to age in place successfully, consistency and dependability regarding care provision are essential (Dostalova et al. 2022).

In summary, the concept of ageing in place has long been a goal of older people and is now more widely recognised as being the optimal environment in which older people receive care (Barret et al. 2011; Cutchin, 2003). However ageing in place is often dependent upon the availability of support in the first instance from informal carers, and secondly within the form of care in the home (Donnelly et al. 2016; IPH, 2018). Providing care when supporting an older person to age in place presents a unique setting for care provision and aims to enable the older person to retain connections with a place of familiarity. Homecare workers have a fundamental role in empowering older people to age in place and remain living in the own homes and communities (Lundstrom & Mc Keown; Timonen, 2018; Kiersey & Coleman, 2017). Continuity of care has been found to be more beneficial for older people and resulting in fewer hospital admissions, a greater sense of certainty for older people in terms of what to expect from their care and culminating into greater levels of satisfaction with care provision (Dostalova et al. 2022; Aspinal et al. 2012; Ohta et al. 2020).

2.4 Understandings of Isolation and Loneliness

Although often used interchangeably within the literature, the terms isolation and loneliness are distinctly different (Fischer, 2009; Klinenberg 2016; Tilvis et al. 2011). Hawthorne (2006, p. 521) describes isolation as "living without companionship, social support or social connectedness". Social isolation manifests via having little or no social support and low levels of social contact (Hawthorne, 2006). Cotterell, Buffel and Phillipson, (2018) suggest that social isolation may be considered within 3 distinct spheres: the relationship level, the community level and the societal level. The relationship level is concerned the level of contact and strength of relationships with family and friends. For example: this would be poorer where there is family dysfunction or feuds (Cotterell et al. 2018). The community level relates to the opportunities and challenges presented for social opportunities in the locality. This may be impacted by issues such as crime rates, access to transport and availability of social activities and events (Cotterell et al. 2018). The societal level is concerned with the broader impact of societal issues such as racism, cultural beliefs and social policy (Cotterell et al. 2018).

The term loneliness was first documented in England in the 1800s and has been explained as comprising of "a cluster of emotions" (Bound Alberti, 2018, p. 44). Within early literature loneliness was presented descriptively as feelings of melancholy, depression, sadness or longing (Bound Alberti, 2018). Although definitions of loneliness vary, most concur that loneliness involves the negative, stressful, or unpleasant emotions, experienced by a person, due to feeling disconnected from other people (Bandari et al. 2019). Tilleach (1959) described loneliness as the opposite of solitude. Solitude is an expression of peace with being alone, while loneliness results in feelings of despair or sadness (Tilleach, 1959). Austin (1989) identifies loneliness in terms of the feelings this creates for the individual, such as a sense of emptiness and feeling hollow.

2.4 (1) <u>Definitions and measurements of social isolation and loneliness</u>

Gierveld, Van Tilburg and Dykstra, (2018) along with Fischer (2009) propose that loneliness is the subjective interpretation of social isolation, as experienced and perceived by the individual. "Loneliness is a subjective feeling of being without the type of relationships one desires" (Tanskanen & Anttila, 2016, p. 2043). Dahlberg (2009) in her phenomenological research on loneliness, asserts that loneliness is inflicted upon people and is a condition they have no control over. The person has a desire to connect with others and this desire is unmet, sometimes because of the perceived inaction of other people (Dahlberg, 2009).

Rokach (2016, p. 57) contends that loneliness "is a multidimensional experience that is composed of 5 dimensions". Should 2 or more of these dimensions be present, the individual will perpetually experience loneliness. These 5 dimensions as identified by Rokach (2016, p. 57) are:

- Emotional distress: "the internal upset, agony, turmoil, feelings of anguish, and emptiness that one may feel when lonely".
- Social inadequacy and alienation: the self-perception of one's social network (opportunities and reality) and the idea that we must be undesirable or defective in some way if we are lacking social opportunities.
- Interpersonal isolation: the isolation and negative feelings of rejection when perceived social connections are not reciprocated.
- Self-alienation: the person is so pained and overwhelmed by the loneliness they feel that they attempt to detach from themselves in an effort to relieve this pain. This may be described as the individual aiming to separate their mind from their body as they attempt to alleviate the physical effects of the loneliness they feel.
- Growth and discovery: the individual develops as a result of the loneliness they feel. The person evolves in coping with loneliness and reprioritises what is important to them, and consequently finds "personal strength and meaning" they did not know existed within them (Rokach, 2016, p. 61).

In differentiating between social isolation and loneliness, De Jong-Gierveld, Van Tilberg and Dykstra, (2006) argue that one can be socially isolated, yet not feel lonely. Whereas a person can feel lonely, while not actually experiencing social isolation (De Jong-Gierveld et al, 2006). Feelings of loneliness and indeed perceptions of what it means to be isolated socially, as both subjective and based on the evaluation of the individual and their relationship and social goals (De Jong-Gierveld et al. 2006). Victor, Scambler and Bond (2007) propose that the value and meaning the older person places on perceived access to social contact, combined with their individual social needs, will dictate their individual perceptions of their level of social contact versus their social need, and whether such perceptions fall short and culminate into feelings of loneliness.

Zavaleta, Samuel and Mills (2017, p. 369) define isolation as "the deprivation of social connectedness" concerning the frequency of social contacts. Consequently, it is argued that social isolation can be externally measured or assessed numerically, in contrast to the internal measurement of loneliness (Zavaleta et al. 2017; Gierveld et al. 2018). Indeed based on examination of the Canadian Longitudinal Study of Ageing (CLSA), social isolation was measured via the use of

frequency of contact scales (Menec, Nancy, Mackenzie, Shooshtari, & Nowicki, 2019). Menec et al. (2019) used a 5 point scale within their analysis based upon: marital/relationship status, number of people living in their household, the time since their last social contact with children, siblings, close friends or neighbours, retirement/employment status and attendance at specific activities (church, community, sport etc). Each question was scored based on the frequency of such interactions. Zavaletta et al. (2017) and Gierveld et al. (2018), propose that objective measurement of isolation is determined quantifiably, based on the number of social contacts the individual has. Whereas subjective assessment of isolation, is based upon the individual's perception of the quality of their relationships with other people (Pettigrew et. 2014).

2.4 (2) Determinants of social isolation and loneliness

Klinenberg (2016) proposes that certain subgroups of society are more at risk of experiencing social isolation. Lesbian and gay people may be more likely to be estranged from their families, while people who live in socially deprived high crime areas, may be less likely to socialise in their communities (Klinenberg, 2016). Nicolson (2012) in his systematic review of social isolation experienced by older people, proposes that health issues such as incontinence or hearing loss, can further cause and exacerbate isolation. Dahlbery and Mc Kee (2014) in the UK, found that being in the older old age category (<80), being female and having other medical conditions, further increase the likelihood of feelings of loneliness for older people.

Ward, Layte and Kenny (2019) within the Irish Longitudinal Study on Ageing (TILDA), estimate that 400, 000 people in Ireland are suffering from loneliness. The Covid 19 helpline set up by the charity ALONE in 2020, found that over 54% of callers were aged over 70 and were cocooning, while 76% of callers were living alone (Ward et al. 2020). Ward et al. (2019) report that older people with lower levels of education and those aged over 68 years old, are more likely to experience social isolation. Social isolation within this data set were measured via instances of social interaction (Ward et al. 2019). Interestingly, Ward et al. (2019) surmise that rural people in Ireland are more socially integrated than urban dwellers, while older people who live alone are in reality, the most isolated socially. Older people who are socially isolated have poorer self-rated health and in particular more likely to report major depressive episodes (Ward et al. 2020).

Findings by Menec at al. (2019) determine that social isolation is particularly prevalent for older adults in low income areas. Similar to Irish findings based on TILDA, CLSA identified that older older people were more likely to be socially isolated. In contrast to the TILDA study, the CLSA found that

lower education levels were not associated with greater likelihood of social isolation. Menec et al. (2019) propose that this may be impacted by migration patterns where older people with higher education levels move purpose built to retirement communities, and away from family.

Pettigrew et al. (2014) in a qualitative study with 111 Australians over the age of 40 years found that developing new social contacts is more difficult as people age, due to their lack of interaction with institutions such as schools or colleges. Moreover, participants would prefer to be invited to participate, as opposed to be proactive themselves in seeking social opportunities (Pettigrew et al. 2014). Pettigrew et al. (2014) surmise that this stems from the stigma associated with being socially isolated and one's unwillingness to perhaps expose this to other people.

Rokach (2019) discusses gender differences in experiences of loneliness. Rokach undertook qualitative research via a phenomenological lens in Canada and concluded that women tend to have larger social circles and roles than men, as they age. The sample size of 711 is quite notable and further demonstrates depth and breadth in the subsequent conclusions drawn. Rokach (2019) surmises that women feel a greater need for social connection based on their previous social networks, when compared to men.

2.4 (3) Theory concerning social isolation and loneliness

From a theoretical perspective and via a sociological lens, social isolation must be considered as having manifested as a result of the societal structures within which the individual is socialised (Victor, Bond, Sasha & Bond, 2009). Victor et al. (2009) argue that a theoretical explanation for social isolation which does not consider the impact of the context within which the person develops, is limited. One such theory which attempts to explain social isolation and suicide, is that offered by Giddens structuration theory (Machielse & Duyndam, 2020). Giddens contends that individuals possess agency to modify or mediate their actions, yet simultaneously societal structures shape and impact the situation the individual finds themselves in (as cited in Machielse & Duyndam, 2020). Based on Gidden's structuration theory, the individual and their routines and patterns of behaviours may not fit with those they try to socialise and connect with (Giddens, 1996). If the individual is aware of the impact of their behaviour and willing to modify this, they may consciously make this decision, in an effort to reduce their social isolation. Yet if the individual is unaware of the impact of their routines or behaviours or is unwilling or unable to modify these to avoid social isolation, this isolation may be maintained (Giddens, 1996). For example: an older person who is estranged from

their family due to hoarding behaviour or aggressive outbursts, who is unwilling or unable to change these behaviours.

Weiss (1973) in his theory of loneliness explains that this phenomenon can be understood as a response to the social situation the individual finds themselves in. Weiss describes two distinct types of loneliness: social loneliness and emotional loneliness. Weiss (1973) proposes that social loneliness occurs when one's desire for social contact with a group of people is unmet. Emotional loneliness results from the unmet desire for contact with an intimate or romantic partner (Weiss, 1973). Weiss (1973) contends that emotional loneliness is more difficult to cope with than social loneliness, and women are more likely to suffer from emotional loneliness. Weiss's theory on loneliness and overcoming this emotion, suggests that feelings of loneliness subside as time passes and the individual's expectations for relationships decrease (as cited in Cosan, 2019). Cosan (2019) contends that loneliness which is considered short term or situational is responded to differently, compared to loneliness which is perceived to be more long-term. For example: the loneliness felt by an older person whose spouse is in hospital temporarily, compared to an older person whose spouse had died. Weiss (1973) differentiates loneliness from a wish or desire for more social contact and describes loneliness as an exceedingly emotionally difficult and deficit state.

Bronfenbrenner's ecological systems theory further sheds light on the phenomenon of social isolation. Bronfenbrenner (1979) proposes that people are inextricably impacted and affected by the systems within which they are socialised, namely: the chronosystem, macrosystem, exosystem, mesosystem and microsystem. Ecological systems theory is traditionally discussed concerning children. However this theory emphasises the significance of context when discussing ageing and older people. Hye-Young (2020) argues that use of an ecological systems approach for gerontological research contributes to a deeper understanding of the multitude of factors which impact the individual's ability to age well. Hye-Young, (2020) contends that intervention aimed at promoting healthy ageing must be approached from an ecological systems framework, in order to be truly effective.

The chronosystem relates to changes and shifts over time, and how these changes impact the other systems and ultimately the individual (Bronfenbrenner, 1979). For example: the age at which the death of a spouse occurs, the onset of illness and so on. The macro refers to the social and cultural values of the society the individual is socialised within and lives in. Concerning older people this may relate to how society views old age, what societal structures are in place to support ageing etc.

(Bronfenbrenner, 1979). The exosystem is concerned with issues and occurrences which impact the individual indirectly, for example an adult child emigrating for work, or working 60 hours per week, may indirectly impact the older person. The mesosystem refers to the interactions or linkages between the individual microsystems. For example: the relationships and engagement between a GP practice, the public health nurse and home visits, following a hospital stay. The microsystem refers to the immediate surroundings of the individual in their home, the places they interact and are physically (Bronfenbrenner, 1979). This includes the community, social groups and networks. Bronfenbrenner's theory proposes that the interaction of the individual with these interrelated systems, shape and impact every facet of human development (Brofenbrenner, 1979; Darling 2007). Darling (2007) proposes that ecological systems influence the development and engagement of the individual across the lifespan in a bi-directional process. The individual both impacts and is impacted by each of the subsystems within their ecological system (Darling, 2007). Indeed using ecological theory to examine the lives of older people has been shown to provide a comprehensive insight into problems facing older people and how best to address these (Bettis, Kakkar & Chan, 2020).

Hye-Young (2020) contends that intervention aimed at promoting healthy ageing must be approached from an ecological systems framework, in order to be truly effective. By exploring the barriers or challenges presented by one or more of the systems the older person is impacted by, more focused systemic efforts can be implemented to improve outcomes (Bettis et al. 2020). In the context of social isolation, one could consider the impact of each system both on the other systems, and the impact of this on the individual. For example: the macrosytem in any given country will impact how society views, treats and cares for older people. In Irish society, once could argue that the macrosystem contributes to the social isolation of older people, due to a cultural acceptance this. Equally, if an older person's microsystem and mesosystems lack access to healthcare or indeed access or opportunity to socialise, this would both cause and maintain social isolation (Bronfenbrenner, 1979).

2.4 (4) Impact and outcomes of social isolation and loneliness

Tanskanen and Anttila, (2016) conducted longitudinal research on the effects of loneliness in Finland. This study consisted of a large sample size of 8650 older people and found that loneliness and social isolation, were directly linked to mortality. The Loneliness Taskforce (2018) contends that loneliness for older people in Ireland, results in premature nursing home admission, worsening of health problems and premature death. Loneliness is described as equally as harmful to health as the use of alcohol or smoking (Holt-Lunstad, Smith & Layton, 2010). Hawkley and Cacioppo (2010) argue

that social isolation can cause cognitive decline in older people and can increase depressive feelings and reduce self-esteem.

Cacioppo and Hawkley (2009) propose that the needs of humans for social connection is as primitive as their needs for nutrition and shelter and consequently loneliness is significant in affecting cognition. Such findings emerged within studies relating to toddlers in their cognitive development, and relating to older people with Alzheimers pertaining to their cognitive maintenance (Cacioppo & Hawkley, 2009). Cohen-Mansfield and Rotem (2020) also conducted qualitative research regarding older people's experiences of feeling lonely and found that older people associated loneliness with comparing their current opportunities to connect with other people, to past experiences. A feeling of lacking, loss and a void in one's life were further identified as representing how it felt to be lonely (Cohen-Mansfiels & Rotem, 2020).

The lack of choice or control regarding alleviating loneliness was identified as further compounding the negative feelings experienced by the individual (Roos & Klopper, 2010). Olds and Schwartz (2009) propose that a sense of shame is often associated with professing feelings of loneliness and people often describe causal factors and external forces, which have culminated into their state of isolation, yet will not self-identify as feeling lonely. Perlman and Joshi (1987) suggest that society places measurements of success and accomplishment on perceived social acquisitions such as marital status, having children or having friends. Hence individuals can worry that their loneliness could be perceived as social failure, or due to some defective attributes, or awkward anomalies, in their character (Perlman & Joshi, 1987). Such stigma can dissuade some older people from seeking or accepting services aimed at addressing loneliness, as they do not wish to be labelled old and lonely (Olds & Schwartz, 2009; Perlman & Joshi, 1987).

Cacioppo, Hawkley, Norman and Bernston, (2011) argue that perceived social isolation as opposed to actual or measured social isolation, causes the body to react primitively to restore these connections deemed to have been lost. They contend that the pain associated with perceived isolation impacts the human body in such a manner that prompts action such as behaviour change, in an effort to meet this primitive need for social contact (Cacioppo et al. 2011). Conversely, this pain remains if the individual is unwilling or unable to modify their behaviour or negotiate their life in such a way as to promote social contact, and increased morbidity and mortality result (Cacioppo et al. 2011).

Hawkley and Cacioppo propose that any opportunity which promotes social interaction, can be a successful mechanism for reducing feelings of loneliness for older people (2010). Rosedale (2007) contends that loneliness can be perceived on a pragmatic level and can be broken into manageable symptoms or parts which can be addressed. For example: if an older person is feeling isolated, conditions can be mediated to make it more accessible for them to be included and connect with other people. Or if the health of an older person is impacting their ability to socialise, addressing the health issues can alleviate this barrier to participation (Rosedale, 2007).

It could be plausible to suggest that some older people seek homecare, to indirectly address their loneliness. Gerst-Emerson and Jayawardhana (2015), along with previous research by Cheng (1992), found that increased GP visits, emergency room attendance and public health usage, are seen in individuals experiencing chronic loneliness. When no other opportunities for social contact exist, healthcare contact may become the only viable option (Blayzer & Ryerson, 2020). This is particularly relevant within the context of the current study, as many older people in receipt of homecare live alone (ALONE, 2019). Indeed, Gerst-Emerson and Jayawardhana (2015) suggest that the loneliness experienced by older people, can yield higher expenditure on health. Their study in the United States concluded that the negative health outcomes associated with loneliness, include: depression, high blood pressure and cognitive decline (Gerst-Emerson and Jayawardhana, 2015). It has further been reported that loneliness results in more negative health outcomes for older people and an increase in hospital admissions (Molloy, McGee, O'Neill, & Conroy, 2010; Bu, Philip, & Fancourt, 2020; Geller, Janson, McGovern, & Valdini, 1999).

The societal response to the social isolation of older people in Ireland, is evident within the policy and practice developments which address this issue specifically. The National Positive Ageing Strategy (2013) identifies participation and inclusion of older people as a key area of priority for health promotion. Yet the key issues of loneliness and social isolation are not addressed within this strategy. Objectives are related to the broader participation of the cohort, concerning access to information, advocacy and participation in research (DOH, 2013). Friends of the elderly and ALONE, are two agencies in Ireland which provide both in person and phone befriending services, for older people experiencing loneliness. Yet both services are limited in capacity and dependent upon the availability of volunteers, funding and the geographic location of the older person (Friends of the Elderly, 2020; ALONE, 2020). The Loneliness Taskforce was established in 2018 in Ireland and their report makes recommendations to Irish Government on actions needed to address loneliness. The Loneliness Taskforce (2018) recommend the allocation of responsibility for loneliness to a specific

Government minister (Loneliness Taskforce, 2018). The creation of and funding supports for organisations to combat loneliness, were further recommended (Loneliness Taskforce, 2018). Sime and Collins (2019) suggest that a lack of policy and resulting interventions aimed directly at tackling the problem of loneliness, have culminated into the current maintenance and prevalence of loneliness in many developed countries.

Nicholson (2012) argues that health and social care professionals are uniquely placed to respond to the contemporary social issue of social isolation. This role is fundamental in mitigating the potential further damage isolation can cause, to the health and wellbeing of older people (Nicholson, 2012). An interesting finding within the TILDA report in 2020, highlighted the response to the social isolation experienced by older people during the Covid 19 pandemic. An initiative by ALONE saw 500 smart phones being distributed to older people in Ireland, in response to the loneliness experienced by older people cocooning and isolating (Ward et al. 2020). ALONE also created a Covid helpline which provided a phone service 7 days per week from 8am to 8pm, to talk with and provide a listening ear to older people feeling lonely due to Corona Virus restrictions (Ward et al. 2020).

The response to loneliness for older people in the United Kingdom (UK) appears much less fragmented when compared to Ireland. The UK appointed Tracy Crouch as government minister for loneliness in 2018 (Government of United Kingdom, 2018). A strategy has been created to tackle the issue of loneliness in England, with a 20 million pounds investment to enable all sectors of society, from statutory organisations to communities, to address and respond to loneliness (Government of England, 2018). The key goals of the loneliness strategy in England are to: research the extent and prevalence of loneliness, embed loneliness in policy, raise awareness of the impact of loneliness and reduce the stigma which surrounds this (Government of England, 2018). The 2020 annual evaluation of the implementation of the loneliness strategy, reported that significant progress had been made regarding: the training of health and social care staff to recognise and respond to loneliness, the commencement of policy development to address loneliness, and the implementation of pilot schemes to tackle loneliness, across various settings and sectors (Government of United Kingdom, 2020).

In summary, the review of the literature emphasises the potentially devastating effects of isolation and loneliness on the individual (Cacioppo & Hawkley, 2009; Sime & Collins, 2019). Although the terms social isolation and loneliness are often used interchangeably, this section provided a clear narrative on the difference between these two states of being. Isolations is largely concerned with

the frequency of opportunity to interact socially with other people (Berg-Werger & Morley, 2020). Loneliness is the negative emotion one feels when their wish or need for social contact, falls short of their reality or opportunity for social contact. Loneliness is expressed as a feeling of longing and sadness, when the wish for social contact is less than what is desired (Berg-Werger & Morley, 2020; Taylor, 2020). Taylor (2020) postulates that social isolation does in fact moderately correlate to loneliness, but this is hampered by the pairing of both phenomena within much of the gerontological research to date.

The literature illustrates the magnitude of the effects of social isolation and subsequent loneliness on the individual. The use of a theoretical lens from which to examine isolation and loneliness, presents a more in-depth understanding of the issues which compound and maintain these conditions. Consideration of the broader societal factors which impact social isolation and loneliness for older people, presents a greater opportunity for responding effectively to this issue. Yet the governmental and societal response to social isolation as experienced by older people, contrasts quite notably between Ireland and the UK. Given the greater reliance of older people who live alone on homecare provision, combined with the research in Ireland and internationally which contends that older people who live alone are more likely to experience isolation, consideration of social isolation and loneliness will be significant in informing the current study (Ward et al. 2020; Ambrugo et al. 2021; Deevy, 1983).

2.5 Health promotion

Health promotion illuminates the phenomenon of homecare as it prioritises the maintenance of wellbeing for people as they age and simultaneously aims to enable people to "increase control over their own lives" (WHO, 1986). Health promotion and its place within planning for the care of older people is evident within health policy both in Ireland and internationally (UN, 1982; 1991; DOH, 1994; Government of Ireland, 2006).

The WHO (2014) contend that investment in health promotion, can result in four times the return for every euro of investment. For example: health promotion interventions aimed at addressing mental health, can result in subsequent fiscal benefits within 1 to 2 years. Richardson (2012) proposes that healthcare is a less powerful determinant of health, than that of environment or health behaviours. Yet spending on healthcare vastly exceeds spending aimed at addressing other determinants of health (Richardson, 2012). Investment in addressing the social determinants of

health presents benefits across society, such as in education and employment sectors and is not limited to heath care settings (Richardson, 2012).

Fear that increased life expectancy will result in greater economic spending in the long-term, has been suggested as a potential barrier to health promotion for older people (Rappange, Brouwer, Rutten & Van Baal, 2010). Rappange et al. (2010) argue that although it is likely that increased longevity will increase health expenditure per person, such fiscal considerations should not dictate expenditure on health promotion. The broader benefits of health promotion should be considered by policy makers such as healthier lifestyles, greater quality of life and overall improved population health (Rappange et al. 2010).

Health promotion and its significance for older people, is further evident within the Almeda County Studies. The Almeda County Studies were a series of longitudinal research projects which measured health outcomes and their relationship to lifestyle and personal health habits (Housman & Dorman, 2005). These studies examined the health, wellbeing, childhood experiences, marital status and self-reported life satisfaction of participants and the presence of chronic adverse health conditions and mortality rates. Initial findings indicated that social networks and marital status directly contributed to better health outcomes (Belloc & Breslow, 1972). Later data analysis concluded that health behaviours were strongly impacted by socioeconomic status in childhood and educational attainment in adulthood (Belloc & Breslow, 1972). The habits of healthy living associated with longevity according to the Almeda County studies were concerned with diet, drinking alcohol in moderation, getting sufficient sleep and exercising (Housman & Dorman, 2005). A particularly notable finding was that mortality rates are substantially impacted by social networks for older people (Berkman & Syme, 1979). The longitudinal research design enabled the continued investigation of the original study participants. Findings demonstrated consistently that those with stronger social networks and relationships, lived longer (Berkman & Syme, 1979; Housman & Dorman, 2005).

Such ideas were further proposed by Marmot and Wilkinson (2006) who argue that social supports impact health, wellbeing and mortality. They postulate that public health policy must encapsulate the social determinants of health and aim to addresses these, to truly positively impact the lives of people who are most disadvantaged and disproportionately negatively affected by ill health (Marmot & Wilkinson, 2006). Marmot and Wilkinson (2006) acknowledge that life transitions, for example transitioning into retirement for older people, or leaving the workforce due to illness or

disability, can position individuals within a more advantaged or disadvantaged path. Within the context of older people and homecare from this perspective, their need for homecare often illustrates some physical limitations where assistance is required, hence this may indeed further place them in a more disadvantaged state, due to their increasing dependency on others for support.

2.5 (1) Choice and control

A central concept within the realm of health promotion, choice and control enables individuals to be empowered to make decisions for themselves, concerning their health and care (World Health Organisation, WHO, 1986). WHO (1986) contend that empowerment is a key principle for health promotion and through developing personal skills, individuals can make informed choices concerning their health and wellness. Health promotion for older people is largely undertaken to increase their overall functioning and their ability for self-care (Stanisława, Groot, Pavlova, & Baji, 2016). Objective control can refer to "the actual ability to regulate or influence intended outcomes through selective responding" (Rodin, 1990, p. 4). Whereas subjective control relates to the older person's perception of the control they possess (Rodin, 1990). Blanchard Fields (1986) argues that control (either objective or subjective) directly impacts the coping capacity of the older person, as they navigate through their lives.

However, Stanislawa et al. (2016) argue that historically older people have been neglected concerning health promotion, as younger cohorts are more often targeted with mass media health promotion campaigns. Equally in relation to participation, older people are often considered a hard to reach group and are under-represented within research (Spong & Bianchi, 2017). Lijas et al. (2017) argue that a key element of empowerment from the perspective of the individual, is concerned with being included in decision making and matters which concern them. Chambers and Thompson (2008) contend that empowering older people through health promotion, increases their participation and control over their own care. Nevertheless, older people must feel that they possess the power to impact and change decisions about their care, in order to truly feel empowered (Chambers & Thompson, 2008).

Autonomy and empowerment are often tandem states of being as when one becomes empowered, one can become autonomous (Lothian & Philp, 2001). Autonomy relates specifically to the older person exercising choice and control over decisions which affect their lives (Lothian & Philp, 2001). Hedman et al. (2015) suggests that autonomy in later life is concerned with supporting older people

to be informed, to the extent to which they can make knowledgeable choices about their care. Autonomy for some older people relates to their capability to undertake tasks for example: the ability to attend a social event or dress oneself (Hedman et al. 2015). Homecare can enable the older person to exercise control and be empowered to reach their decided goals, with support (Parsons, Rouse, Robinson, Sheridan & Connolly, 2012). Coulton et al. (2006, p. 271) propose that the role of professionals in enabling older people to feel empowered is significant, as "people cannot achieve their fullest health potential, unless they are able to take control of those things that determine their health". It is the fundamental right of each person to make decisions relating to their health and older people should be provided with the information necessary from their care providers, from which to base their decisions (Moulton et al. 2006). Lothian and Philp (2001) report that autonomy cannot be achieved, if sufficient information is not provided to the older person.

Disempowerment may be experienced by some older people as they are no longer expected, or sometimes permitted, to work or engage in activities from their earlier life, such as: caring for children or volunteering (Fenge, 2001). Fenge (2001) argues that both culture and society place restrictions on the lives of older people and oftentimes this is based on assumptions about behaviour, due to chronological age. This ageist perspective may prompt older people to enact the stereotypes expected of them and can cause an increase in dependency (Fenge, 2001). Yet health promoting care aims to change this, enabling older people to become empowered and make choices concerning their lives and their care. Netten et al. (2011) argue that autonomy is even more significant to people who may have less control over their ability to function and perform everyday tasks. Krause (2007) suggests that feelings of control decrease across the lifespan as people age, which amplifies even more so, the need for empowerment within the homecare relationship. Krause (2007) argues that personal control is akin to agency and is concerned with the individual's perceived ability to impact external factors which affect them. For example: the type of care they receive, where they live and how they spend their time. Faulkner (2001) suggests that professionals have a fundamental role in promoting empowerment, in their provision of care to older people. Faulkner (2001) argues that older people who lack agency become increasingly dependent on those who support them and their self-care skills decline.

Skills in the areas of problem solving and self-advocacy are more likely in older people who have had advantageous educational opportunities, compared to those who do not (Ross & Mirowsky, 2002). Robinson and Lachman (2017) argue that previous socioeconomic and employment opportunities further influence the individual's personal control, in their later years. Older people who have

worked outside of the home, have been shown to be more capable of exercising greater control as they age (Robison & Lachman, 2017). Such indications suggest that women are disproportionately negatively affected by both past employment and educational opportunities, as culturally they were largely expected to remain at home and care for children. This results in women being disadvantaged regarding control as they navigate their later lives (Robinson & Lachman, 2017).

Choice theory was coined by psychiatrist William Glasser to provide greater depth in analysis of choice (2004). Glasser (2004) proposes that all people are driven intrinsically to meet their primary needs of: surviving, love, belonging, freedom and fun. Glasser (2004) further argues that humans fundamentally have a need for power and that this need will inform the choices they make. Glasser (2020) argues that individuals largely have the power to exercise choice and control over themselves and their lives, yet do not have control over other people's lives and actions. Choice theory suggests that people make choices based upon their desire to have their needs met and their wishes fulfilled (Glasser, 2020).

Higginson, Warren and Wood (2011) explain that control in the human behaviour context relates to our current experience, versus the ideal or desired experience and what we do to reach this. Individuals dynamically make choices and take actions based on these choices, which they perceive will move them closer to this desired state or presentation (Higginson et al. 2011). In relation to older people such choice could relate to their care, the time and duration of a homecare visit, their need for interaction or socialisation, their choice of care worker or the tasks being undertaken. A reluctance to complain may further be an attribute of some older people, in attempting to continue to have their fundamental needs met. One qualitative study in the UK found that older people tend not to voice concerns in relation to their care: "recognising their vulnerability, will bend over backwards not to offend the people in whose hands they find themselves" (Woolhead, Calnan, Dieppe & Tadd, 2004). Equally a report by the Parliamentary Ombudsman in the UK, found that older people are apprehensive about complaining, as they worry about the consequences relating to their care (Parliamentary and Health Service Ombudsman, PHSO, 2016). Other reasons older people are less likely to complain about their care include: being unaware of how to make a complaint, living alone and lacking social networks (PHSO, 2016).

Rabiee and Glendinning (2014, p.8) through interviews with older people in receipt of homecare in the UK reported that many older people are "reluctant to complain" and didn't want to "make a

fuss". This could further be attributed to the older person consciously aiming to retain their control to remain at home and may view complaining as a potential threat to this (Woolhead et al. 2004). Lecei and Lepičnik (2014) argue that love and belonging are the most fundamental needs of people, based upon Glasser's choice theory and that these needs will impact the choices and subsequent behaviour of the individual, as they seek to have these needs met. Choice theory assumes that this love and belonging, is what leads to a happy life and this is the primary goal of individuals when they act to build relationships (Lecei & Leoicnik, 2014).

Calahan and Towers (2014) report that difficulties arise in the effort to increase the choice and control afforded to older people concerning their homecare. Key challenges in practice when aiming to increase choice and control for older people, have been identified as: housing which is not fit for purpose, the ability of the older person to advocate for themselves due to frailty and ill health, and the availability of homecare services (Calahan & Towers, 2014).

Mallers, Claver and Lars (2014) propose that control is fundamental to successful ageing and older people who feel they possess control over their own lives, continue to develop and grow as they age. A lack of control can result in increased dependency for the older person and premature death (Mallers et al. 2014). Reidi, Mantovan and Them (2012) argue that older people fear moving to a nursing home, as they perceive this will equate to a loss of independence and control. Reidi et al. (2012) report that older people further fear their increasing care needs, as they feel this will result in a loss of control over their own lives and choices.

Quine and Morel (2007) in their study surveying older people on their thoughts relating to nursing home entry, found that people who live alone, expressed greater fear of admission to nursing homes. 55% of the sample population studied by Quine and Morel (2007), were afraid of a decline in their physical health and of losing their independence, eventually resulting in their admission to a nursing home. Notably this study consisted of a large sample of 8881 older people aged over 65 living in the community and was undertaken in Australia. Hillcoat-Nalletamby (2014) found that many older people feared that institutionalisation would result in them losing control over decision making in their own lives. This study found that older people viewed autonomy as having access to help should they need it, but retaining the ability to complete tasks themselves and refuse help if they so wish (Hillcoat-Nalletamby, 2014). This research consisted of a sample of 183 older people in Wales, living in residential settings. In practice, such fears regarding control could further explain the reluctance of some older people, in making a complaint about their care. Equally choices made by

the older person relating to their homecare, may be a conscious effort to avoid nursing home admission. Sherwin and Winsby (2011) argue that autonomy within healthcare has become enmeshed within legislation, policy and practice with an expectation that recipients of care will self-advocate and deliberate, to make the most informed decision. Burger, Mc Ward and LaTorre (1989) propose that people can also choose to relinquish control willingly. Relinquishing control, particularly regarding stressful or adverse situations, can be viewed an act of self-protection and preservation (Burger et al. 1989). Ultimately, Fry (1989) argues that perceived control in old age is directly linked to well-being. As control decreases, so does well-being and a cycle of learned helplessness can be inadvertently activated (Fry, 1989). Fry (1989) contends that the less frequent opportunities for choice and control arise for older people, the less they anticipate such opportunities in the future.

Health promotion and the fundamental elements of choice and control will inform the current study, as such issues are particularly significant to ageing and older people (Quine & Morel, 2007). Indeed the choice and control relating to remaining in one's own home, is a recurrent theme within the literature regarding older people (Reidi et al. 2012; Mallers et al. 2014). Consequently, health promotion will contribute to the development of the methodological approaches of the current research.

2.6 Ageism

Ageism is described by Third Age (2016), as the unfair treatment or prejudice of an individual or group, due to their age. Ageism in Ireland is often fuelled by negative stereotyping and results in the exclusion and lack of opportunity, afforded to older people (Third Age, 2016). Officer et al. (2016) propose that ageism can impact governments regarding the extent to which they address the needs of older people. The negative portrayal of older people within the media, as frail and burdensome on the health service, exacerbates the issue further (Officer et al. 2016). As this study aims to ascertain the unique experiences and perspectives of older people relating to homecare, consideration of ageism will be fundamentally relevant to informing this research.

The Australian Human Rights Commission found that younger people and particularly those with little or no interaction with older people, have their perceptions of older people negatively impacted by the media (2016). Such media depictions present older people as vulnerable, sick and slow (Human Rights Commission, 2016). Anti-ageing societies where ageing is something to be avoided, instil fear in the population resulting in older people having a negative perception of themselves

(Donizzetti, 2019). Donizzetti (2019) argues that the power of the media can equally be employed to change such negative perceptions of ageing and older people. Normalising images of older people ageing positively and participating in society, could contradict such negative stereotypes and create a new narrative concerning ageing and older people (Donizzetti, 2019).

Phelan, (2008) asserts that ageism within society is evident within the unfavourable treatment of older people, due to their age. This can manifest in more value being placed on the health and wellbeing of younger people, deemed more capable of contributing to the labour market, and is visible within the provision of services eg. within hospitals and within the policy remit of a country (Phelan, 2008). Such ageism at a societal level in Ireland is evident regarding legislation. Legislation governing the care of children, is somewhat comparable with such legislation governing the care of older people, within residential settings in Ireland (DCYA, 2020; Government of Ireland, 2007). Both settings are subject to HIQA inspections regarding compliance with minimum standards relating to: the quality of care provided, staff qualifications and training, and protecting the welfare and safety of residents (HIQA, 2016; HIQA, 2018). Yet the contrast is stark when comparing legislation concerning care in the community, and the home, when considering both service user groups. Legislation for the protection and welfare of older people in Ireland in receipt of homecare, is non-existent (Sage Advocacy,2017). Sage Advocacy (2017) argue that lack of legislation which places a statutory responsibility on the state, to provide homecare for older people, places older people with relatively low care needs in a position where they have no option, but to enter residential care. Such lack of legislative protection reduces the autonomy older people possess in relation to their care needs and where they live (Sage Advocacy, 2017). Concerns for the protection and welfare of older people receiving care in their homes is further notable (Cullen, 2019).

In contrast, the legislative protection of children in living at home in Ireland is robust. Legislation ranges from the Childcare Act (1991), to the Children First Act (2015), (Government of Ireland, 1991; Government of Ireland, 2015) and provides a clear and comprehensive statutory instrument to protect the safety and welfare of children, as “paramount” (Childcare Act, 2015, part 2). Such contrasts are depicted in figure 2. (a) below, which offers an illustration of key legislation in Ireland regarding the care of children, compared to that regarding the care of older people. Such a stark disparity substantiates the belief that the care of older people is not prioritised by Government in Ireland (Third Age, 2016; Browne, 2016; ALONE, 2019). A shared and accepted understanding exists in Ireland, pertaining to the vulnerability of children and their need for protection. Yet such concern for older people and their protection and welfare, is much less apparent. This presents an

acceptability of the less favourable treatment of older people within society, as this is being illustrated by the Government in this top down approach.

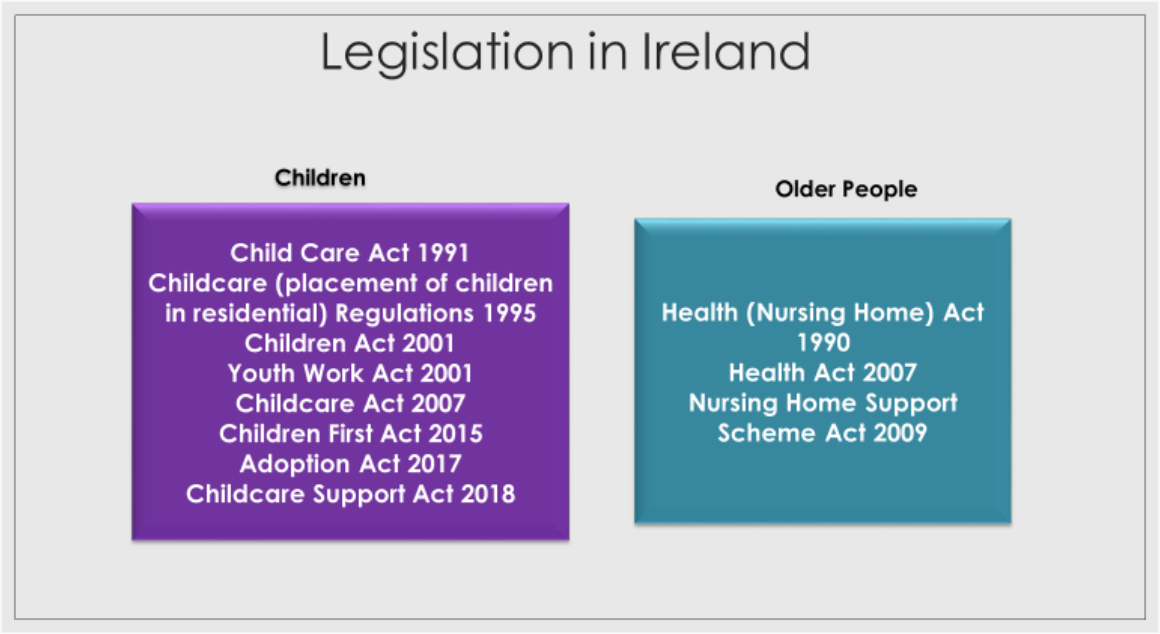


Fig. 2. (a) Legislation in Ireland governing both the care of children and the care of older people. (DCYA, 2020; Government of Ireland, 2007; Government of Ireland, 1990; Government of Ireland, 1995; Government of Ireland, 2009).

Fried, however, argues that older people are "the world's only increasing natural resource" and have life experience, education and wisdom to share with other generations (2016, p. 168). Fried (2016) proposes that investment in the health of older people aimed at increasing longevity, could be returned with participation and engagement from older people in society, for an extended period of time. Ayalon and Tesch-Romer (2017) argue that ageism is prevalent within the healthcare systems of most developed countries. The perceived burden on the healthcare sector which the media often emphasises, has both led to and exacerbated ageism within healthcare provision (Ayalon & Tesch-Romer, 2017). Ageism results in older people having their autonomy removed to some extent and experiencing a lack of agency regarding their own lives (Nelson, 2005).

2.6 (1) Self-Ageism

Self-ageism occurs when older people themselves internalise negative age stereotypes and this can culminate with older people expecting poor health and well-being as they age (Ayalon & Tesch-Romer, 2017). Nelson (2005) argues that stereotypes can result in self-fulfilling prophecies where older people are expected to be dependent, frail and in need of care and support. If such messages

directly and indirectly are communicated to the individual across their lifespan, this can indeed result in such assumptions becoming the reality (Nelson, 2005). Gu, Dupre and Qiu (2016) propose that self-ageism can impact on the behaviours and choices of older people, resulting in perceived feelings of self-uselessness. Self-uselessness decreases self-efficacy and increases mortality for older people (Gu et al. 2016). An increasing sense of dependency on other people, alongside passive responses to self-care and health needs, have further been identified as resulting from self-ageism (Wurm, Warner, Zieglemann, Wolff & Schuz, 2012).

2.6 (2) Ageism and homecare workers

Hansen (2016) argues that ageism affects homecare workers, in addition to the older population. The descriptions of homecare work as dirty work and concerned with meeting the basic bodily function needs of older people, depicts a further stereotype of the aging body and subsequent dependency (Hensen, 2016). Shinan-Altman, Soskolne and Ayalon (2020) suggest that homecare workers are perceived as being in quite a low status role and one which is undertaken by individuals with low educational attainment and few alternative employment opportunities. Neysmith (2018) argues that older people are blamed for their use of health services and the impact that aging has on Government spending. Neysmith (2018) suggests that the burden portrayed by the media that older people are placing on the exchequer, deflects from examination of the actual cause of crises in developed countries, regarding care: namely that Government have not planned appropriately, nor developed sufficient services, to meet the ageing population's care needs. Adams et al. (2002) report that ageism impacts how older people interact with healthcare services. Professionals who provide care to older people, often describe the challenges associated with this work and the additional time associated with it, which further inadvertently enables the conservation of ageism (Adams et al. 2002).

The literature illustrates the profound impact of ageism on older people, pertaining to policy and consequently on the homecare sectors (Donizzetti, 2019; Sage Advocacy, 2017). Therefore consideration of ageism will be significant within the context of the current study and the methodological approaches which will be employed.

2.7 Summary

In summary, this section of the literature review has highlighted the significance of ageing in place for older people. Understanding of ageing in place and what this means for the older person, is fundamental within the realm of homecare. Loneliness and the devastating impact this can have on the life of the older person was examined. Isolation and how this a term often used interchangeably with loneliness was explored, providing clarity on the distinction between both and the impact of each on the older person.

Health promotion for older people and how this can enhance life expectancy and feelings of well-being across the lifespan, were discussed. Choice and control as key concepts related to health promotion for older people, should be a priority for both policy makers and homecare workers. Empowering older people to retain and realise control over their own lives as they age, is paramount in ensuring their wishes, needs, and preferences regarding their care are met. Health promotion for older people should be the preferred goal of all interventions, supporting people as they age.

Finally, ageism and how this issue impacts the societal response to the needs of older people, was explored. Ageism permeates every sector and setting of society. Hence acknowledgement of this, will present a more comprehensive depiction of the experiences of older people and homecare workers, regarding their experiences of homecare. Each of the concepts explored in this section are significant in both impacting and informing, the position of older people and the context within which, the homecare sector operates.

Part 2

2.8 Homecare Work

Homecare work is an under researched phenomenon in the field of health and social care (Mayo-Wilson et al. 2014). The HSE (2019) define homecare as supporting older people to remain in their own homes for as long as possible by providing practical support with: “getting in and out of bed, dressing and undressing; and showering and shaving”. Kiersey and Coleman (2017) describe homecare as the provision of tasks within the home to an older person or a person with a disability, including: personal care, cooking and cleaning. However in Ireland, homecare has moved more towards the personal care element of service and based on the most essential tasks (Kiersey & Coleman, 2017; HSE, 2019). The Homecare Bill (2020) elaborates on homecare tasks to include: arranging appointments, providing companionship, providing transport and supporting the older

person with exercise (Government of Ireland, 2020). Homecare has been described as the foundation of enabling older people to remain in their own homes, as they age (Working Group on Long-Term Care, 2008). Although they provide an invaluable role which impacts immensely on the lives of older people, the role of the homecare worker is often a challenging and precarious one (Hayes & Moore, 2017; Dempsey et al. 2016).

Lang (2010) contends that homecare as a setting for care is quite unique, as home is where people are living their everyday lives. This differentiates homecare from all other types of health and social care, as the setting is intrinsic to the provision and receiving of this care (Lang, 2010). Yet it has further been argued that homecare workers are an invisible group, due to the non-hospitalised position of their roles, outside of the traditional boundaries offered by more typical health and social care settings (Nasol & Franscisci-Menchaves, 2021).

Largely a female dominated profession, homecare is sometimes described as a vocational calling (Lewis, 2014). However, neoliberalism has greatly impacted the homecare market and its evolution in Ireland to date (Metclaf, 2017). A key objective of the current study is to examine the experiences of homecare workers, concerning their roles in Ireland. Consequently, examining the key ideas within the homecare literature and research to date, will be instrumental in developing and undertaking the current study.

2.8 (1) Gender and Caregiving

Gender roles within society have long dictated that women be responsible for the care of dependent children and sick or infirmed family members (Rubio-Marin, 2016). Societal and cultural expectations of women regarding care provision are commonplace (Sharma, Chakrabarti & Grover, 2016). Ruiz and Nicolas (2017) concur and suggest that women oftentimes feel naturally obligated to provide care, particularly when the person in need of such care is a family member. Benoit and Hallgrimsdottir (2017) argue that many of the tasks delegated to the homecare worker are domestic in nature and consequently are considered low skilled and tasks that are naturally performed by women. Sharma et al. (2016) further suggest that the move away from institutionalisation to more community and home-based supports, places greater pressure on individuals providing homecare. Esplen (2009) argues that gender imbalance in care roles undervalues the work of women who provide care, as the societal and cultural norms creates this expectation of them. Such expectations of women to provide care “reinforce gender inequality” in society (Esplen, 2009, p. 17).

Acknowledgement of such gendered expectations surrounding caregiving, will inform the current study as a key concept which may have contributed to the experiences of homecare workers. Little has been undertaken to promote a greater gender balance within caring professions, according to Block, Croft, De Souza and Schmader (2019), particularly when such roles entail domestic duties. Block et al. (2019) argue that policy makers and governments have invested substantially in increasing the gender balance in sectors such as science and engineering. From 1993 to 2003, the number of males in caring professions actually decreased in the USA (Block et al. 2019). Statistics in Ireland illustrate that women made up 79.3% of staff employed within the health service in 2016, which equates to 4 out of every 5 staff members (CSO, 2016). Regarding social care professionals, the 2016 census reported that 84.4% are women, and the remaining 15.6% are men (CSO, 2016). The 2019 census reported that 79.9% of staff within "human health and social work activities" are women. This demonstrates an increase in the percentage of males within caring roles in Ireland, over this 3 year period (CSO, 2019), which contrasts findings from Block et al (2019) and signifies a potentially shift. The CSO (2019) further state that within the EU, 78.2% of the human health and social work sector are women. Ireland's statistics concerning the women within the health and social care sector are just slightly above the EU average (CSO, 2019).

Pertaining to homecare, such gendered expectations of care provision, means that women often feel societal pressure and guilt, to seamlessly meet the care needs of older people (Gill-Monte, 2012). Being undervalued as a professional and oftentimes exposed to challenging and volatile working conditions, further compounds the challenges many women face as a result of the gendered nature of caregiving (Nakaishi et al. 2013; Green & Ayalon, 2015). Clarke and Raveenswood (2019) propose that aged care workers differ from other caring professions, as staff spend the majority of their time in direct contact with the care recipient, and are most often lone working. In their qualitative research with 32 aged care workers, Clarke and Ravenswood (2019)) found that 22 of their participants reported seeing other female family members caring for elderly people and viewed such women as role models. Stacey (2005, p. 849) reports that homecare workers derive dignity from completing the personal care task or "dirty" work, associated with their roles. Such dirty work relates to intimate tasks concerning personal hygiene, which homecare workers do every day, to promote the health and dignity of the older people they look after. Stacey (2005, p. 849) argues that most homecare workers interviewed in their study, expressed pride in their work and acknowledged that personal care and care relating to incontinence is "a valuable service that most people won't even talk about, let alone perform".

Francis and Netten (2003) conducted interviews with 30 homecare workers relating to their motivation to work in the homecare sector and found that most had a genuine love for their work, while some participants reported having cared informally for family members previously. Hence paid employment felt like a natural progression from this previous care provision (Francis & Netten, 2003). Such ideas regarding the societal and cultural expectation of caregiving based on gender, will be pertinent to consider within the context of the current study, given the percentage of women who work in the homecare sector.

2.8 (2) Choosing Homecare as Employment

Witter et al. (2018) report that many people who choose to work in a health care or helping careers, describe themselves as being caring in nature and with an intrinsic desire to help people. Through life history interviews with 103 health care workers, across 4 different countries (Uganda, Sierra Leone, Cambodia, and Zimbabwe), Witter et al. (2018) found that healthcare workers felt a personal calling to work in a caring role. Atkinson, Cozier and Lewis (2016) found that homecare workers are motivated by a wish to help people and make a difference in their lives. Vidman and Stromberg (2018) have found that many care workers derive satisfaction from improving the wellbeing of the older people they provide care to. Feeling needed and that their work had meaning, were factors which impacted positively on care provider's motivation to do the work that they do (Vidman & Stromberg, 2018).

Timonen and Lolich (2019) found that homecare workers themselves, recognise the significance of their efforts is what impacts the quality of care provided. Timonen and Lolich (2019) conducted a qualitative study in Ireland with 104 participants via focus groups. Their sample included homecare managers, social workers, health care professionals and policy planners (Timonen & Lolich, 2019). Results indicate that participants felt that the quality of care was subjective, based on the efforts of the individual homecare worker, as opposed to the company they work for. Timonen and Lolich (2019) reported that some homecare workers don't really care and chose to work in this role for convenience, and that this is evident in the care they provide. Guarnizo and Rodriguez (2017) suggest that the greater the level of intimacy in the tasks delivered, the greater the level of informality in the homecare role occurs. For example: if the homecare worker is supporting the older person with personal care tasks such as providing showering and toileting assistance, this creates a more informal relationship between the two parties (Guarnizo & Rodriguez, 2017).

Boerner, Gleason and Jopp (2017) reveal that homecare workers forge meaningful relationships with their homecare clients and these relationships can decrease the likelihood of stress and burnout. Based on a qualitative methodology of semi-structured interviews with a sample of 200 homecare workers, Boerner et al. (2017) concludes that the closeness of personal relationships, impacts positively on the meaningfulness the homecare worker attributes to their role. Gil-Monte (2012) suggests that guilt is an emotion frequently felt by people working in caring professions and such guilt is often counteracted with increased interaction and additional care provision. Guilt within the context of care provision, stems from a lack of supports and resources within such roles and the increased demands care work can place on the individual worker (Gil-Monte, 2012). Mottaghi, Poursheikhali and Shameli (2019) propose that empathy from health and social care professionals may culminate into increasing feelings of guilt. The more empathetic the worker is, the greater the guilt they feel. The inability of the professional to reduce the physical pain or distress of the person they care for and the empathy they feel, can disproportionately increase their sense of responsibility to provide care (Mottaghi et al. 2019). It could be argued that such guilt, combined with the relationship the homecare worker develops with the older person, may impact substantially the experiences of both homecare workers and older people within the homecare relationship.

2.8 (3) Neoliberalism and Homecare

Mercille (2017) and Grey (2015) propose that neoliberalism must be considered, in order to comprehensively understand the evolution of health care in Ireland. Mercille argues that privatisation, marketisation and financialisation of health care for older people in Ireland, have resulted in the current competition in the homecare and nursing home markets in Ireland (2017). Mercille emphasizes that neoliberalism has impacted the response to the care needs of older people and resulted in the current quasi market system in Ireland (2017). Consequently, neoliberalism and its impact to date on the delivery of homecare in Ireland, will be acutely relevant to the current study.

England, Eakin, Gastaldo and Mc Keever (2007, p. 170) describe the impact of neoliberalism on homecare, as the “logic of managed competition” in the market. England et al. (2007) argue that healthcare reform in many developed countries, emerged in response to financial crises and resulted in a planned decrease in the remit of the welfare state, regarding the provision of care in the home. This suggests that both governments and the private market have vested interests in the same goal, which culminates into a competitive fiscal playing field where care recipients land squarely on the bottom of the agenda (England et al. 2007). Kawam (2012) argues that neoliberalism is misplaced

within the realm of homecare in countries where this public health need has to date, been the responsibility of the welfare state. Kawam (2012) proposes that neoliberalism enables governments to relinquish this responsibility and prioritise the finances of the state, to the detriment of some of the most vulnerable individuals.

Airth and Oelke (2020) suggest that neoliberalism places profit before the needs of marginalised groups and that combined with ageism, can have a catastrophic impact on the lives of older people in need of care. They propose that older people without the means to choose and pay for the care they need, are at the mercy of the providers they do have which are funded through the state (Airth & Oelke, 2020). Choice is a fundamental principle of neoliberalism, yet without the fiscal resources, autonomy and ability to decision make, this system serves only those in society who have not been marginalised and are most able (Metclaf, 2017). Cosgrove and Carter (2018) suggest that those who perhaps are unable to compete in terms of access to care, can be viewed from this neoliberal perspective as an individual problem, rather than a societal one. Such views further disempower and afford blame to people who have not been able to participate in the labour market to an extent, which enables them to meet their health and care needs as they age (Cosgrove & Carter, 2018). Although rationalised and explained as for the greater good of the nation, the economy and the needs of society as a whole, the impact of neoliberalism can be largely negative for both care workers and care recipients, at the coalface of care delivery (Gray et al. 2015).

Hudson (2016) argues that neoliberalism can have a negative impact on the workforce, as focus is geared towards reducing costs and keeping overheads to a minimum. In practice this may result in poor working conditions for homecare workers such as having to pay for their own training and no reimbursement for travel costs between the homes of older people (Hudson, 2016). Hudson (2016) reports that such working conditions reduce standards in the provision of care, as staff retention and training are problematic.

The MRCI (2015) found that migrant workers are over-represented within the homecare sector in Ireland. Nasol and Franscisci-Menchaves, (2021) assert that neoliberalism has resulted in racial disparity for immigrant homecare workers, further marginalising this already vulnerable group. The vulnerability and marginalised status of homecare workers further contributes to the acceptability of poor working conditions and profit driven goals in care provision (MCRI, 2015; Gray et al. 2015). Garrett (2017) contends that the impact of neoliberalism further contributes to the inability of care providers to meet the needs of the older person comprehensively, as their work has been equated

to specific tasks and durations. Limited fiscal resources within the homecare sector, culminates into care which is based on meeting only the most basic of needs and not encompassing the social or emotional unmet needs of the older person, in some instances (Oireachtas, 2018; McDonald, Lolich, Timonen & Warters, 2019). Homecare workers have found themselves under substantial increasing pressure with ambiguous demands, in light of the impact of neoliberalism on the homecare market (Hudson, 2016; Gray et al. 2015; Airth and Oelke, 2020). It appears plausible to suggest that a multitude of factors created and maintained via the evolution of neoliberalism within the homecare context, substantially affect the experiences of homecare workers within their administration of homecare duties.

The effects of neoliberalism are further evident within the experiences of older people. Messer (2014) proposes that older people who are poor, are more likely to accept care which is substandard and not complain about or question this. Messer (2014) suggests that financial dependence on the state to provide homecare, further dissuades other people from voicing concerns. Older people worry that should their homecare be removed, this may negatively impact their financial state and perhaps place some of this financial responsibility on their family members (Messer, 2014). Ultimately, neoliberalism has placed additional disadvantage on the most disadvantaged in society (Sakellariou & Rotarou, 2017). Older people and people with disabilities, are more likely to have less financial resources from which to engage with the available market choices for care. Health conditions and vulnerability serve as further barriers, compounding the freedom of exercising choice relating to care, which other groups in society enjoy (Sakellariou & Rotarou, 2017).

2.8 (4) Working Conditions

The MCRI (2015) argue that the pay and conditions of homecare workers in Ireland are problematic, with many homecare workers earning low wages and not being paid for travel time. Haeusermann (2018) argues that the role of homecare workers has been evolving to a more professionalised service, as homecare staff are expected to provide individualised, planned care and work within a multidisciplinary capacity. Homecare workers are increasingly responsible for documenting each action or occurrence accurately, in order to promote accountability in the provision of care, as a direct result of neoliberalism on the homecare sector (Haeusermann, 2018). Boris and Klein (2006) highlight the low status of homecare workers, with wages often being less than half of that of other health and social care professionals. Such poor compensation for their work results in most homecare workers being categorised as working poor, with many already marginalised due to age, ethnicity and sex (Boris & Klein, 2006). It is realistic to assume that such issues may present

challenges with recruitment and retention of participants for the current study, given the substantial challenges faced by homecare workers in their day to day roles.

Hanson et al. (2015) report that more than half of the homecare workers they interviewed, experienced verbal aggression in their role during the preceding year. Twenty three percent reported experiencing violence in their role, and 25% disclosed that they had been subjected to sexual harassment (Hanson et al. 2015). This study utilised a participatory approach, with homecare workers being trained to conduct peer phone interviews with a sample of 1,214 female homecare workers. Nakaishi et al. (2013) argue that 44% of the 83 homecare worker participants in their qualitative study, reported being the victim of physical abuse within their role, and 41% disclosed sexual harassment. Through both interviews and focus groups, Nakaishi et al. (2013) found that there appears to be some level of acceptability of abuse, associated with the role of the homecare worker. Homecare workers and managers described sexual and physical abuse as often "expected" and "unavoidable" within their role, largely due to health conditions of the older people they provide care to, such as Alzheimers and Dementia (Nakaishi et al. 2013, p. 446).

McPhaul, Lipscomb and Johnson (2010) argue that risks associated with violence in homecare are increased, in cases where the care recipient has a cognitive impairment or if previous instances of violence have occurred in this home. Mc Phaul et al. (2010) argue that additional issues such as night-time visits, the geographic location of the home of the older person and the unknown elements of potential risks or hazards, further compound the vulnerability of the homecare worker in performing their duties. Other health and social care settings such as hospitals or residential units, support staff with clear procedures and protocols, to respond to incidents of violence in the workplace. Yet the home as the workplace setting, omits such safety measures (Mc Phaul et al. 2010). Quinlan, Bohle and Rawlings-Way (2014) found that homecare work, places workers in a vulnerable position due to precarious working conditions and the lack of prior knowledge about potential risks. Homecare workers tend to accept such poor working conditions and risks to their physical and emotional wellbeing, due to the lack of job security they face (Quinlan et al. 2014). Sterling et al. (2020, p. 1453) describe homecare workers as invisible and "often neglected by the medical community and society at large". Homecare workers often juggle poverty, alongside their role of providing homecare, which increases their vulnerability as a marginalised group (Sterling et al. 2020).

The home as a setting of work for homecare workers, while simultaneously being a home for the older person, creates a unique environment for the provision of care (Lang, 2010). Parks (2003, p. 9) describes the home as a setting as "riddled with ethical problems" and where women are expected to provide care in the home, for barely minimum wage in most cases. Rolf (2016) describes homecare workers as working in the shadows and argues that homecare work still exists, largely outside of either the health or social care spheres. The assumption that women in the community and within families would provide such care, has resulted in homecare only being recognised as a care sector, within the last two decades (Rolf, 2016). Nasol and Franscisci-Menchaves (2021) argue that the home as a non-traditional setting for care, further alienates and marginalises homecare workers. Such invisibility results in homecare workers being excluded from the collective self-advocacy efforts of other health and social care professionals (Nasol & Franscisci-Menchaves, 2021

Green and Ayalon (2015) argue that some homecare workers tend to accept poor working conditions and abuse within their role, as they become more familiar with the older person. Or if the abuse is frequent, it becomes more the norm (Green & Ayalon, 2015). Green and Ayalon (2015) suggest that a lack of peer support due to lone working, and lack of interaction with managers and supervisors, may prompt homecare workers not to report much of the abuse they experience. Additional challenges for homecare workers relate to the autonomous nature of their role. Homecare workers have little opportunity to consult with other staff, within their organisation (Olson, 2010). Homecare workers face emotional demands in their role and can be accused of stealing, or subjected to abuse while in the home of the older person, resulting in a heightened sense of exposure for the homecare worker (Kim, Noh & Muntaner, 2012; Delp, Wallace, Geiger-Brown & Muntaner, 2010).

Staff turnover is high within the homecare sector, with retention being a prominent issue for many homecare providers (Hussein, Ismail & Manthorpe, 2016). Hussein et al. (2016) acknowledge that staff turnover in the private sector is higher, due to poorer pay and working conditions. It has further been found that with travel time being unpaid for many homecare workers, their total number of hours often equate to less than minimum wage (Hussein et al. 2016). Flemming and Taylor (2007) propose that 60% of the 47 homecare workers they surveyed, rarely feel they have sufficient time, to meet the needs of the older person they provide care to. Homecare workers reported feeling stressed due to insufficient time, in which to complete the necessary tasks and to travel to their next client (Flemming & Taylor, 2007). Issues such as zero hours contracts, further contribute the high staff turnover within the homecare sector. Homecare workers on zero-hour contracts have no job

security, their hours of work are not guaranteed and can change from week to week (Atkinson, Crozier & Lewis, 2016).

Chan, Jones and Wong (2013) found that healthcare workers with insufficient time, report that this impacts negatively on those in receipt of their care. Their study conducted longitudinal research with 5 nurses, over a 12-month period. Although this is a substantially small sample, the type of information sought required a more in-depth methodology, to capture the experiences of the sample comprehensively. Chan et al. (2013) suggest that when healthcare staff have multiple specific tasks to undertake, this becomes the priority and interaction with the person they are helping, is beyond the scope of their time most days. Anderson and Westgaards undertook a mixed methods approach and conducted 33 1-1 interviews, in addition to surveying via questionnaires, 80 homecare workers, supervisors and managers (2015). Anderson and Westgaard (2015) report that homecare workers in Norway, describe feeling under constant pressure in their provision of care due to time constraints, resulting in compassionate care being limited, while more acute physical care needs are met. Homecare workers describe priority for their time to be dedicated to the specific tasks documented, as opposed to general caring duties. One participant within this study stated that "they are not hired to be social companions" (Anderson & Westgaard, 2015, p. 5).

In Ireland, SIPTU (2009) found through their workshop consultations with 109 homecare workers, that time constraints present substantial challenges to them in their roles. Poor scheduling and not enough time being allocated to transit between the homes of older people, results in some workers having to cut their time with clients short, to counteract this (SIPTU, 2009).

The MCRI (2015) identify the blurring of lines faced by some homecare workers, between their work time and private time. The home as a setting is far removed from the structure provided by a clinical setting, and Abrams, Vandrevala, Samsi and Manthorpe (2019), contend that lone working places additional layers to the complexity of the homecare role. The emotional attachments which homecare workers form with the older people they care for, can further impact the boundaries of the professional role (Abrams et al. 2019). Austin, Bergum, Nuttgens and Peternelj-Taylor (2006) argue that professional boundaries, are an essential component within helping relationships and protect both the caregiver and care recipient.

However, Austin et al. (2006) acknowledge that professional boundaries can be blurred, when working closely with vulnerable people and constantly evolving to meet their care needs. Making

decisions autonomously, is an integral element of the homecare worker's role and such decisions require competence and a level of expertise (Benoit & Hallgrimsdottir, 2017). Hence the ambiguity concerning the public or private, the formal or informal spheres within which homecare is provided, is maintained (Benoit & Hallgrimsdottir, 2017).

Cleland et al. (2021) argue that relationships between older people and homecare workers become more substantial, when the older person doesn't have any other social connections. For older people with no other opportunities for socialisation, the homecare visit becomes a key point in their day where they would positively anticipate the carer coming in. Older people described their homecare workers as friends whom they share close bonds with (Cleland et al. 2021). Ayalon and Roznier (2017) argue that relationship satisfaction within the home as a setting for care, is even more substantial, due to the blurred boundaries this presents. They describe the home as the intersection between formal and informal care provision and contend that satisfaction from the homecare worker or the older care recipient, prompts greater satisfaction to the other partner in the care relationship (Ayalon & Roznier, 2017).

Kihlgren, Blomberg and James (2014) conducted a qualitative study with 15 older people in receipt of homecare and adopted a Participative Appreciative Action Reflection (PAAR) approach to data collection. The aim of Kihlgren et al. (2014) study was to examine barriers, facilitators and ideas to create a meaningful life for older people in receipt of homecare. Participants analysed and provided reflections on the meaning they attributed to the data they shared. The rationale of this approach acknowledges the participants as experts pertaining to knowledge generation and construction of explaining the meaning of their daily lives (Kihlgren at al. 2014). Each participant attended 2 interviews which were 30 to 90 minutes in duration. Findings indicate that the relationship older people forge with homecare workers, does indeed contribute to a meaningful life, based on the experiences of older people. Participants identified the homecare worker knowing them, their needs and preferences, as an important part of this relationship and this building of familiarity created a favourable opportunity for a relationship to develop (Kihlgren et al. 2014). Findings by Kihlgren et al. (2014) propose that not knowing homecare staff presents as an obstacle towards a meaningful life for participants in their study. Participants described "giving themselves" to somebody for care, and the need to be able to rely on them, which only develops with continuity and an established relationship (Kihlgren et al. 2014, p. 75).

Kihlgren et al. (2014) study contributes rich and insightful insights regarding older people's attribution of factors which impact a meaningful life from their experiences, perspectives and analysis. Although the sample size may be considered quite small, the richness of data gathered and the active co-production of knowledge generated based on the PAAR approach to the data collection and analysis, appears appropriate in addressing sufficiently the research aim (Kihlgren et al. 2014). Furthermore the unique and in-depth approach to inclusion of participants as active researchers, adds strength to the findings derived within this study.

An additional development affecting homecare workers in Ireland more recently, is the introduction of electronic monitoring, in an effort to enhance efficiency in care provision. Staff employed by some private homecare providers in Ireland, must log in as they enter the home of the older person and log out as they leave. Yet many homecare providers will not pay staff who spend longer than the pre-specified time, in the home of an older person (Moore & Hayes, 2017). Moore and Hayes (2017) argue that unpaid time in homecare work is commonplace. Homecare workers feel a sense of obligation to the older people they care for and could not leave their home if the older person felt unwell, had fallen or was still in need of care. The informality of providing care in the home, in addition to this equating to paid employment, compound the stressors faced by many homecare workers (Delp et al. 2010). Delp et al. (2010) argue that the boundaries of more traditional roles in healthcare, differ in the context of the home as a setting for care. Homecare workers provide care and interact with vulnerable, and oftentimes lonely older people. Hence developing a genuine and caring relationship, is much more likely (Delp et al. 2010).

Additional factors which impact the provision of homecare stem from the for-profit sector, who operate businesses providing homecare services. Many of these private companies in Ireland, are subcontracted to provide homecare hours via the HSE home support service (HCCI, 2019). SIPTU (ND) report that the homecare sector in Ireland and Europe, sees workers afforded less favourable conditions than in other sectors. Fersch and Jensen (2010) suggest that competition within the homecare sector impacted by neoliberalism, can result in poorer quality of care for older people as resources are stark. The quasi market system can create an environment where much debate remains, as private companies and individual homecare workers aim to address both "market principles and professional ethics" in their provision of care (Fersch & Jensen, 2010, p. 23). Butler (2015) reports that due to being undervalued, there is a high staff turnover within the homecare sector, which may culminate in older people not having their care needs met with consistency and

compassion. Bergman et al. (2016) highlight that measuring the success of homecare intervention is challenging, yet regulation of the sector lends to minimum standards and levels of service provision.

Anderson (2015) suggests that homecare workers, are considered the bottom of the social hierarchy within their roles and consequently expected to engage with the practical and menial tasks associated with homecare. Green and Alayon (2017) argue that these issues culminate into exploitation for some homecare workers, as they accept conditions which would be unacceptable within another profession, due to their vulnerability and marginalised status. Simeone, Vellone, Pucciarelli, and Alvero (2021) propose that such marginalisation, reduces the willingness of many homecare workers to participate in research. It is plausible to suggest that homecare workers within the precarity and vulnerability of their roles, may be afraid to voice concerns or report the challenges they face in their role, due to fear of job loss or even poorer working conditions (Simoene et al. 2021; Green & Alayon, 2017). Bonevski et al. (2014) suggest that groups who are socioeconomically disadvantaged, are often hard to reach concerning research. Equally when such hard to reach participants have been recruited, the issue of retention for the duration of the study can further be problematic (Bonevski et al. 2014).

2.8 (5) Summary

The multitude of factors impacting homecare workers in their delivery of care in Ireland, are complex and overlapping. The gendered expectations of care provision, coupled with blurring of professional boundaries, can culminate into poor working conditions for some homecare workers. Furthermore, the emotionally onerous role of the homecare worker is often normalised within society, placing further pressure on homecare workers to provide additional unpaid care (Abrams et al. 2019). Relationship development between the homecare worker and older person, further illustrates the unique nature of the home as a setting for care (Kihlgren et al. 2014). Turner et al. (2018) propose that homecare workers are more likely to accept poor working conditions and additional hours of unpaid care, if they love their jobs and the work that they do. Some homecare worker's "personal values may predispose them towards caring for others regardless of material rewards" (Turner at al. 2018, p. 2).

Indeed Palmer and Eveline (2012) argue that homecare workers are undervalued and that this is a gender based issue, which is impacted by its acceptability within the wider society. This undervaluing of homecare workers is then retained and reinforced within the homecare organisation (Palmer & Eveline, 2012). Consequently, if the expectations of care are high, the pay is low, and there is an

acceptability of care to be provided with little reward, such care will continue to be provided (Palmer & Eveline, 2012). These factors compounded by a neoliberal agenda, further contribute to the lack of existing evidence to date concerning homecare workers experiences, and further emphasise the rationale for the current study (Kiersey & Coleman, 2017).

Such literature regarding homecare workers and the multitude of factors which impact them in their provision of care to older people, will inform the current study specifically relating to the context of devising the data collection and analysis processes. The status of homecare workers as a marginalised and hard to reach group, may impact recruitment for this study. Equally the disadvantages homecare workers may continue to experience within their roles, will further be significant to consider throughout the methodological processes of the current research project.

PART 3

2.9 Theory Relevant to Older People and Homecare

This section of the literature review will explore theory which informs the position of the current study, relating to how older people may come to require and receive homecare. Gerontology is concerned with research and inquiry relating to ageing and older people (Bowers, 2020). Bowers (2020) proposes that gerontological research is the epitome of care for older people. If care needs can be pre-empted based on accurate data and evidence, more appropriate care planning and provision can occur (Bowers, 2020). Bernard, Ray and Reynolds (2020, p. 215) argue that gerontology aims to "transcend disciplinary boundaries" and envelope an interdisciplinary effort, to better understand all things aging related. The study of ageing enriches understanding contributing to the development of theory, policy and collaborative efforts between professionals, in an effort to enhance the ageing process and our response to this (Bernard et al. 2020). The gerontological theories of the life course, disengagement and activity will be examined in more detail, specifically pertaining to how they inform and enhance understanding of the older person and their need for homecare.

Theory can provide practitioners, policy makers and the general public, with a lens from which to examine issues which affect older people and consequently enable a more planned and concise response to their needs socially, psychologically and physically (Dooser & Somar, 2018). Within gerontology, there are a number of theories which aim to illuminate the physical, social and

psychological changes the individual experiences as they age. Biological theories of ageing such as programming and wear and tear theories, attempt to explain the gradual wearing and depletion of cells within the body as one ages (Bwiza, Son & Lee, 2022). Wadensten (2006) argues that psychological and psychosocial theories aim to explain the changes ageing presents for the individual behaviourally, cognitively, socially and regarding roles. Multidisciplinary approaches to studying ageing such as life course theory, present the opportunity to examine a broad range of factors which recognise the "value of linking life stages", to create a comprehensive picture of the position of the older person (Crosnor & Elder, 2002, p. 309). Finally, sociological perspectives on ageing focus on the interplay between the individual and society as they age (Powell & Hendricks, 2009).

Given the breadth and depth of potential theories from which to explore the phenomenon of ageing, only theories deemed most relevant to the topic of older people and homecare will be examined. The interdisciplinary theory of the life course will be explored as this presents opportunities for considering earlier life events and how these have shaped the current presentation of the older person. Psychological or psychosocial theories of ageing are particularly relevant to the current study (Wadensten, 2006). Sociological theories are further pertinent to consider as individuals age within the structures and backdrop of how society views and responds to this, based on cultural norms and beliefs (Powell & Hendricks, 2009).

2.9 (1) Life Course Theory

Life course theory offers opportunity for greater examination of the impact of life events and how they may have cumulatively resulted in the circumstances the older person finds themselves in today (Lindeboom & Ewijk, 2005.) Within this vein, life course theory can provide plausible explanations for why some older people may require formal homecare services, based on the social and societal impact on their earlier lives and the position they find themselves in today. Elder (1998) argues that life course theory offers a lens from which to view and understand developments and occurrences for individuals, across the life course. Life course theory aims to "capture cumulative advantage/disadvantage over time" (Mc Donald & Thomas, 2013, p. 1236). Elder (1998) proposes that life events, social ties and societal and historic events, affect individuals and groups of individuals throughout their lives. For example: economic recession may cause some adults to emigrate, perhaps resulting in older people with no adult children or grandchildren living in the same country as them.

Some older people may have left school early due to economic recession and therefore be limited with their employment prospects and have poorer health outcomes (Schwandt, 2019). Or an older person born during war times, may have suffered from hardship during their childhood and can have a shorter life expectancy than that of their peers from other countries (Lindeboom & Ewijk, 2005). Each of these life transitions impact the potential health and social care needs of the older person, and consequently their need for requiring formal homecare services as they age (Elder, 1998).

Yet Hendricks (2012) argues that life course theory is not consistent enough to be considered reliable and that variations in outcomes based upon studying the life course, are too broad. Hendricks (2012) suggests that two people can have the same conditions of early life and transitions, but respond to these very differently. Thornton (2005) concurs and further proposes that life course theory can result in people and groups being labelled, perhaps unfairly, and categorized based on earlier life occurrences. From such perspectives, life course theory could be viewed as a negative lens from which to view the lives of older people and one which perhaps stereotypes or prejudices, particular individuals or groups.

Nevertheless, the WHO (2018) propose that life course theory and the longitudinal research associated with this, enables governments to plan effectively for specific cohorts of people in society. The fundamental principles of life course theory according to Elder and Shannahan (2007) are:

- Timing: is concerned with the chronological age of the individual and the transitions which occur across the lifespan, as expected. For example: the timing of marriage, starting a family or an older person retiring from the work force (Black, Holditch-Davis & Miles, 2009).
- Linked lives: refers to the idea that individuals are affected by and affect, the lives of people they are linked to. Parents affect children and children affect parents eg. if there is parental addiction or unemployment, this will affect the children and other parent. Siblings affect one another, by the nature of their linked relationship eg. if a sibling is living with a disability or chronic illness. Linked lives in relation to older people may include: grandparent status, location of adult children, or lack of any major links to other people eg. an older person who was never married, is childless and has no extended family.
- Human agency: is concerned with the will of the individual to make changes in their own lives, perhaps contrary to advantage or disadvantage (Hitlin & Elder, 2007). Agency refers to the individuals' ability to direct their own lives and alter their expected life course.

- Historical time and place: relates to the timing of birth, childhood, adulthood and old age. The year in which someone is born will impact them across their lifespan and into old age. The availability of medical intervention and adequate nutrition will be dictated by when the individual was born (Black, Holditch-Davis & Miles, 2009).

In considering the potential benefits and critiques associated with life course theory and its use in informing the care needs of older people, the potential for insight based on employing some of the key ideas of this theory, appears appropriate. Two life course principles in particular, will inform this study, and offer insight regarding older people's experiences with homecare. Linked lives and agency, will now be examined in more detail.

2. 9 (1) (1) *Linked Lives*

"Life's strongest storylines are punctuated by and enmeshed with other people" (Settersen, 2015, p. 217). Social relationships are inherent to well-being across the lifespan, within the context of the linked lives principle of the life course theory (Carr, 2018). Gilligan, Karraker and Jasper (2018) propose that families and interconnections between family members, are beneficial to individuals. This intrinsic link to and interdependency between family members, is significant for older people, with grandparents placing particular value on their relationships with younger members of their family (Gilligan et al. 2018). Settersen (2015) argues that lives are encapsulated within and based upon, our relationships and experiences with other people. Life events are intertwined and shared between individuals, which creates "meaning, stability and continuity" (Settersen, 2015, p. 223). Yet some older people may lack such relationships due to childlessness or bereavement and this may culminate in their requiring formal homecare support, to assist them to remain at home as they age (Carr, 2018).

Ivanova and Dykstra (2015) propose that older people without family members rely more heavily on formal services, to support them as they age. Research in Ireland supports this notion and recognises the substantial role of informal carers (usually family members) in supporting older people to remain at home as they age (Timonen & Doyle, 2008; Donnelly et al. 2016). However changes to women's participation in the labour market over time, has reduced substantially their availability to provide informal care to family members or neighbours (Barry, 2010). Older people with adult children are more likely to be supported to age in place and remain in their own homes for as long as possible (Larsson & Silverstein, 2004). Whereas older people without family members to provide care, may have less choice and find themselves unable to remain in their homes, as their support needs

increase (Ivanova & Dykstra, 2015). Such ideas mirror those associated with choice theory and the opportunity to age in place as a preference (Glasser, 2004; Herber & Johnston, 2012). Larsson and Silverstein (2004) found through their Swedish study that formal care provision for older people is compensated for significantly, with informal care from family members. This research consisted of a sample size of 673 participants and was longitudinal in design. Larsson and Silverstein concluded that although Sweden's provision of formal care for older people is based upon established regulation and taxation, that the formal homecare support alone (without additional informal homecare and support) is insufficient to ensure that older people can remain at home and avoid long term stay settings (2004).

Fictive kinship may explain the evolution of relationship between the older person and homecare worker, via the lens of the life course theory. Euctice and Fisher (1991) report that homecare workers become enmeshed in the lives of the older people they care for and oftentimes develop close relationships with them. The linked lives principle of life course theory further accentuates the potential for the development of fictive kinships, as some older people in receipt of care find themselves without such links within their own families or existing informal networks of support (Ivanova & Dykstra, 2015). Kay (2013) argues that homecare work can develop into kinship for some older people, where both parties view and treat one another as family. Kinship is associated with the emotional connectedness and obligations felt by parties, which signify their commitment to the relationship (Kay, 2013). Karner (1998) suggests that homecare workers often mirror care tasks that would traditionally be provided by family members.

In the absence of family members to provide care, the evolution of a fictive kinship relationship is more likely, within the homecare relationship (Karner, 1998). Older people themselves identify the importance of the social element of their homecare (Kajonius & Kazemi, 2016). Piercy (2001) argues that homecare roles are often task orientated and specific, addressing the physical care needs of the older person. Yet when fictive kinship develops, this relationship can meet the emotional and social needs of the older person for closeness and is more likely to develop if the homecare worker has been providing care for an extended period of time (Piercy, 2001). Kay reports that such kinship relationships are reciprocal, where both the homecare worker and the older person feels "cared about and cared for" (2013, p. 1147). Carr (2018) contends that consideration of life course theory and more specifically the linked lives element of this, is fundamental to addressing and meeting the needs of people across the lifespan.

2.9 (1) (2) *Agency*

Agency, another particularly significant principle of life course theory, is concerned with the extent to which an individual can make decisions for themselves and be active in participating in society (RomaIoli & Contarello, 2019). RomaIoli and Contarello (2019) contend that agency, or lack thereof, can result in older people becoming viewed by other people as dependent or incapable. Liang and Luo (2017) argue that agency in later life is impacted by life experiences from childhood and across the life span. For example: older people who faced adversities earlier in life, are less likely to possess agency in later life (Liang & Luo, 2017). Elder (1994) proposes as people age, they continue to be affected by past life transitions. Economic pressure, martial issues and availability of health and social care resources, undoubtedly dictate the level of agency displayed by the individual as they age (Elder, 1994). Wray (2003) however, argues that financial independence and level of engagement with activities, are limited in discussing agency for older people. Wray (2003) suggests that older people can realise and exercise agency, through means such as maintaining relationships with family and friends and making decisions about their health and their care. Yet Wray (2003) further argues that the societal expectations of successful ageing are limited and can further present a skewed view of agency in later life.

Klaiss (2014) contends that gender can impact women's agency, as many cultures place a societal expectation on women concerning care provision for family members and children. Evans (2002) contends that women experience bounded agency, agency which is limited and hampered by societal structures. Indeed Hernandez and Iyengar (2000) propose that agency, even when based upon self-determination, is shaped and impacted by culture and background. Agency is either restricted or facilitated by cultural background and interactions with institutions within society, for example pertaining to education (Evans, 2002). In essence, people exercise agency against the cultural backdrop from where they were socialised or now live (Hernandez & Iyengar, 2000). Hernandez and Iyengar (2000) argue that agency can be promoted by a culture which promotes independence, or indeed the latter may occur. In the context of older people and homecare, such debates concerning agency and how this is impacted by issues such as gender and culture are significant. The societal context and background of the older person will undoubtedly influence the agency they foster, concerning decisions about their care as they age.

Consideration of agency as a fundamental principle of life course theory will be instrumental to providing both context and insight regarding older people and care in the home. The literature

concerning agency and how this illuminates culture, gender and care across the life span, will further be pertinent to critically examine within the context of the findings of this study.

2.9 (2) Disengagement and Activity Theory

2.9 (2) (1) Disengagement theory

Cumming and Henry (1961) suggest that older people gradually disengage from society and simultaneously society disengages from older people (as cited in Sudbery, 2009). The disengagement theory of ageing proposes that this is a mutually beneficial process whereby the older person benefits by not contributing to the labour market, as their abilities decline. Equally, society benefits from the older person disengaging, as this creates employment and fiscal opportunities for younger people (Youmans, 1969). Mirroring much of the discussion to date surrounding social isolation and loneliness, disengagement theory aims to provide a causation for the withdrawal of older people from society and vice versa (Cummings and Henry, 1961). Methods used by Cummings and Henry (1961) were based on a grounded theory approach and involved examining ageing via a sample of 211 people aged 50 to 90 years old, living in Kansas City.

Maddox (1964, p. 80) argues that older people welcome disengagement from society and such disengagement may represent "successful ageing". Disengagement theory postulates that social and psychological withdrawal from activities and people, is "inevitable" with older people gradually, yet consistently, disengaging (Maddox, 1964, p.81). Society is equally as consistent in disengagement from the older person as they gradually "reject" them, in favour of younger people to fill social and employment roles (Tornstam, 1989 p. 56). Martin (1972) explains the older person is no longer being subject to taxation through paid employment and when their children grow into adults and leave home, they are no longer interacting with educational institutions such as schools and colleges.

In the context of homecare need and use, disengagement theory may offer plausible ideas to explain this. Disengagement theory suggests that older people want to withdraw and perhaps spend more time alone. Equally if society simultaneously withdraws and disengages from the older person, it's plausible to suggest that greater social isolation may occur (Maddox, 1964; Tornstam, 1989). Loneliness stemming from social isolation has further been found to increase the use of health and social care services, so may increase the need for homecare for the older person (Gerst-Emerson & Jayawardhana, 2015; Cheng, 1992). Zhang, Liu, Tang and Dong (2018) contend that disengagement for older people can significantly impact their need for social interaction within their homes, as they withdraw from society. Social isolation can occur as a direct result of disengagement from society

(Zhang et al. 2018). Hence it is plausible to suggest that disengagement theory may offer an insight regarding the withdrawal of older people from society, their subsequent need for social contact, and potential need for care within their homes.

However it must be noted that within the gerontological community, strong criticisms of Cummings and Henry's disengagement theory exist. Prasad (1964) argues that withdrawal from employment can be a negative experience for older people and result in the loss of a significant role which is associated with identity. Asiamah (2017) argues that disengagement theory assumes that older people's abilities gradually decline as they age, and this is evident in their ability to maintain social activities and relationships. Such assumptions may evoke the idea that older people will inevitably become more reclusive and that isolation is a normal part of ageing (Asiamah, 2017). Johnson and Mutchler (2014) argue that early gerontology was synonymous with depicting a negative image of older people, relating to declining health and loss of independence. Critiques of disengagement theory question the validity of its conclusions relating to older people exercising free will and actively promoting their health and maintaining social ties as they age (Johnson & Mutchler, 2014).

Equally notable when critically considering disengagement theory, this was initially developed between 1957 and 1960, which Achenbaum and Bengtson (1994) argue was within the first few decades after WWII ended. This time of great change and development in a post war era undoubtedly impacted both the data subjects and potentially the conclusions drawn. Achenbaum and Bengtson (1994) surmise that Cummings and Henry were premature in their conclusions and further argue that colleagues within the University of Chicago drawing on the same data set, reached a completely different set of deductions. Indeed Hochschild (1975) goes as far as to say that the data analysed by Cummings and Henry unequivocally did not demonstrate disengagement. Hochschild (1975) argues that 34% of participants in Cummings and Henry's study had daily interaction with other people. Therefore the notion of disengagement was measured somewhat subjectively by researchers (Hochschild, 1975). Hence it could be argued that the development of disengagement theory was perhaps not evidence based within the data analysed and consequently may be more based upon the overzealousness of Cummings and Henry in deriving a theory (Hochchild, 1975; Achenbaum & Bengston, 1994). The grounded theory approach may have hastened the development of a theory of disengagement, perhaps negating alternative explanations provided by the data. Equally, Randall (1962, p. 99) argues that Cummings and Henry's research was based on a very "small group of individuals in a highly selective sample, in one geographical location". Nonetheless, Lynott and Passuth-Lynott (1996) contend that disengagement theory

presented the first ever postulation that ageing was not based solely on the individual, but rather concerned with the role and impact of society on ageing and the ageing person. This perspective very much reiterates the societal responsibility for the social isolation of older people as suggested by both Brofenbrenner, (1979) and Darling (2007). Yet disengagement theory further attributes mutual responsibility for withdrawal to the individual, as they inevitably engage less with their community (Maddox, 1954).

One movement however which appears to contradict the notion of disengagement for older people, is that of the University of Third Age. The University of Third Age, or U3A, is an educational community where older people are supported to both develop and share their intellectual and artistic interests (Hawthorn University of Third Age, 2022). The U3A was first established in France and Belgium in the 1970s and was created within existing universities. U3A provide courses of study older people can enrol in and further provide social and physical activity groups to their members (Gierszewski & Kluzowicz, 2021). U3A opened in Dublin in 2016 and they promote lifelong learning and deliver courses in conversational German, current affairs and poetry appreciation (U3ADLDK, 2022). Gierszewski and Kluzowicz (2021) argue that U3A acknowledge older people as active participants who have educational needs. U3A further recognise the knowledge and expertise possessed by older people, as a useful resource which can be used to teach others Gierszewski & Kluzowica, 2021).

2.9 (2) (2) Activity Theory

Martin (1972) describes activity theory as consistently in contrast to disengagement theory. Activity theory is based on the premise that meaningful activity maintains a sense of self for older people, as participation provides opportunities for "positive affirmation of their performance of their role" (Winstead, Yost, Cotten, Berkowsky, & Anderson, 2014, p. 894). Winstead et al. (2014) argue that activity throughout the ageing process has positive benefits such as a greater self-reported well-being and a reduction in symptoms of depression. Activity theory postulates that although the individual may experience loss of roles eg. as a parent/caregiver, in employment etc. the number of additional activities the person is participating in, will offset the potential negative effects of role loss (Lemon, Bengston & Peterson, 1972). Lemon et al. (1972) report that the greater the depth and frequency of the activity or role, the greater the benefit for the older person in maintaining their sense of self and general life satisfaction.

Greig et al. (2012) suggest that activity theory enables older people to express their views and values within the activities they engage in, further conserving their sense of self. An example of such engagement may be participation within an active retirement group, or membership of a club or committee. Such participation may impact the older person regarding their need for homecare, or indeed how they are impacted by their homecare experience. Westerhof, Whitborne and Freeman (2012) report that the aging process itself and how the individual experiences and views this process, impacts their sense of self. The older person consistently evaluates their sense of identity and self, based on the physical, social and emotional effects of ageing, and the feedback they receive from their interactions with the world around them (Westerhof et al. 2012). Based on this premise, older people who are engaging in their communities and in activities which enhance their sense of self or well-being, may be less likely to require homecare services. However also notable, Zainab and Naz (2017) surmise that older people who engage socially and within their communities are more likely to have greater functional ability.

Activity theory further identifies three distinct spheres of activity: solitary, formal and informal (Litvin & Shiovtz-Ezra, 2006). Previous research reports that informal activities provide for the greatest benefit for the older person, as such activities are based upon intimate relationships with family and friends (Litvin & Shiovtz-Ezra, 2006; Lemon et al. 1972; Knapp, 1977). It is plausible to suggest that older people without family members or close friends, may achieve such informal activity within their interactions with their homecare workers.

Knapp (1977) contends that the stability of roles and activity as the individual makes the transition from middle to old age, is the key principle of activity theory. Maintaining consistent levels of activity, results in greater feelings of well-being (Knapp, 1977). Knapp further argues that the "degree of congruence between the actual and desired social participation" of the older person is significant, and this further proposes that activity theory and disengagement theory are not mutually exclusive (1977, p. 554). Hence homecare and the stability and regular frequency of this service, could offer a viable means of engaging and maintaining activity over time (Knapp, 1977).

2. 9 (2) (3) Summary

This section of the literature review provided a critique of theory aimed at providing varying insights regarding the phenomenon of ageing, as it relates to older people and homecare. The linked lives principles of life course theory, offers some plausible explanations for how life occurrences and their impacts can culminate in some older people requiring formal homecare, as opposed to being cared

for by family members (Carr, 2018; Settersen, 2015). Stemming from the notion of linked lives, fictive kinship depicts the relationship which may develop between the older person and their homecare worker, and how such a relationship can be beneficial to both parties in the homecare relationship (Karner, 1998; Kay, 2013). Whereas the principle of agency highlights why some older people may exert greater control over their own lives and their care, as they age (Wray, 2003; Sanchez-Garcia et al. 2019).

Disengagement theory suggests that societies may expect and consequently accept, the withdrawal of an older person from participation as they age (Tilvis et al. 2011). Such perspectives may result in the exclusion of older people and complacency regarding their lack of visibility and involvement in society (Asiamah, 2017; Johnson & Mutchler, 2014). In contrast, activity theory proposes that older people can employ previously successful strategies, to retain their sense of self as they age and consequently experience less distress as they adjust to ageing and the impact this has on their lives (Knapp, 1977; Carstensen, 2006). In the context of the current study, activity theory could culminate in older people remaining more active socially and maintaining activity levels as they age. As such, the older person may not need homecare support, as they adjust to occurrences and events in their life. Whereas the latter could mean an older person is less able to cope with their changing life circumstances and consequently may require formal support in the form of homecare, to assist them as they age.

PART 4

2.10 Policy and Legislation

This part of the literature review will examine the policy and legislative contexts within which people age, both internationally and in Ireland. Homecare provision occurs within the confines of such national and international policies and laws. How societies view and respond to the phenomenon of ageing, is further evident within the policies and laws they have adopted.

International policy and the recommendations of the UN directly informs policy for older people in Ireland (Donnelly, O'Brien, Begley, & Brennan, 2016). Donnelly et al. (2016) suggest that Irish policy concerning older people mirrors many of the principles of international policy, such as the importance of providing support to older people who need it, dignity for older people as they age, and the significance of health promotion. Both international and national policy will frame the

current study and place in context the impact of policy development, on the homecare sector in Ireland pertaining to the experiences of older people and homecare workers.

Firstly, international policy pertaining to older people will be examined. Subsequently the Irish policy and legislative developments as they relate to older people and homecare, will be explored.

2. 11 International Policy

Consistent themes within international policy, recognise the active participation of older people in decision making. Such policies advocate for care and support services to be available to older people and acknowledge the significance of health promotion, for all people as they age (UN, 2002; UN, 1991; EUSTaCEA, 2010). The phenomenon of homecare occurs within the context of this broader international policy and therefore will be relevant in informing the current study.

International policy concerning homecare varies from country to country, with some countries creating overarching or centralised policy, while others are created at a municipal or regional level (Genet, Kronemanm Saltman, Hutchinson & Boerma, 2012). International policy largely acknowledges the significance of independence for older people as they age, and advocates for choice, participation and inclusion (UN, 1991; UN, 2002). Themes consistent within all international policies for older people, relate to the promotion of health for people as they age. The WHO (2009) suggest that policies for older people must focus on preservation of function and well-being and should support the creation of adequate care services, for older people across settings. However, there are cornerstone policies with the European Union (EU), which inform national policy and planning for older people by individual governments:

The *Vienna International Action Plan of Ageing* was derived from the first World Assembly on ageing, in 1982*,* which took place in Vienna, Austria (UN, 1982). The key objectives of the Vienna action plan relate to improving life expectancy, promoting dignity and promoting health for older people. The Vienna international action plan on ageing made recommendations relating to research, training and education, housing, dignity, independence and participation (UN, 1982). The European Federation for Older Persons, (2015) argue that the Vienna action plan provided a cornerstone guiding document which governments used to create and implement national policies and legislation concerning older people. Although evidence of evaluation of the Vienna plan is limited, Andrews and

Clark (1999) argue that research pertaining to the needs of older people increased significantly, after this recommendation was made within the first world assembly. This contributed to a greater understanding for the need for consistent research relating to old age, as a tool for promoting effective government planning and policy development (Andrews & Clark, 1999).

The *UN Principles for Older Persons 1991* were created in pursuance of the Vienna action plan on ageing (UN, 1991). The UN principles for older persons are:

- Independence: access to opportunities to generate income, access to education and training and be able to remain at home for as long as possible
- Participation: remain integrated in society and participate in groups
- Care: have choice in relation to decisions about their care, access to residential care, care in the community and access to health care
- Self-fulfilment: access to resources and opportunities for self-development
- Dignity: be free from abuse and treated fairly, without discrimination (UN, 1991).

Tang and Jik-Joen (2006, p. 1139) acknowledge the evolution of "declarations and principles" concerning the rights of older people and best practice approaches for their care. Yet Tang and Jok-Joen argue that legislation is necessary, as the latter results in inconsistency and ambiguity in the realisation of these principles, as governments are not legally obligated to implement these (2006). Indeed within the Irish context, such ideas are evident. Polices are not statutory instruments and as such, older people do not have a right within legislation to avail of homecare and remain in their own homes as they age (Kiersey & Coleman, 2017; O'Sullivan, 2012).

The Madrid International Plan of Action on Ageing (United Nations, UN, 2002) was the second assembly on ageing and provided governments with clear goals, for promoting healthy active ageing, with full participation in society for older people. The 3 key tenets of the Madrid action plan relate to: older persons and development, advancing health and wellbeing into old age and ensuring enabling and supportive environments. The recommendations of the action plan relate to the empowerment and participation of older people in decision making, the realisation of rights for all older people, and the implementation of strategies which enhance healthy ageing within communities (UN, 2002). The UN (2002) further specify that older people should be included in all elements of decision making concerning their own care.

Governments have a primary responsibility for implementing the recommendations made within the Madrid international plan and to ensure that the care of older people, remains central to the policy agenda of the country (UN, 2002). Such ideas are in keeping with those of the Ottawa Charter for health promotion and much of the WHO literature surrounding this (WHO, 1986; WHO, 2018). Health promotion aims to enable and empower people to increase control over their health and their lives. The health promotion principles of participation and empowerment are mirrored within Madrid international plan for older people (UN, 2002; WHO, 1986), further emphasising the significance of healthy ageing for older people.

Zaidi (2018) argues that measuring the extent to which the Madrid action plan has been implemented is challenging, due to lack of a centralised monitoring approach or method. Lack of research data, combined with subjective perspectives on the execution of actions, results in ambiguity concerning implementation (Zaidi, 2018). Zaidi recommends the creation of a toolkit to monitor the achievement of specific goals and recommendations of the action plan going forward (2018). Lack of data in general pertaining to older people and wellbeing, is further problematic (Bennett & Zaidi, 2018). Bennet and Zaidi (2018) conclude that many governments worldwide have prioritised the needs of older people and the recommendations of the Madrid action plan within policy frameworks. Yet the Madrid action plan is not legally binding and consequently implementation will remain sporadic (Bennet & Zaidi, 2018).

The European Charter of Rights and Responsibilities of Older People in Need of Long-Term Care and Assistance (2010) provides a guide for policy makers and organisations providing care to older people, outlining fundamental rights older people should be afforded (EUSTaCEA, 2010). These rights are outlined below in figure 2. (b):

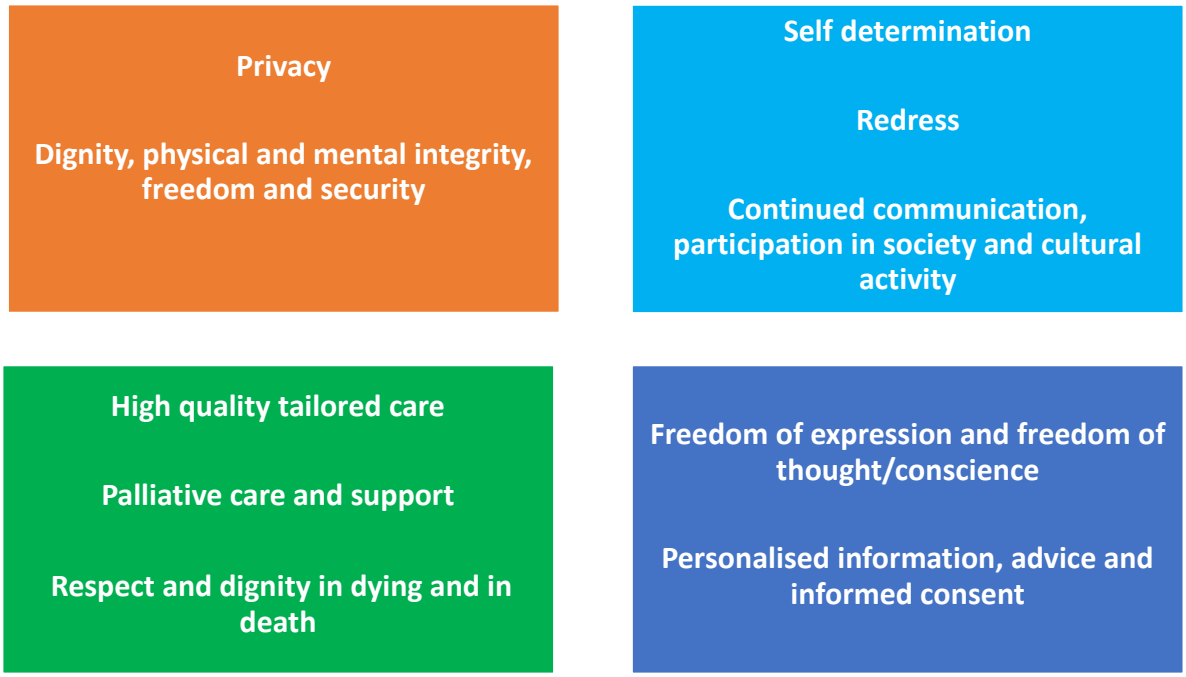


Fig. 2. (b) The European Charter of Rights and Responsibilities of Older People in Need of Long Term Care and Assistance (2010)

The European charter, recommends that care providers support the autonomy of older people in receipt of care and provide adequate information to older people, so that they can make informed decisions. Older people should be supported to make choices concerning the time care is provided and be involved in the planning of their care and decisions relating to any potential changes to the care they receive (EUSTaCEA, 2010).

As international policy matures, the contribution and participation of older people at a citizen level contributing to decision making and policy development, is recognised as paramount (UN, 2002). Progressive examples of such can be seen in Poland in the form of senior's councils. Councils comprise of older people who consult with and advise policy makers and those responsible for the allocation of resources for services, specifically for older people locally. Such councils have been in operation since 2000 and it is now mandatory that municipal decision makers consult with senior's councils, since new legislation was introduced in 2015 (Frączkiewicz-Wronka, Kowalska-Bobkob, Saganc, & Wronka-Pośpiech, 2019).

Calls for the creation of a United Nations Convention of Human Rights for older people have been discussed for over a decade (Age Platform Europe, 2020). The Open Ended Working Group on Ageing (OEWGE) was established in 2010 and their remit is to review the existing legislation concerning the rights of older people, work to identify potential gaps, and make recommendations (UN, 2022). The

OEWGE are recommending that the rights of older people be recognised within a distinct United Nations charter. As a member state, Ireland contributes to the annual meeting of the OEWGE (Age Action, 2022). However Age Action contend that the Irish Government is against the creation of a new convention for the rights of older people. Age Action do not agree and strongly urge the Irish Government to support the drafting of a convention to protect the rights of older people (2022). Ataguba, Bloom and Scott (2021) argue that the Covid 19 pandemic has amplified the vulnerability of older people worldwide and has illuminated the omission of a single body responsible for the promoting their rights. Ataguba et al. (2021) surmise that a human rights convention for older people is crucial now more than ever given the increases in life expectancy and the unpreparedness of most developed nations to respond effectively to this. Indeed when compared to other groups in society such as children, people with disabilities and migrants, older people's rights at an international level are sorely lacking (Ataguba et al. 2021).

During the Covid 19 Pandemic, Age Platform Europe made renewed calls on behalf of three quarters of United Nation member states to continue discussions towards enshrining the rights of older people via a statutory instrument. The platform highlight the ageism, neglect and discrimination experienced by older people throughout the pandemic and the growing need for action to protect human rights of older people (Age Platform Europe, 2020).

2. 12 The Development of Homecare Provision, Policy and Legislation in Ireland

At its inception, the care of older people in Ireland who could not be maintained at home or had no family to care for them, was primarily provided within workhouses through the state (Timonen, 2008). From approximately the 1850s, religious orders such as the Sisters of Mercy would provide additional care within the workhouse setting to older people who were sick (Timonen, 2008). County homes were then established to replace workhouses under the Poor Relief Act of 1938, and aimed to house those who were aged and infirm and unable to be cared for in the community (Department of Children, Equality, Disability, Integration and Youth, DCEDIY, 2021). All county homes were within buildings which had previously served as work houses, and conditions were reported to be deplorable (DCEDIY, 2021). Timonen (2008) concludes that the vast majority of care provision for older people in Ireland via state intervention was institutional, and often catered for older people who were very poor.

Religious orders of the Catholic Church in Ireland, began to provide care to those who were sick or infirmed in the community, in the late 1930s/early 1940 according to Timonen (2008). The idea

behind such care provision stemmed from a desire to provide charity to those in need, who lacked the family or resources to pay for this themselves. The Catholic Church conceded that the principle of subsidiarity, was fundamental to Catholicism and that any care needs should be provided by family or the church, with state intervention being sought only when absolutely essential (Donohue et al. 1999). Mulvihill (1993) argues that voluntary agencies such as the Legion of Mary and St. Vincent de Paul, were historically funded by the Government in Ireland to provide care to older people in their own homes. Yet Mulvihill (1993) suggests that little research has been undertaken concerning the role and impact of voluntary organisations, in the care of older people at home. Mulvihill further proposes that the discretionary nature of the service was often problematic, in the absence of robust policy.

Bunreacht na hEireann/ The Irish Constitution (1937)

Article 40 (5) of the Irish Constitution states that the dwelling of the individual "inviolable" and can't be forcibly entered. In essence this affords privacy and protection to the home of an individual (Government of Ireland, 1937). Article 41 (2) of the recognises the role of women within the home and therefore will not obligate a woman to work outside of the home and neglect her "duties in the home". This acknowledges the gender role of the woman in the home and community in terms of responsibilities relating to care and domestic tasks. Finally, Article 45 (4) (1) stipulates the role of the state in safeguarding and contributing to the support of "support of the infirm, the widow, the orphan, and the aged" (Government of Ireland, 1937). In summation, the Irish constitution places care and work undertaken in the home, largely as the responsibility of women. While article 40 part 5 prescribes indescriminable rights to the individual to have privacy and the right to refuse entry to their home (Government of Ireland, 1937). In totality, it could be construed that the constitution to an extent promotes the expectation that women should be expected to provide care at home and that this should be undertaken without formal intervention from the state. Indeed TD Mary Mitchell O'Connor (2013) argues that the constitution pigeon holes women in terms of managing the duties of the home as their responsibility, without taking into account that most women work outside the home. This conversation is part of an ongoing debate surrounding the sexist terminology within article 41 (2) and the call for changing this to be gender neutral and represent more modern and flexible gender roles within society (Mitchell O'Connor, 2013).

The Care of the Aged: Report of an Inter-Departmental Committee on the Care of the Aged (1968) marked a notable shift in thinking concerning the care of older people in Ireland. An inter-

departmental committee was appointed by the Minister for Health in 1965 and they sought public consultation from individuals, community groups, voluntary bodies and organisations who had an interest in the care of ageing people in Ireland (Government of Ireland, 1968). The main aims of the Care of the Aged Report were to enable older people to remain at home and provide suitable accommodation to those who could not be maintained in their own homes and communities (Government of Ireland, 1968).

This report identified the need for greater supports to enable older people to age at home and the significance of a partnership approach between families, the public and voluntary agencies (Government of Ireland, 1968). The Government of Ireland, (1968) made recommendations for financial, housing and community supports to be put in place to facilitate the maintenance of older people in their own homes and communities, for as long as possible. The Care of the Aged Report further identified the need for social workers and home-help provision for older people facing difficulties as they age at home and further emphasised the need for legislation to govern the home-help service. The report further recommended training and education for staff and volunteers providing care to older people. Recommendations for research on the topic of older people's care, with a specific focus on the rationale for the institutionalisation of some older people, were further put forward (Government of Ireland, 1968). Finally, the Care of the Aged Report identified the significance of the myriad of public, family and voluntary care combined, which is crucial to provide the comprehensive care older people require to remain at home (Government of Ireland, 1968).

The Health Act of 1970 initially made provisions for the maintenance of people at home, who may otherwise be cared for in residential and long-term care facilities (Government of Ireland, 1970). Section 61 of the 1970 Health Act refers to "a sick or infirm person or a dependant of such a person" whom "but for the provision of a service for him under this section, would require to be maintained otherwise than at home" (Government of Ireland, 1970). This is the only legislative framework in Ireland which directly refers to the care of older people in their homes. The Office of the Ombudsman (2010) argue that the Health Act of 1970 lacks clarity concerning the issue of service provision from the state. The terms "eligibility and entitlement" are often used interchangeably, with little consistency relating to exactly what the law states. It has been argued that "the manner and extent to which services are to be made available and the nature and extent of the services to be provided, are not specified" within this piece of legislation (Office of the Ombudsman, 2010). The terminology used within the Health Act of 1970, does not legally obligate the HSE to provide home

support, as the Act states that the Health Board (now the HSE) “may” make arrangements for the support of older people in the home (Murphy, Whealan and Normand, 2015).

However the omission of clear and robust legislation pertaining to older people and their care needs in Ireland is notable. It has been argued that this is partially caused by the gendering of care and subsequent expectation for this to be provided informally, by women in the community (Sharma et al. 2016; Epslen, 2019). Indeed Russel, Grotti, Mc Ginnity and Privalko (2019) argue that Article 41.2 within the Irish Constitution Bunreacht na hEireann, further compounds such expectations of women providing care in the home. Article 41.2 states that “the State recognises that by her life within the home, woman gives to the State a support without which the common good cannot be achieved” (Government of Ireland, 1945). Russell et al. (2019) note that Ireland within the context of such gendered care expectations is markedly behind their European counterparts, concerning the care provided to older people.

The National Council for the Aged (1983) state that 1972, saw the first instance of funding being allocated to home-help services. This resulted in the heath board officially establishing the home-help department, which illustrated a notable shift from a service which was delivered in totality by voluntary agencies, up until this point. The formal home-help service aimed to compliment voluntary services, which continued to account for the majority of homecare provision (National Council for the Aged, 1983). “Many of those involved give their time without charge, regarding their work as a friendly service to those in need” (National Council for the Aged, 1983, p. 18). The Health Board (now the HSE) provided this service with the establishment of the home-help department. Home-helps provided support with tasks such as personal care, shopping and completing domestic duties (Haslett et al. 1998). The NCAOP (1994) suggested that companionship was one of the primary tasks provided by home-helps in the 1980s and 90s. The NCAOP (1994) proposed that older people were loved by and loved their home-helps in many cases and that this intrinsic care and compassion, made the home-help service unique.

Initially, the home-help service aimed to recruit women in the community to provide paid care to older people in their own homes. The central aim of the home-help service was to prolong the period the older person could remain in the own home, as opposed to a residential care setting. Many women who had elderly neighbours were providing care on an informal and voluntary basis (Hasslett et al. 1998; Deevy, 1983). The Health Board intended to create some formality within this

existing care relationship. Home-helps would be paid for this service and attend to the needs of the older person, via pre-arranged days and times (Haslett et al. 1998).

At this time Deevy (1983), a nun working with the Little Sister of the Assumption, wrote a guide for home-helps with the aim of promoting the highest standards of care within the service. Deevy (1983, p. 5) described the role of a home-help as "more suited to the local housewife and her personal and family needs". Deevy proposed that home-helps should provide a listening ear to the older people they care for and their role should be based on "understanding and love" (1983, p. 13). Carey and Carroll (1986) describe the "good neighbour" approach as a mechanism by which older people could remain in their own homes, rather than in nursing homes. Combined with care from health boards and voluntary agencies, informal care completed the medley of care available to older people lacking family to provide such care. Yet Carey and Carroll in 1986 argued that such care was not documented and no inventory of older people in receipt of care or their care needs existed.

Women were often culturally stereotyped as caring according to Connor, Smith and Whelan, (1988) and this further illuminated the societal expectation of women to provide care to older people. Less potential labour market earnings, combined with a viewed availability to provide care, are cited as rationale for the role expectations in Ireland during the 1980s (Connor et al. 1988). The unique nature of the home-help service was captured at this time by Haslett et al. (1998) via a public consultation on homecare, on behalf of the National Council of ageing and older people. They found that the befriending element of the home-help service was somewhat unique in that no other named professional, would provide the companionship and care that home-helps provide, often becoming a much needed friend to the older person in receipt of care (Haslett et al. 1998).

In the Irish Journal of Medical Science, Corridan (1975, p. 137) proposed that "childlessness is the kernel of the geriatric problem". Such a statement encapsulates the perspectives of many professionals concerning the care needs of older people in Ireland in the 1970s. Corridan identified the "vast bulk of" those older people residing in nursing homes in the 1970s, could be explained within the following 3 reasons: older people living alone, childless older people and the very old (1975, p. 138). Corridan (1975, p. 143) suggested that "domestic help of a basic kind be provided where necessary", to reduce the financial implications of nursing home care. This implies that the initial establishment of a formal homecare system in Ireland, was motivated at least partially by economic implications.

The Years Ahead Report (1988) is the principal policy to date, relating specifically to the care of older people in Ireland. This policy recommended that GP's be given additional supports to assist and help to maintain older people, being cared for in the community. The expansion of the home-help service and its evolution into a more comprehensive service was further recommended within this policy, in order to more effectively support older people to remain in their own homes. Markedly, the Years Ahead Policy recommended that the Health Boards be legally obligated to provide services to enable older people to remain at home, who would otherwise have to move into long-term care facilities (The Working Party on Services for the Elderly, 1988).

However, an evaluation of The Year's Ahead Report found that the home-help service was still functioning as a discretionary service, rather than legally obligated, as this policy had recommended (Ruddle, Donoghue & Mulvihill, 1997). The National Council for the Elderly describe the home-help service as "core" and essential for older people (Ruddle et al. 1997). The evaluation recognised that the home-help service supports older people to maintain "a quality of life and a level of functional autonomy which enables them to live independently in the community, and consequently avoid unnecessary hospitalisation or admission to long stay institutions" (Ruddle et al. 1997, p. 179). Furthermore, this evaluation report highlighted the underfunding of the home-help service, despite significant monies being allocated. The actual cost had been significantly underestimated, leaving the service continually operating under severe financial constraints. The evaluation of The Years Ahead Report also emphasised the fluctuating tasks being undertaken by home-helps, across the various Health Board areas. All Health Boards provided the service to assist primarily with domestic chores and practical tasks such as laundry and shopping. However, some Health Boards felt that without appropriate training, provision of personal care to older people was not possible (Ruddle et al. 1997). Indeed, some older people have little choice but to move to long-term stay settings in Ireland, when sufficient supports cannot be provided for them in their own homes and communities (Donnelly et al. 2016).

Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990's (1994) reiterated the aims of The Years Ahead Report, concerning the care of older people. The strategy highlighted the significance of supporting older people to be maintained in their own homes in dignity, restoring independence and supporting care in the community (Dept. of Health, DOH, 1994). Shaping a Healthier future further outlined aims relating to "strengthening the role of the home-help and other primary care professionals in supporting older people and their carers who live at home"

(DOH, 1994, p. 67). A target of supporting no less than 90% of people over the age of 75, was identified as a primary aim within this strategy (DOH, 1994).

Adding Years and Life to Years and Life to Years: A Health Promotion Strategy for Older People (1998), recommended the training of all staff, formal and informal relating to care of older people. This Health Promotion Strategy recognised the need for competent and skilled individuals in promoting the health of older people, and further outlined objectives relating to enabling older people to remain in their own homes, through further development of the home-help service (DOHC, 1998).

Quality and Fairness a Health System for You (2001), aimed to address and adequately plan the future health needs of the Irish public. In relation to older people, this policy aimed to promote the concept of care in the community, through funding community groups to assist in supporting older people in their own homes. This policy planned to create an environment within which community groups, could begin "providing support services such as shopping, visiting and transport" (DOHC, 2001, p. 70). Quality and Fairness a Health System for You recommended that the Health Board should remain responsible for executing care provision to older people in a health promotion capacity, through the continual implementation of the policy; Adding Years and Life to Years, (1998) (DOHC, 2001).

The Irish government recognised the burden of long-term stay facilities and hospital beds on the exchequer and continued to develop and expand the homecare sector (Timonen & Doyle, 2008). The service evolved from the neighbourly and partially informal support provided by "a local housewife" and based upon the need for friendship, to those living alone (Deevy, 1983), to one where specific tasks were outlined as within the home-help remit. A clear job description for homecare workers exists now and the scope and rationale for the service relates specifically to the personal care provision and helping the older person getting in and out of bed (HSE, 2020). Such an evolution in the nature of tasks and rationale for homecare, signifies a notable shift in the thinking behind the homecare service.

Towards 2016: Ten-Year Framework Social Partnership Agreement 2006-2015, prioritised enabling older people to remain in their own homes independently, and having access to a "spectrum of care services" (Government of Ireland, 2006, p. 60). This framework aimed to maximise the use of

community and home-based care for older people and enable older people to actively engage in their communities (Government of Ireland, 2006).

The Law Reform Commission in their 2011 report on the legal aspects of homecare in Ireland, recommended the commencement of HIQA inspections within the homes of older people. Such inspections were to be based on the 2007 Health Act, which governs inspections for residential settings. Furthermore, the Law Reform Commission recommended for the regulation of homecare providers with registration criteria, regular inspections and to encompass public, private and independently employed carers creating minimum standards across Ireland's homecare market (2011). The Law Reform Commission (2011) further recommended minimum training and education for homecare providers, and regular professional supervision with their line manager. Finally, the commission argued that the HSE Draft National Quality Guidelines for Homecare Support Services, should "form the basis for National Standards for Professional Homecare to be prepared by HIQA under the Health Act 2007" (Law Reform Commission, 2011, p. 42). Such findings reflect the lack of formality and urgency concerning the regulation of the homecare sector. The use of terms such as "should" and "recommend", as opposed to must, or stipulate, imply a laissez-faire approach to regulating homecare

In 2005, the Health Service Executive was established and replaced the Health Board in acquiring responsibility for the provision of homecare services (HSE, 2011). Today, the HSE provide care and support to older people in Ireland within their own homes, in the form of the homecare support service (HSE, 2019). Previously encompassing the home-help department and homecare package service, the newly named homecare support service was established in 2018 (HSE, 2018). Tasks undertaken by HSE home support workers include assistance with personal care (washing and showering), positioning of the service user (to prevent pressure sores for people with limited mobility), and assisting with meals and essential household tasks (Citizen's Information, 2013). CARDI (2012) argue that laundry, shopping, cleaning and meal preparation are further carried out by HSE homecare workers as they support older people in their homes. The HSE (2019-b), however, limit their description of the home support service provision as relating to essential tasks specific to personal care, and no longer includes domestic duties. The Houses of the Oireachtas (2018) state categorically, that home support services delivered by the HSE are not concerned with undertaking housework, as was previously the case within the home-help service. The home support service currently delivered is for the sole purpose of supporting and enabling people to remain in their own homes, through the provision of necessary tasks relating to personal care (Houses of the Oireachtas,

2018). Such developments relating to the orientation of the homecare worker's role, indicate the evolution towards a more specific and more formal provision of homecare support.

HSE Draft National Quality Guidelines for Homecare Support Services (2008), were devised by the HSE to regulate the care of older people in their own homes. The HSE guidelines for homecare support services addressed issues such as training and monitoring of staff, rights of older people in receipt of homecare and issues of abuse and neglect. The HSE guidelines for homecare support services were created after a public consultation and collaboration with relevant stakeholders, including groups representing the voices of older people (HSE, 2008). However when passed to the National Task Group on Homecare Packages and Home-Help Services (a group established by the HSE) in 2010, the national quality guidelines were not approved. Rationale for this decision related to the preparedness of the HSE to implement the changes outlined within the guidelines without additional time (NESC, 2012).

The Long-Term Care Report (2008) was created to inform the Irish Government concerning the long-term care of older people, including the Fair Deal Scheme for Nursing Homes. The Long-Term Care Report (Working Group on Long-Term Care, 2008, p. 6) advised that the cost of caring for older people within their own homes, was substantially less than that of long-term care. The report recommended that homecare should "compliment rather than replace" the supports provided by family members. The Working Group describe the home-help service as a foundation to enabling older people to remain at home (Working Group on Long-Term Care, 2008). Such recommendations further reiterate the expectation of care provision by family members in the community and the shifting of responsibility for the maintenance of older people at home.

The 2008 HSE Homecare Guidelines remained in draft status, as the HSE and private care providers "worked towards implementing them" (NESC, 2012, p. 4). Derived from these guidelines, The Health (Professional Homecare Bill) 2012 proposed an amendment to the 2007 Health Act, to incorporate the provision of homecare to be included under HIQA's regulatory functions. Yet Care Alliance Ireland (2014) argue that the 2012 Health (Professional Homecare) Bill was unsuccessful and did not progress to be enacted into law. The subsequent Homecare Bill of 2014, Care Alliance Ireland (2014) argue is almost identical in content.

In 2012, to assist with the provision of homecare support, the HSE announced the "procurement" of private homecare providers, to provide home-help hours on their behalf (HSE, 2014). The HSE

describes this as a step towards improving the standard of homecare delivery, through the employment of trained and suitably qualified staff (HSE, 2012). The HSE (2012) state that each local health office area has approved private care providers from which service users can choose from. The tasks delivered by private homecare providers vary from cooking, to engaging in domestic tasks, providing personal care, medication reminders and supporting older people to engage in social activities within their communities (Caremark, 2015; My Homecare, 2015; Bluebird Care, 2015). Other companies such as Home Instead Senior Care, further provide care workers who organise appointments, monitor nutrition and provide transportation on outings or to appointments (Home Instead Senior Care, 2015).

The National Positive Ageing Strategy (2013), aims to promote the inclusion, participation and wellbeing of older people in Ireland. This strategy further recognises the lifespan approach necessary to promote positive ageing and the significance of making changes earlier in life to further enhance health and wellness as people age. Four national goals are identified within the positive ageing strategy of 2013 with goal 3 identifying specifically the aim of enabling people to remain in their own homes as they age:

1. Increasing participation and inclusion for people as they age through removing barriers
2. Supporting people to promote their health and wellness as they age
3. Enabling people to feel dignified and secure as they age and remain living in their own homes and communities for as long as possible
4. Supporting research concerning ageing to inform policy about ageing well in Ireland (Government of Ireland, 2013).

The national positive ageing strategy proposes approaching Ireland's ageing demographic from an optimistic perspective, as opposed to the pessimistic outlook often discussed in the media (Government of Ireland, 2013). This strategy further emphasises the significance of challenging such negative stereotyping of older people and focusing on the opportunities presented by ageing. This strategy's aim is to prioritise meeting the needs of older people who may be additionally marginalised due to ethnicity, rural dwelling or disability status (Government of Ireland, 2013).

Following on from the recommendations of the Law Reform Commission 2011, *the Professional Homecare Bill (2014)* makes provisions for the regulation of homecare in Ireland. The Professional Homecare Bill will provide for the Social Service Inspectorate "to establish a registry of all professional homecarers" (Government of Ireland, 2014, section 4). Section 6 stipulates that

assessment of need should include service user desired outcomes, and companionship needs should further be included within each care plan. The 2014 Bill defines homecare as: care delivered to an adult which is intended to enable them to live independently. The Bill identifies relevant staff members as: home-helps, nurses and homecare attendants, delivering "various therapies and personal care, and palliative care" (Government of Ireland, 2014, p. 3). The proposed Health (Professionals Homecare) Bill 2014, stipulates that HIQA will be responsible for the implementation of the 2008 HSE Draft Standards (National Quality Guidelines for Homecare Support Services). Sections 40 and 45, outlines some of the duties that homecare providers may administer, including: "meal preparation, light housekeeping, providing transport, assisting with walking and exercise, assisting with personal hygiene and dressing". The Homecare Bill (2014, p. 6) further stipulates the homecare provider's responsibility relating to ensuring that "only suitably trained personnel may provide professional homecare" and workers should be adequately supervised.
It could be argued that the creation of the Homecare Bill signifies a shift in thinking regarding the care of older people. The prevention of institutional care was the initial key remit for the introduction of formal homecare provision, stipulated within the Health Act of 1970 (Government of Ireland, 1970). Whereas the Homecare Bill (2014), communicates a more holistic and broad ranging rationale for homecare provision, aiming to meet not only the physical needs of the older person, but also their social needs and personal goals (Government of Ireland, 2014).

The HSE in 2014 published the *Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures*. This policy applies to all HSE services and also services which are HSE funded. The safeguarding policy outlines different types of abuse and where such abuse may occur. The principles of the HSE safeguarding policy are concerned with the protection of vulnerable people and the empowerment of such individuals (HSE, 2014). This national policy explains the key responsibilities of staff in responding to safeguarding concerns and presents a clear pathway for reporting such concerns. Safeguarding planning is further outlined within the HSE Safeguarding policy with a strong focus on the roles and responsibilities required of health care workers at each key stage (HSE, 2014). This policy is particularly significant for homecare workers as they are either in direct employment via the HSE, or are working for private care providers, funded through the HSE (NESC, 2012; HSE, 2014;2012). Homecare workers are bound by the stipulations within this policy, to identify and respond appropriately to safeguarding concerns regarding older people they provide care to (HSE, 2014).

Timoney (2018) states that as homecare is increasingly becoming privatised in Ireland, much debate still remains within the Irish Government concerning whether or not complete privatisation of the homecare sector will occur. The HSE has demonstrated substantial increases in agency pay in recent years, according to Whyte, Wren, Keegan and Brick (2020), as a consequence of the privatisation of the homecare sector. Whyte et al. (2020) in their analysis of HSE expenditure, found that the HSE staff embargo introduced in 2009 prompted the recruitment of health and social care staff from private care agencies throughout the country. O'Neill (2020) argues that the private homecare market has a for profit ethos and proposes that the use of private providers, results in inconsistencies within care provision, affecting the opportunity for the older person and the homecare worker to build relationships. O'Neill further maintains that the privatisation of the homecare sector has been undertaken in a clandestine manner, with a lack of transparency surrounding the process (as cited in Timoney, 2018).

The Assisted Decision Making and Capacity Act of 2015, aims to strengthen and enhance the autonomy and decision making capacity of all individuals. This Act stipulates that an individual should be supported to make decisions concerning their health and wellbeing, with the onus being on the service providers to enable such decision making occur. The Assisted Decision Making and Capacity Act (2015) further abolishes the previous ward of court system where decision makers are appointed on behalf of someone who was deemed to lack the capacity necessary to make decisions for themselves, and instead provides a decision making support person to empower continued decision making (Government of Ireland, 2015). This Act aims to fortify the rights of the individual and enable them to retain power and control pertaining to decisions around their health and social care provision (Government of Ireland, 2015). In the context of homecare provision, the Assisted Decision Making and Capacity Act (2015) may be particularly pertinent regarding advanced directive and pre-planning for homecare, should one become incapacitated in the future and perhaps unable to communicate verbally one's wish to remain at home (Government of Ireland, 2015).

The Safeguarding Vulnerable Adults Bill was published in 2017 with the primary aim of establishing a safeguarding authority who will be statutorily obligated to both investigate and respond to suspected cases of abuse and neglect. The Safeguarding Vulnerable Adults Bill stipulates that the safeguarding authority will have a legal right to access a service for the purpose of investigation and assessment regarding compliance (Government of Ireland, 2017). Furthermore this bill requires that certain persons are mandated reporters and must legally report any reasonable concern, relating to the neglect or abuse of a vulnerable person (Government of Ireland, 2017). Given the sometimes

vulnerable nature of older people in receipt of homecare due to ill-health, social exclusion and mobility issues, this safeguarding legislation when passed will be instrumental within the homecare sector in Ireland (Sydor, 2003; ALONE, 2019).

The Citizen's Assembly Report was published in 2017, concerning the ageing population in Ireland. This report was based on detailed submissions from public consultations which included carers, Sage Advocacy, expert advisory groups/panels and citizens of the assembly. The key recommendations relating to home and community care for older people include:

- The government should prioritise increased funding for homecare support for older people in Ireland
- A social insurance payment should be implemented to derive the additional funding needed for the care of older people
- A dedicated minister for older people should be appointed
- Intergenerational care opportunities should be developed to meet the care needs of older people
- Regulation of the homecare sector in Ireland should be prioritised, should be government decide to extend health and social care regulation.

O'Shea, (2017) in his submission to the Dail pertaining to the financing of care for older people in Ireland with dementia, argues that the spending on long-term care is twice as much as community based care for this group. O'Shea further reasoned that in the absence of legislation to promote accountability, the fiscal responsibility for homecare will continue to be neglected in favour of residential care. O'Shea (2017) described the investment in homecare to date and weak. O'Shea concluded his submission to the Dail with a strong recommendation to prioritise community based care, to support more consistently the maintenance of older people in their own homes (2017).

Since 2017 the HSE (2019-b) offer a consumer directed home support, where older people are given a weekly allowance and choose and pay for their own home support. The person chooses from a list of agreed providers, after they have been assessed and approved for home support. The older person is then responsible for sourcing, arranging and paying for their own homecare, at the hourly rate of the private provider of their choice (HSE, 2019-b).The HSE (2019-b) contends that consumer direct home support increases the choice and control of the older person in relation to their care. Phelan, Duggan, Fealy and O'Donnell. (2018) found through their pilot study on consumer directed care, that some older people may be disadvantaged through this method of home support, as the

care tasks undertaken may be in contrast with their needs assessment and care plan. As the older person has greater choice, private providers will be in direct competition for home support hours (Phelan et al. 2018). Cash, Moyle and O'Dwyer (2014) in their literature review on consumer directed care, found that overall recipients of this type of care report greater satisfaction, than those in receipt of traditional care provision. Cash et al. (2014) acknowledge that the capacity of the care recipient to make decisions impacts their experiences of consumer direct care, with those who have greater a capacity and ability benefitting most. Yet Ferguson (2007) argues that consumer directed care encourages the autonomy of care recipients and reduces their dependency on state services. Empowerment is a central concept of consumer directed care (Ferguson, 2007), which accentuates a health promotion model of care for older people in Ireland. Empowerment enables the individual to increase control over their own lives and make choices for themselves regarding their care (Hedman et al. 2015; WHO, 1986; Chambers & Thompson, 2008). This places the control back into the hands of the older person and prompts them to retain this control, relating to their homecare support needs (HSE, 2020).

The consumer direct home support service in practice, results in the older person being allocated a weekly budget for their homecare hours. They negotiate directly with preapproved homecare providers pertaining to the days, times and tasks they wish to be undertaken (HSE, 2018).
The Law Reform Commission in (2019) contend that the issue of regulation concerning older people in Ireland, is still lacking pertaining to safeguarding. The Law Reform Commission (2019) argue that although the introduction of the Assisted Decision Making and Capacity Act (2015) is a welcome development in terms of the promotion of rights for vulnerable individuals, this Act is not sufficient in terms of safeguarding. The Adult Safeguarding Bill was introduced into the Seanad for discussion in 2017, and the Law Reform Commission (2019) state that when enacted, safeguarding legislation will promote compliance in Ireland regarding the ECHR 2003 Act.

Ultimately the Law Reform Commission (2019) unequivocally contend that safeguarding of vulnerable people at risk of abuse is both a necessary and welcome development concerning those most at risk in Irish society. This issue paper further acknowledged the previous suggestion of the Law Reform Commission (2011) that HIQA would inspect homecare within the same capacity as they undertake with residential care settings for older people in Ireland. However they acknowledge the coming to light of multiple cases of abuse and neglect concerning ageing and other vulnerable people in the media in Ireland within the last 10 years (Law Reform Commission, 2019).

The homecare report published by *Sage Advocacy* in 2020, discusses the care needs of older people in Ireland, in light of the learning presented by the Covid 19 pandemic. Sage Advocacy acknowledge the catastrophic impact of Covid 19 on older people residing in nursing homes, while further proposing that effective options for care need to be created and supported by policy, to enable older people to age well. The homecare report recognises that the lack of homecare availability, reduces choice for older people and culminates into earlier nursing home admission. Sage Advocacy (2020) argue that the current service provision is restrictive and limited with little integration between services, resulting in a two tier system which is ineffective in meeting the choice and care needs of older people.

Key recommendations within the 2020 Sage Advocacy report pertaining to the care of older people are outlined below:

- The implementation of a seamless integrated care system for older people where care provision may be viewed as a continuum of service provision
- Local community care hubs within the community to support older people in their homes
- The sufficient training and ongoing support of nursing and long-term care workers
- Housing policy aimed at creating vibrant supportive communities, where older people age in place with supports (eg. shared villages, homeshare, multigenerational living, co-operative housing)
- The benchmarking of developments regarding the implementation of an integrated care model (Sage Advocacy, 2020).

The Homecare Bill reached the second stage of debate within Dail in 2020, when it was introduced in the Houses of the Oireachtas by Deputy Colm Burke. Deputy Mary Butler advocated that HIQA propose that a more streamlined method of regulation of homecare (in comparison to the regulation and inspection of nursing homes) should be concerned with the registration and certification of the service providers. All members who contributed to this debate in 2020 concurred concerning the necessity for a timely implementation of this Bill given the vulnerability of older people, combined with the exponential growth of older people in Ireland (House of the Oireachtas, 2020). Deputy Pauline Tully contributed that the current omission of legislation governing the homecare sector has resulted in some homecare workers providing care, while experiencing poor working conditions, low pay and unpaid travel time and expenses. Deputy Patricia Ryan added that the Homecare Bill was now before the government some 9 years after it was initially proposed by the law reform commission in 2011. Deputy Colm Burke concluded discussions on the homecare bill

by reiterating the most substantial pressing matter associated with this Bill: the prevention of abuse and the protection of older people in Ireland (Houses of the Oireachtas, 2020).

HIQA in their 2021 position paper on the regulation of homecare argue that for the rights of older people to be realised, as full review and reform of homecare in Ireland is necessary. HIQA (2021) propose the development of a homecare framework which will ensure access to homecare for everyone and the protection and promotion of human rights for older people. In the 2020 programme for Government, a commitment was made to regulate the homecare sector in Ireland. The programme for Government further aims to "to support older people to live in their own home with dignity and independence, for as long as possible" via the establishment of statutory homecare scheme (Government of Ireland, 2020, p. 50). Most notably, part 6. 1 (a) of the Professional Homecare Bill (2020) stipulates that the companionship needs of older people are to be encompassed within general duties of the homecare worker. The Homecare Bill provides examples such as supporting the older person to visit with friends and neighbours, and further stipulates that a companionship plan should accompany the care plan for the older person after assessment for homecare is undertaken (Government of Ireland, 2020).

Currently within homecare provision in Ireland, the lack of clear legislation governing this sector, presents a picture of uncertainty for both older people in receipt of homecare and homecare workers. The number of home-help hours allocated is based on an individual needs assessment and eligibility for the service (HSE, 2014). The HSE (2018) state that they endeavour to provide older people with choice, relating to the time of the homecare visit, yet this is not always possible due to staff availability. Notably, the allocation of homecare hours is discretionary, with no "automatic right to avail of it" (NESF, 2009, p. 3).

The HSE (2018-a) report that 24-hour home support is not possible due to limited funding. Yet in some cases, no resources may be available, and the older person will be placed on a waiting list for home support (HSE, 2019-b). The NRSF (2009, p. 2) suggest that home support is "tailored to the needs of an individual, based on their medical condition and level of care required". Aimed mainly towards older people at risk of entering long-term care, homecare support varies in its provision from one local health office area to the next. The North/South Interparlimentary Association (2013, p. 16) state that each HSE area is "is required to have in place an effective mechanism for on-going regular reviews" of homecare support. Dail Eireann (2019) argue that the issue of variation in the allocation and availability of homecare support hours throughout Ireland, remains problematic.

Described as based on finite resources, Dail Eireann agree that no guarantee of home support hours can be provided to older people and oftentimes geographic location, will impact whether or not an older person will be successful in their application for home support (2019).

2.12 (1) Policy and Legislation Summary

International policy recognises and advocates for the empowerment of older people and supporting older people to remain living in their own homes and communities for as long as possible (UN, 1982;1991). International policy further accentuates the significance of research on ageing and older people, to promote best practice and the most appropriate governmental responses to ageing demographics ((EUSTaCEA, 2010; UN, 2002). Most notably in recent international policy developments is the call for the creation of a United Nations Convention, specifically for the rights of older people (Ataguba et al. 2021; Age Platform Europe, 2020).

In Ireland, religious orders historically provided care within the community to older people who were sick or infirmed, who had no family and were poor. The Care of the Aged: Report of an Inter-Departmental Committee on the Care of the Aged (1968) signified a notable shift in the focus of care provision to older people in Ireland, to care in the home and community. From here the Irish Government have been consistent in their development of policy and legislation aimed at supporting and protecting older people in Ireland (Government of Ireland, 1968; DOHC, 1998; DOHC 2001; HSE, 2014; Government of Ireland, 2013; 2015). The recognition that ageing at home is the preference of most older people is evident within the evolution of policy in Ireland to date, while the need for greater resource allocation, staff training and legislation to regulate the homecare sector in Ireland have been emphasised consistently within the policy rhetoric. Yet to date, much of the policy aims pertaining to homecare in Ireland have yet to be realised (Dail Eireann, 2019; O'Shea, 2017).

Homecare support in Ireland has been on the policy agenda consistently since 1988. Yet evaluations of policy concerning homecare have identified the need for greater resources to be allocated to the homecare sector, to enable older people to remain at home for as long as possible (DOHC, 2001; Age Action, 2012; O'Shea, 2017). The omission of legislation to govern the homecare sector remains problematic, as regulation and consistency in the provision of service continues to be unpredictable (Cullen, 2019; Timonen, Doyle & O' Dwyer, 2012; Houses of the Oireachtas, 2012; 2020).

This repeated lack of commitment to the homecare needs of older people in Ireland is substantial and unambiguous (Conyard et al. 2020). Plans have been meticulously created using the existing

evidence based on best practice to form a clear blueprint of legislation, to govern the homecare sector and meet the needs of older people in Ireland as they age at home (Kiersey & Coleman, 2017). Yet such plans remain incomplete as they have yet to be enacted in to law and consequently are not statutorily obligated House of the Oireachtas, 2020). Conyard et al. (2020, p. 116) conclude that the current provision of homecare for older people in Ireland is "not fit for purpose" and recommends the regulation of this sector, to create a safer care environment for both older people and homecare workers.

2.13 Part 5: Homecare Research

This section will present the research and developments concerning homecare provision in Ireland to date. Firstly, an overview of the key ideas and progress to date surrounding homecare for older people in Ireland will be provided. The hard to reach status of older people as participants will be explored, as this assists in explaining the dearth of research undertaken within the homecare sector in Ireland to date. Subsequently a more detailed and critical analysis of core research studies undertaken in Ireland, will be presented. Each study included in this more detailed discussion are deemed to have contributed significantly to understanding of the phenomenon of homecare in Ireland.

Homecare development in England will then be examined in an effort to identify the contrasting approaches to homecare within both countries. Finally, the summary will highlight the key evidence derived from this part of the literature review.

2.14 Homecare Research in Ireland

The phenomenon of homecare for older people in Ireland is under-researched (Timoney, 2018; MCRI, 2013; Kiersey & Coleman, 2017). Yet the lack of robust legislation to govern the homecare sector, further maintains ambiguity surrounding homecare and exactly what this means for both older people and homecare workers (O'Sullivan, 2012; Houses of the Oireachtas, 2020; Age Action, 2017). Recruiting and retaining older people within research studies can be challenging, as they can be deemed to be a hard to reach group (Gatlin & Johnson, 2011). Gatlin and Johnson (2011) define hard to reach groups as groups who are difficult to locate and recruit within research projects. When the research topic is sensitive in nature, this can be further problematic for recruitment of

participants from hard to reach groups (Sydor, 2013). Social disadvantage, disability or a lack of support, can make some groups harder to reach (Cortese, Trusscot, Nikidehaghani & Chapple, 2019). Cortese et al. (2019) argue that disadvantage and possible poor health or economic status, becomes cyclical for hard to reach groups with little opportunity for improvement in their circumstances, due to their hard to reach status.

Thurman and Harrison (2020) argue that functional ability can further dissuade hard to reach groups from participating in research. They perceived the time and effort required to participate, can act as a barrier for hard to reach groups and in particular those living with disability (Thurman & Harrison, 2020). Lijas et al. (2017) describe older people as a hard to reach group and further suggest that those aged over 85 and those from more deprived backgrounds, are even harder to reach as research participants. Flanagan and Hancock, (2010) argue that older people in the context of being a hard to reach group, may feel the stigma associated with their vulnerability and perhaps developing dependency, if they are in receipt of care services.

Including such hard to reach groups within research is even more important, as they are largely underrepresented previously (Sydor, 2013). Canvin et al. (2018) suggest that older people adjust their expectations or modify their behaviours, to cope with increasing needs, in an effort to avoid discussing their care needs with other people. Older people can feel a lack of trust when disclosing issues relating to their care needs or perhaps vulnerabilities, which may result in their voices not being heard (Lindquist, Ramirez-Zohfeld, Forcucci, Sunkara, & Cameron, 2018). Lindquist et al. (2018) found that older people in their study reported fearing being taken advantage of, should they express their perceived deficits or weaknesses to professionals (Lindquist et al. 2018). Bor (2015) suggests that older people are often reluctant to discuss emotional issues or problems they are experiencing, as they worry that they will be labelled and judged by professionals.

The research undertaken on homecare in Ireland to date, highlights that older people are quite satisfied with the homecare they receive and benefit from the companionship this affords them (Boyle, 2011; Hasslett et al. 1998). Boyle (2011) reports that older people have largely provided positive feedback relating to availing of homecare services in Ireland and remaining in their own homes. However, there appears to be no consistency or standardisation concerning eligibility criteria or measures/methods of assessment and the subsequent allocation of home-help hours (Boyle, 2011). Furthermore, the National Economic Social Forum (NESF, 2009) found that multiple different home-help or private care workers, may be providing care to one service user. Whereas Lloyd (2010)

argues that older people are in a very vulnerable position when they first begin receiving homecare. Many are leaving hospitals or have decompensated substantially, in their ability to provide self-care (Lloyd, 2010).

Barry (2010) surmises that the care of older people in Ireland historically has been viewed as the responsibility of family members and communities, with more formal provision usually occurring when such familial and social supports were unavailable. The substantial role of the Catholic Church in Ireland, regarding the care of vulnerable older people has further been highlighted within the research (O'Sullivan 2019). O'Sullivan (2019, p. 288) describes the church as "a very significant stakeholder in Irish social services". Convery (2001) argues that families had and still have a moral responsibility to care for ageing family members and that this responsibility negates such responsibility from the state to adequately plan, fund and deliver care in the home to older people. Furthermore, there appears a stark contrast in the Governmental response to the care needs of older people in Ireland, when comparing the statutory entitlement to nursing home care, to care in the home (Timonen at al. 2011). Wright (2020) in his statutory homecare briefing document on behalf of Home Instead senior care, argues that the lack of a statutory entitlement to homecare, biases families towards nursing home care where statutory right to care can be realised. Wright (2020) argues that in the absence of a statutory entitlement to homecare, older people are not being afforded choice concerning their care as they age.

In contrast, the Nursing Home Support Scheme (previously the Fair Deal Scheme, 2009) provides statutory regulation for nursing homecare for older people, based on a needs assessment. This needs assessment evaluates the care needs of the older person, in addition to the supports available to them. Once approved, under the Nursing Home Support Scheme (2021), an older person will pay only part of the cost associated with their residential care, based on their means, and the Government will pay the remainder (Government of Ireland, 2009: Government of Ireland, 2021).

Equally problematic is the potential ability to measure or quantify the impact of informal, community and family care provided to older people in their homes, and how formal homecare provision can be offset against this, in the absence of measurement tools (Mc Daid, 2001; Grosse, Pike, Soelaeman & Tilford, 2019). For example: Mary's neighbour shops for her twice per week. Mary's niece helps her to shower 3 times per week. Mary has applied for home support from the HSE as her niece is experiencing health problems and may need to visit less frequently. So how will Mary's need for home support hours be calculated? Mary already has 5 hours of informal support

and is having many of her support needs met. Whereas Tom has no informal care and is being released from hospital. Tom needs help with multiple care tasks such as toileting, eating his meals and washing. How can the home support needs of both Mary and Tom be met with limited resources? What if Mary's neighbour stops doing her shopping? What if Tom has no homecare support? Will Tom need nursing home care in this case?

Ultimately, the omission of a statutory entitlement to homecare, culminates into a climate of uncertainty and ambiguity for older people regarding having their needs met and enabling them to remain at home as they age (Age Action, 2017, Houses of the Oireachtas, 2020; Timonen & Doyle, 2008). This creates an unpredictable and unfair position for older people and places them at the mercy of those responsible for decision making concerning homecare.

2. 14 (1) Core Research Studies on Homecare in Ireland

Lundstrom and Mc Keown in 1994 undertook a mixed methods and comprehensive study on the delivery of homecare in Ireland. The primary aim of this study was to examine the effectiveness of the home-help service, based on the experiences of service users. Subsequent aims were concerned with exploring the partnership role of voluntary agencies in delivering care simultaneously alongside the home-help service (the numbers of which were 71 in 1992 and 73 in 1994) (Lundstrom & Mc Keown, 2994). Finally, this research aimed to investigate the significance of the informal care provided by family members and neighbours, in the context of the totality of care in the home in Ireland (Lundstrom & Mc Keown, 1994).

This study consisted of both interviews and questionnaires and was undertaken in stages, between 1993 and 1994. The study design was sequential with earlier data gathered used to inform subsequent phases of the research (Lunstrom & McKeown, 1994). The key phases of Lundstrom and Mc Keown's study in chronological order were:

1. 64 home-help organisers were surveyed via the quantitative element of this study, through use of questionnaires.
2. 38 home-help organisers were interviewed.
3. Interviews were undertaken with 30 participants in receipt of homecare, 10 participants not in receipt of homecare and 7 informal carers.

4. Interviews were undertaken with 38 home-helps and 19 participants within the Health Board who had responsibility for overseeing the provision of home-help services, in each Health Board region. Finally,
5. Finally, 195 participants who were aged over 65, whom were in receipt of home-help services were interviewed (Lundstrom & Mc Keown, 1994).

Key findings of this study suggested that the overwhelming majority of older people surveyed (97%) were satisfied with their home-help service and that most initially applied for home-help after an injury or hospitalisation (Lundstrom & Mc Keown, 1994). Interestingly this study found significant variation in the tasks provided by home-helps in urban vs. rural settings, with rural home-helps performing more personal care tasks and urban home-helps performing more tasks outside of the home (shopping/collecting medications etc.) (Lundstrom & McKeown, 1994). Sixty Four percent of participants in receipt of homecare identified the social contact element of this service as very important to them. Many recipients of homecare describe their home-help as like a daughter to them and someone they have great chats with and who they value regarding social interaction (Lundstrom & McKeown, 1994).

Findings propose that no standardisation in terms of how applications for home-help and the number of days and hours which are allocated, were processed. Similarly the rates of pay for home-helps varied significantly between Health Board areas, and most homecare worker reported receiving a very low wage (Lundstrom & McKeown, 1994). Participants who were working as home-helps reported providing additional care to older people who lived alone in an unpaid capacity and reported being concerned for the welfare of some of their clients. Interestingly Lundstrom and McKeown (1994, p. 196) surmised that the status of the home-help service was not commensurate with the service provided and that it was often referred to as a "cinderella service" where a lack of recognition is evident.

A notable strength of this study relates to the geographical dispersion of participants from each phase, which encompassed those from both urban and rural locations. This substantiates Lundstrom and Mc Keown's focus the importance of data being truly representative of those with lived experiences of homecare services, as a key objective of their study. Limitations were not directly identified within this study by the authors themselves (Lundstrom & Mc Keown). The breadth and scope of the issues examined within Lundtrsom and McKeown's study may further be considered a notable strength. The inclusion of sample populations from service users to homecare providers and

managers culminates into a comprehensive picture of the reality of homecare in Ireland, from several unique and informed perspectives.

The impact of Lundstrom and Mc Keown's research on the home-help service in Ireland has been instrumental and is regularly referred to within later studies as being comprehensive and robust (Timonen & Doyle, 2008; Buckley & Linehan, 2005; Doyle, 2012; Coffee, 2004; Haslett et al. 1998). The large scale and in-depth nature of this study, combined with the dearth of comparable research on the topic of homecare in Ireland at this time, places Lundtrsom and McKeown's 1994 study as a cornerstone document for the planning of future policy, legislation and delivery of homecare.

Haslett et al. (1998) were commissioned by the Department of Health to undertake a public consultation concerning the home-help service in 1997. The primary aim of this consultation was to: "culminate in recommendations as to how a quality Home Help service might be made available to all who need it, on a statutory basis if necessary" (Haslett et al. 1998, p.12). The methodology for this consultative research was qualitative and consisted of both 1-1 interviews and focus groups with: home-help service users, home-help organisers, home-helps and carers. Data was collected geographically within all 8 health board areas throughout Ireland (Haslett et al. 1998).

The sample within Haslett et al. (1998) study consisted of: 100 home-helps, 40 home-help organisers, 114 public health nurses and 144 other service providers (voluntary providers, occupational therapists, community welfare officers, social workers and psychiatric nurses in the community). Sixty four older people participated, while 68 carers further partook in this study (Haslett et al. 1998)

The key findings of this nationwide consultation concluded that the homecare service lacked recognition for its role in within community care for older people and was slow in its development to date (Haslett et al. 1998). Older people in receipt of home-help services who participated expressed an attachment to their homecare worker and articulated the importance of receiving care from just one person. Findings suggested that the needs of family carers should be taken into account when agreeing the number of home-help hours an older person will receive each week. Findings indicated that older people who live alone tended to receive more substantial home-help hours, when compared to those who lived with family (Haslett et al. 1998). Haslett et al. (1998) found that home-helps provided invaluable emotional support to older people and that future training provision

should include modules conducive to this. Meeting the needs of the "whole person" was highlighted as being key within the remit of homecare provision (Haslett et al. 1998, p. 7).

Interestingly recommendations of Haslett et al. (1998) study advocated for the continuation of homecare hours to be delivered at the discretion of the home-help organisers, as this was seen to allow for flexibility where necessary. Haslett et al. (1998) further recommended a minimum of a 2 hour visit, as opposed to the 1 hour minimum at that time, in addition to training and an increase in wages for home-helps. Equally interesting were the arguments put forward for and against legislating of the home-help services. Streamlining and standardising the home-help service in line with other health and social care services were reported as reasons why the home-help service should be legislation, in addition to clarity of entitlement to services and a reduction in pressure for family carers. Arguments against legislation in Haslett et al. (1998) consultation were concerned with a reduction on flexibility and a substantial increase in costs, should older people be legally entitled to home-help hours.

A perceived limitation of this study could be the specific aim as stipulated by the Department of Health when they commissioned the researchers to undertake this study. This undoubtedly limited a broader more open collection of data pertaining to the home-help service more generally. A strength of this public consultation appears to be the broad array of participants from family carers, to social workers, home-helps and recipients of care. This presents insight into the impact of the home-help service from multiple varied perspectives. Equally, the sample size was quite large in the context of a largely qualitative study. The geographic dispersion of participants from each Health Board area throughout the country could be viewed as a notable strength of this study and more likely to have generated data which was truly representative of the reality of homecare throughout the country (Haslett et al. 1998).

Gallagher's research in Ireland in 2008 was based on a mixed methodology utilising surveys, ethnography and interviews. The aim of this research was to establish the commonalities and differences between 2 localities, concerning the experiences of older people relating to connectedness and a sense of community where they live.

Gallagher conducted 150 interviews with older people in 2 locations on the west coast of Ireland living within their own homes and communities. Interviews were undertaken with 165 older people

living in sheltered accommodation and fictitious names were used for both locations. This study was longitudinal and data were gathered over a 5 year period from 2005-2008 (Gallagher, 2012).

Sampling methods for this study appear unique. The community dwelling older people were recruited via knocking on doors and people were verbally invited to participate. The sheltered housing participants were recruited via their housing providers inviting them partake and arranging times and dates for interviews to be undertaken (Gallagher, 2008).

Key findings of Gallagher's 2008 research proposed that older people who reported great social connectedness via social, voluntary and religious activities, reported greater wellbeing. Older people who attended bingo and their local pub described the meaningful connections they felt at these locations. Gallagher (2008) surmises that the significance of connectedness and inclusion for community dwelling older people is momentous, and consequently policy makers and community groups should focus efforts on facilitating such connectedness for those who don't, or are unable to, engage in community life. This study found that older people both contribute and are recipients of rich connections and shared experiences as community members and contends that older people attribute significant meaning to such connections. Gallagher (2008) argues that the social gatherings and relationships with non-family members within community setting, create and maintain a sense of connection to both the geographical location within which the social contact occurs and with the people involved.

The findings of this study may be weakened by the recruitment strategy employed. The participants living in sheltered accommodation may have felt pressured to partake, due to their status of vulnerability by reason of being residents of sheltered accommodation (Gallagher, 2008). Equally, this study did not directly examine homecare, but rather connectedness and community for older people in Ireland. Nonetheless, the insight provided by Gallagher's 2008 study emphasises the significance of social inclusion and non-familial connection for older people ageing in place.

Timonen and Doyle in 2008 conducted a study on the development of domiciliary care services for older people in Ireland. The key aim of Timonen and Doyle's research was to review the policy development which culminated into the existing system of homecare being delivered in Ireland. They further aimed to ascertain the impact of such developments on the ground, from provider's perspectives (Timonen & Doyle, 2008). The methodological approach included a detailed desk review of policy development and its implementation in practice, combined with qualitative

interviews aimed at examining the context and structures which influence homecare provision. This study's sample population were homecare managers/organisers currently employed in the homecare sector in Ireland and based on 3 different types of organisations: for profit providers, not for profit providers and public sector providers (Timonen & Doyle, 2008). In total, 63 participants were recruited. Twenty participants were employed in not for profit organisations, 23 in public sector providers and the remaining 20 participants employed in for profit organisations. All participants were based in the greater Dublin area (Timonen & Doyle, 2008).

Key findings of this study by Timonen and Doyle (2008) suggest that informal care provision by family members, still very much remained a central component of homecare in Ireland and the capacity of older people to age in place. Timonen and Doyle reported that the evolution of homecare to the existing quasi market system, had inadvertently emphasised the necessity for regulation of the homecare sector. The competitiveness of private providers, prompted an increased focus on accountability and enhanced quality (Timonen & Doyle, 2008). Participants further cited the benefits of the quasi market system of homecare in terms of the flexibility and increased availability specifically relating to out of hours contact, not previously offered by the HSE. Timonen and Doyle concluded that the inconsistencies associated with the allocation of home-help hours, compounded the necessity for more specific and structured policy governing homecare (2008). Notably, the authors of this study described the home-help service as "not sufficient for individuals with extensive care needs" (Timonen & Doyle, 2008, p. 10).

Timonen and Doyle's research undoubtedly contributes to and enhances the minimal research previously undertaken on the topic of homecare in Ireland, and further illuminates the challenges and opportunities presented by the evolution of the homecare market in Ireland to include private care providers. Their review of the literature and policy to date further appears comprehensive in providing a clear picture of how the evolution of homecare provision has occurred in Ireland (Timonen & Doyle, 2008). However a potential weakness of this study could be argued is the relatively small sample size of 62 participants. The authors themselves identify the geographical location of the study occurring in the Dublin area only, as a potential limitation of transferability concerning findings. Even so, the depth and breadth of the policy development undertaken by Timonen and Doyle (2008) is a welcome addition to the limited mapping documenting the evolution of homecare in Ireland.

Donnelly, O'Brien, Begley and Brennan in 2016 conducted a research study in Ireland pertaining to the availability of care for older people and their preferences for such care. The primary aims of their research was to examine needs and availability of care, in addition to what community supports may enable older people to remain at home or return home (if they are residing in hospital or residential settings) (Donnelly et al. 2016).

A mixed methods approach was undertaken with both questionnaires and telephone interviews conducted with social workers responsible for the care of older people. Questionnaires were delivered online and were completed by 38 social workers, who were reporting on behalf of 788 older people on their caseloads. The qualitative phase of this study consisted of telephone interviews with 21 social workers and the duration of which were between 40 and 90 minutes. Participants from both phases of this study were dispersed throughout the country.

The key findings of this research suggest that the overwhelming majority of older people on the case loads of participants, wish to age at home. Findings contend that 85% of the older people being reported on, are involved in decision making concerning their care, based on the perspectives of participants (Donnelly et al. 2016). Donnelly et al. (2016) report the momentous role of family carers in the maintenance of older people as they remain at home and that older people without family carers, are more likely to be admitted to a long-term stay facility. Findings further suggest that the older people are not granted sufficient homecare hours to meet their needs, and often would benefit from their homecare worker sitting having a cup of tea with them, although this is not within the remit of the homecare service (Donnelly et al. 2016). Participants described the change of personnel (different homecare workers attending 1 older person) as distressing for some older people and particularly unsuitable for older persons with a diagnosis of dementia (Donnelly et al. 2016).

A potential strength of the study undertaken by Donnelly et al. (2016) is the inclusion of professionals who engage with older people in the community, their families and liaise with homecare providers. Furthermore, the advocacy component of the social work profession, enhances the value attributed to their input in reporting on the needs of the older people on their caseloads (Donnelly et al. 2016). However, by proxy participants sharing their perspectives on the lives experiences of someone else, may not be deemed as potent as if the information had been sought from older people themselves. Equally the sample size, particularly for the quantitative phase of this study, was quite small. Also notable is that Donnelly et al. (2016) did not identify weaknesses or

limitations of their study. Nonetheless Donnelly et al. (2016) presented the views and experiences of those advocating for the needs of older people, concerning their wish to remain at home as they age. Illuminating the role of informal family carers as fundamental to enabling and empowering older people to age at home, is an important finding to share and further highlights the plight of older people ageing alone (Donnelly et al. 2016).

Dempsey, Normand and Timonen in 2016 in Ireland, conducted mixed methods research with the aim of establishing older people's preferences concerning their homecare. They further examined the flexibility of home-helps with regard to working hours, aimed at enhancing person centred care. The study was approached using a mixed methodology of both qualitative and quantitative elements. Dempsey et al. (2016) further approached this research via a sequential design. Focus groups consisted of 23 older people (aged over 65) in receipt of homecare. Dempsey et al. (2016) further conducted questionnaires with 242 HSE homecare workers and 147 carers from voluntary organisations.

Findings suggest that older people are satisfied with their homecare and participants expressed affection and care for their regular homecare worker. However, some older people reported a lack of consistency in their care and felt they did not receive adequate hours of care, to meet their individual care needs (Dempsey et al. 2016). Older people in receipt of homecare further reported that their homecare worker was often rushing to complete tasks, and not having sufficient time to talk to them. Homecare workers were surveyed largely in relation to their availability and willingness to work unsociable hours. Nevertheless, both homecare workers and older people emphasized the significance of companionship within the homecare relationship. This study concluded that more time was necessary from the perspective of both older people and homecare workers, to meet the needs of older people holistically (Dempsey et al. 2016). Over 50% of respondents (homecare workers and voluntary agency workers) indicated that should they have additional time, they would use this to spend time talking with the older people they care for.

Dempsey et al. (2016) concluded that the current task-based model of homecare delivery, omits the flexibility needed within the unique homecare relationship. The methodological approach utilised within this study appears both comprehensive and robust as it collected data from 3 different sub-groups of the population impacted by and involved in, the phenomenon being studied. A potential limitation of this study may be perceived as the inclusion of 1 voluntary home-help agency which was located in Dublin. It could be argued that the inclusion of this organisation may have impacted

the results of this study to perhaps not be generalisable or typical pertaining to homecare delivery. Equally, focus group participants were recruited from Kildare and Dublin only. Hence the data collected may not be representative of the reality of homecare for other recipients more geographically dispersed throughout the country (Dempsey et al. 2016). Nonetheless, this study yields rich insights pertaining to the views of parties at the coal face of homecare provision and emphasises the significance of homecare and the regularity of having a visitor, particularly for older people living alone (Dempsey et al. 2016). A further strength of this study could further be the large sample size, given the hard to reach status of the sample population groups being researched (Spong & Bianchi, 2017; Bonevski et al. 2014).

Kiersey and Coleman in 2017 conducted a systematic review examining the legislation of homecare in 4 other European countries: Germany, Netherlands, Scotland and Sweden. The aim of this research was to establish the methods used in these countries to create and sustain legislation to govern homecare, and ascertain effective mechanisms of monitoring compliance, to protect older people in receipt of care (Kiersey & Coleman, 2017).

Kiersey and Coleman's (2017) research question was concerned with describing approaches to the regulation of homecare in the each of the 4 countries identified, specifically pertaining to financing, legislation, staff and service user experiences. The methodological approach adopted to address the research aim was a detailed and systematic scoping review. This scoping review involved identifying and collating evidence from research articles, government policies and large scale projects conducted by the WHO, European Commission and Organisation for Economic Co-Operation and Development (OECD) (Kiersey & Coleman, 2017). Kiersey and Coleman (2017) further identified gaps within the published literature and sought specific documents they deemed to be useful to building a comprehensive picture of homecare regulation in Germany, Netherlands, Sweden and Scotland.

Key findings of this report propose that all 4 countries approached the regulation of homecare differently, yet the fundamental goal of enabling older people to remain living at home was consistent between countries. Kiersey and Coleman found that clear national standards which are supported by legislation are essential elements of effective homecare, which aims to protect vulnerable people (2017). Monitoring for compliance among homecare providers and clear eligibility criteria were present in each comparison country (Kiersey & Coleman, 2017). The specific tasks identified in this report as part of the homecare remit include: domestic tasks and personal care. Notably, Kiersey and Coleman (2017) report that social and emotional support is further included

within the homecare remit in Sweden only. Nursing is considered within the homecare umbrella in Germany, but is assessed and managed separately within Scotland, Netherlands and Sweden. Kiersey and Coleman's (2017) findings suggest that monitoring and inspection are central to promoting best practice and minimum standards of care provision. Kiersey and Coleman (2017, p. 19) describe the Irish Government's vision for homecare development as "weak" and argue that overall, there is a lack of evidence from which to plan for homecare. However the choice of the older person relating to their homecare should be a key guiding principle, when the Irish Government begin to regulate this sector (Kiersey & Coleman, 2017).

Kiersey and Coleman (2017) further highlight the dearth in evidence available internationally, pertaining to homecare provision, financing and evaluation. Such research further substantiates the need for the development of an evidence base for homecare in Ireland, for the purpose of continually striving for the best possible outcome for older homecare recipients. Kiersey and Coleman (2017) argue that older people need be empowered to exercise choice regarding their homecare. This may relate to the services provided, which provider will be responsible for their care and the days and times of the homecare visit (Kiersey & Coleman, 2017).

Kiersey and Coleman (2017) identify a notable limitation within their approach to this study being limited to a scoping review, citing a lack of availability of the specific information necessary, to provide a truly comprehensive answer to their research question. In fact they acknowledge that their research questions have not been fully addressed as a result of the dearth in research pertaining to regulation and financing of homecare services (Kiersey & Coleman, 2017). A notable strength of the methodological approach undertaken is the rigorous process of sourcing and reviewing evidence. Kiersey and Coleman (2017) demonstrate within this report with an exhaustive list of key search terms included. They further explain when and why decisions were made by the researchers to narrow the scope of the potential literature included (Kiersey & Coleman, 2017). Also a strength of this report is the candidness of the researchers in acknowledging that the research question was not entirely addressed, due to the lack of available research with the specific focus of homecare regulation within the countries of comparison (Kiersey & Coleman, 2017). Overall the report provides a coherent and systematic examination of the regulation and financing of homecare in 4 European countries and contributes to a greater understanding of necessary steps for Ireland to legislate and regulate the homecare sector. Ultimately, Kiersey and Coleman (2017) conclude their scoping review by acknowledging the fundamental principles of: consultation, standards, choice, equity and sustainability, which they surmise are essential to the regulation of the homecare sector.

McDonald, Lolich, Timonen and Warters (2019), conducted a study in Dublin examining the concept of time and its relevance to homecare support for older people. The aim of the study by McDonald et al. (2019) was to investigate the perceptions of various stakeholders involved in the process of applying for and delivering homecare, pertaining to time. Social workers, service users, homecare providers, family members and homecare managers partook in this study which adopted a qualitative research methodology (McDonald et al. 2019).

Initially researchers examined data from Horizon 2020-funded project titled SoCaTel, which aimed to address care gaps within the care of older people. SoCaTel is a platform based app which enables relevant stakeholder to identify and propose solutions to the needs of older people concerning long term care (McDonald, 2019). After examination of the SoCaTel data, the primary method of data collection was through facilitating 21 focus groups with a total of 104 participants. Three in-depth 1-1 interviews were further conducted. Focus groups consisted of 3 to 7 participants, with the duration of which were between 60 and 90 minutes each (McDonald et al. 2019). Participant ages ranged from 25 to 100, with care recipients making up the largest proportion of participants (n46). McDonald et al. (2019) contend that time is particularly significant in later life, as it may take additional time to build up a trusting relationship between the care recipient and provider. Older people living with degenerative illnesses such as dementia, often require considerably more time to identify, establish and develop appropriate care provision (McDonald et al. 2019).

Findings from this study by McDonald et al. (2019) propose that time spent searching for information about care specific to the unique needs of the older person could be substantial. Participants reported feeling overwhelmed by the sheer volume of information and some described a trial and error based approach to sourcing appropriate care. Findings further suggest that time spent waiting for homecare services can cause frustration and result in unmet needs for the older person (McDonald et al. 2019). Professionals trying to put such care in place for example: social workers preparing a patient for discharge from the hospital, or public health nurses in the community supporting the older person when they return home, are further impacted by time spent waiting (McDonald et al. 2019).

Most notably, McDonald et al. (2019) found that time associated with consistency in care was further problematic, based on issues such as zero hour contracts for homecare staff and the inflexibility of time spent with the older person (perhaps if they needed additional time). Participants

strongly felt that companionship time should be considered within the homecare remit (McDonald et al. 2019). Most stakeholders within focus groups agreed that time impedes the relationship building element necessary within homecare. Time to get to know the older person and aim to truly promote their health and wellbeing, is not factored into the current rigidity of time bound homecare visit slots (McDonald et al. 2019). Ultimately, Mc Donald et al. (2019) surmise that the issue of time is a systemic problem within formal homecare provision.

A significant strength of this study conducted by McDonald et al. (2019) is the breadth of stakeholder involved. Having staff who are present at different points in the homecare journey (from hospital to home) provides for varied unique insights concerning the impact of time on the older person, in a very tangible way. A perceived limitation of McDonald et al. (2019) study is the lack of identification of any limitations of their methodology, within the published article. The geographical location of participants is quite limited (Dublin only), and consequently may not be presenting a picture of homecare which is evident in other parts of Ireland. Nevertheless the issue of time pertaining to homecare is a very pertinent one and this research is quite novel in examining this issue, specifically in the Irish context (McDonald et al. 2019).

2.15 Homecare in England

In contrast to Ireland, homecare provision in England has been underpinned by robust legislation and is subject to the same minimum standards and criteria as residential settings, since the year 2000. The Care Quality Commission (CQC,2015-a) are responsible for the regulation of homecare services for older people. The CQC (2015-a) “are an independent regulator of health and social services”. Similar to HIQA in the Irish context, the CQC inspect and monitor homecare services and publish reports based on their findings (CQC, 2015-a). Minimum standards of training and education are specified within the legislation and all homecare providers are statutorily obligated to register with the CQC, in order to be permitted to provide homecare services (SCIE, ND; CQC, 2015-c). Detailed background checks and police vetting procedures for homecare staff, are further stipulated within the legislation, in an effort to increase the safeguarding of vulnerable older people (DOH, 2002).

England has been chosen as a comparison to Ireland in relation to their homecare provision, as they have successfully developed and continue to enhance legislation and regulation pertaining to homecare for older people (Government of England, 2013; CQC, 2015-a). Furthermore, with a similar

growing cohort of older people, being an English speaking country and a close neighbour of Ireland, England appeared an apt comparison (Mortimer & Green, 2015).

2.15 (1) Legislation of homecare in England

Regulation of social care in England is well established and is consistently evolving to meet the safety, welfare and protection needs of potentially vulnerable service users (NHS, 2015; DOH, 2015). Older people's services and more specifically homecare, is presented and regulated within the professional umbrella of health and social care services in England. As such, the same protections, minimum standards and robust legislation afforded to other care recipients in England, are further afforded to older people (CDC, 2005; DOH, 2002; Government of England, 2013).

An overview of the development of legislation and standards in England with specific relevance to homecare is provided in Table 2.1 below:

Title and Year of Introduction	Key stipulations of Act/Policy/Standards
The Care Standards Act (2000)	• Make provisions for the Care Standards Commission to be established as a regulatory body for all social care services in England and Wales • Stipulates that social care providers must register in order to be deemed fit to provide social care services (Government of England, 2000).
Common Induction Standards (2005)	• Stipulates that social care workers must be deemed competent within the first twelve weeks of commencing employment • Managers must verify that social care workers have met the learning outcomes associated with: role, personal development, communication, equality and inclusion, duty of care and safeguarding (CDC, 2005).
The Domiciliary Care Agencies Regulations (2002)	• Requires homecare workers to register prior to commencing work • Manager must attest to the homecare workers competence, skill & suitability for their role (DOH, 2002)
The National Health Service Reform and Care Professions Act (2002)	• Places statutory responsibility on Council for Regulation of Healthcare Professionals to investigate and report on the performance of regulatory bodies within the best interests of the public (Government of England, 2022)

The Health and Social Care Act 2008 (and updated regulation in 2014)	• Outlines the statutory responsibilities of regulated providers relating to: consent, dignity, responding to complaints, of staff performance, and records keeping • Requires that any individual providing a health care service for the NHS, must hold a license to do so (Government of England, 2013)
That National Minimum Training Standards (2013)	• Stipulates the responsibilities of local councils in: promoting well-being, assessing and meeting the care and support needs of adults in the community • Introduces a single eligibility criteria test for care and support, and states that an assessment must be undertaken by the local council (Government of England, 2014).
The Care Certificate (2015)	• Guarantees minimum levels of training and competence and replaces the Common Induction Standards and the National Minimum Training Standards. • Stipulates minimum induction training standards for social care workers and the responsibilities of managers registered with the CQC in assessing competence of new employees (NHS, 2015)

Table 2.1: Legislation and policy development concerning homecare in England

2.15 (2) Research on homecare in England

The evolution of homecare in England is well researched, with the views of older people utilised consistently to improve service provision (Sykes & Groom, 2001; Patmore, 2004; Rabiee & Glendinning, 2014). England operates within a quasi-market system, similar to Ireland and the number of homecare providers operating in England in January 2021 was 8, 678 (Home Care UK, 2021). The number of people aged over 65 in England increased by 18% between 2005 and 2014, or by 1.5 million people (Mortimer & Green, 2015). The population of older people is set to increase by a further 49%, by the year 2035 (Mortimer & Green, 2015). The Institute of Public Care in England (IPC, 2012, p. 3) define homecare in England as encompassing domestic tasks, personal care, social activities, "recovery and rehabilitation and support for people who are dying". State funded homecare is delivered to roughly 400,000 older people per year in England, with this figure likely to rise, as the population of older people increases (ICP, 2012).

Their concept of “experts by experience” see the CQC recruiting social care recipients, to carry out inspections and ensure minimum standards are being met (CQC, 2015-a). CQC (2015-b) state that all homecare providers in England must meet a set of minimum standards in order to register with them and be permitted to deliver homecare services. They further argue that homecare recipients or someone advocating on their behalf, will be included in discussions about the care provided and pertaining to on-going decision making relating to care (CQC, 2015-b).

Sykes and Groom (2001) conducted research into the experiences of older people in receipt of homecare in England, from a human rights perspective. Forty participants were interviewed, and this research undertook a cross sectional methodology. Findings suggested that time was a significant factor relating to the level of satisfaction older people perceived in relation to their care. Time of arrival and duration of the home visit, tended to dictate the experience as a negative or positive one. Sykes and Groom (2001) found that most of the participants were unaware of the protocol which led to the number of hours provided, or how to make a complaint. The majority of older people who participated in the research undertaken by Sykes and Groom, (2001) felt they had little involvement in their care, were unaware of what information their care-plan contained and experienced little choice or control. A small number of older people reported incidents of homecare workers not attending at the agreed day and time, resulting in the older person not having their social care needs met (Sykes & Groom, 2001).

Patmore (2004) conducted research into the quality of homecare provision in England, through qualitative interviews with 23 homecare providers. This research concluded that different providers, had varying policies governing the tasks the homecare worker could undertake. For example: some providers reported assisting older people with outings and undertaking gardening duties. Yet other providers, provided only essential tasks (Patmore, 2004). Patmore further found that the timing of visits varied considerably between providers, some noting that lack of availability of staff, which meant that some older people had their homecare worker visit to put them to bed as early as 6pm (2004). The issue of familiarity with homecare staff was addressed to some extent within this research. Some providers assigned a keyworker to the older person in receipt of care and aimed to provide this worker to attend to the older person, as a matter of preference. Yet other providers actively discouraged the development of relationships between older people and individual homecare workers, as this causes upset if the homecare worker leaves (Patmore, 2004).

In 2013, the CQC conducted research into the provision of homecare services in England and inspected 250 homecare providers. The CQC visited 738 people in receipt of homecare and reviewed the responses of over 1,000 questionnaires. The findings of this mixed methods research surmised that 74% of 250 providers inspected, were meeting national standards. These providers were found to be performing well relating to: service user safety, information sharing, encouraging independence, reporting concerns and involving care recipients in their care (CQC, 2013). Less positive findings concluded that many recipients revealed they lack choice in relation to their care worker, frequently having care workers arriving at their home whom they had never met and had not been informed would be coming. One care recipient had 13 different homecare workers, covering 35 visits to their home (CQC, 2013). Unison (2012) reiterates the issue of consistency from the perspective of homecare workers and contends that 37% of the 431 homecare workers they surveyed, reported that they are routinely allocated to different clients, which reduced the opportunity for continuity of care. The CQC (2013) found that some homecare workers were not aware of safeguarding or whistleblowing policies within their organisation, while an unambiguous method of evaluating the quality of service provision, was not evident in some care providers. Formal appraisal systems were not always put in place and care recipients often were not informed of how their feedback was translated into practice improvements, with no evidence of action on this (CQC, 2013). Late visits or non-attendance were further noted issues (CQC, 2013). Recommendations from the CQC (2013) based on their findings from this research, included care providers becoming "more proactive" in seeking feedback from care recipients and their families, all care staff to be introduced to an individual prior to providing care and continued work to reduce late calls or non-attendance. Further recommendations included additional training for staff around safeguarding policies and procedures (CQC, 2013).

Rabiee and Glendinning (2014) conducted research into the choice and control older people feel they possess, via the use of direct payment schemes funded by local councils. The aim of personalisation and personal budgets in homecare (the name given to direct payments in this context) is to promote the choice, control and needs of the older person being met in an individualised capacity (Rabiee & Glendinning, 2014). Rabiee and Glendinning (2014) interviewed 18 older people with the aim of ascertaining their perceived choice relating to: the provider of care, the care worker they receive, the time of the visit and the types of tasks undertaken. They concluded that older people who reported being unhappy with the care worker they received, were able to change care workers on request. Yet some participants argued that they had been cared for by staff they were unhappy with, but felt "reluctant to complain" and didn't want to "make a fuss" (Rabiee &

Glendinning, 2014, p. 8). In relation to choice and control around the needs of older people and tasks undertaken, many older people within this study reported that the homecare organiser came to them and outlined what tasks would be undertaken, as opposed to discussing this with the older person's input. Most older people, expressed reservation about asking their homecare worker to undertake any task which was not outlined within their care-plan, out of fear they may get the worker in to trouble and due to time constraints (Rabiee & Glendinning, 2014).

2.16 Comparative Discussion

The consistent development of legislation and policy concerning homecare in England, contrasts substantially with the tiered system of regulation in Ireland, which is specific to service user groups (people living with disabilities, children, older people etc.) (Government of Ireland, 1991; 2015; Government of England, 2000; 2022). Furthermore the research undertaken in England presents a comprehensive picture of homecare provision which represents the voices of both older people and homecare workers (CQC, 2013, Rabiee & Glendinning, 2014; Sykes & Grooms, 2001). In Ireland, however, the dearth in research pertaining to older people and the effectiveness of care in the home is irrefutable (Timonen, 2012; Mc Gill, 2009; Delaney, Cullen & Dolphin, 2008; Kiersey & Coleman, 2017). Lack of transparency relating to service provision, further accentuates the need for homecare specific research according to Boyle (2011). Based upon the limited research undertaken in Ireland, a picture of inconsistency in care provision to older people is painted (Timonen & Doyle, 2008; Gantly, 2012).

Some key issues highlighted within the research in England, mirrors findings from Irish studies pertaining to homecare. Inconsistency with homecare workers providing care, has been noted in both countries. The time and duration of homecare visits appears to vary from one homecare provider to the next, both in Ireland and England (CQC, 2013; O'Sullivan, 2012). Further notable feedback from older people in receipt of homecare in both countries, emphasised a lack of choice or control relating to their care (CQC, 2013; NESF, 2009).

Such research accentuates the rationale for the current study, and in particular for the qualitative methodology which will ascertain the experiences of both parties in the homecare relationship. Equally, understanding of how a comparable country delivers homecare, can further contextualise the current study and experiences of both older people and homecare workers.

2.16 (1) Summary

This part of the literature review provided an overview of research in Ireland which has contributed to understanding pertaining to homecare, based on the experiences and perspectives of relevant stakeholders. Yet homecare is still considered an under-researched phenomenon in Ireland (MCRI, 2013; Timoney, 2018). The hard to reach status of older people is further notable to acknowledge as this impacts directly the evidence base concerning homecare in Ireland to date (Lijas et al. 2017; Flanagan & Hancock, 2010).

This section provided a critique of core research studies undertaken in Ireland which have contributed substantially to understanding of homecare in Ireland. In particular, Lundstrom and Mc Keown's 1994 study is viewed as a cornerstone document which illuminates the phenomenon of homecare and has contributed substantially to collective insight on this topic. More recently, the comprehensive scoping review by Kiersey and Coleman in 2017, provides a detailed mapping of the regulation and legislation of homecare, in 4 comparable countries. Hence their study presents clear and tangible methods which could be undertaken in Ireland, to regulate the homecare sector (Kiersey & Coleman, 2017).

Nonetheless, the majority of research studies conducted on the phenomenon of homecare in Ireland contend that older people need consistency in care provision and a statutory right to avail of homecare (Lundstrom & Mc Keown, 1994; NESF, 2009; Haslett et al. 1998; Donnelly et al. 2016). Furthermore the instrumental role of informal carers within the myriad of homecare provision in Ireland has been identified within research undertaken in Ireland (Donnelly et al. 2016; Timonen & Doyle, 1998). However variation in service provision, allocation and specific task within homecare delivery between geographical locations in Ireland, has further maintained ambiguity and uncertainty for both older people and homecare workers (Kiersey & Coleman, 2017; Haslett et al. 1998).

Policy in England concerning the care of older people appears in unambiguous contrast to that of Ireland. Homecare for older people is regulated and legislated within the health and social care sector remit and is afforded the same resources and criteria as services for children and people with disabilities (CQC, 2015-c; DOH, 2002). Homecare staff have minimum training requirements and homecare services are subject to inspections from the CQC for compliance with regulations (CQC, 2015-a). Such evident efforts within policy and legislation in England communicates a message of priority of care and equality towards older people as a care recipient group within society.

2.17 Part 6: Evaluation Tools Health and Social Care

Evaluation frameworks are sometimes used to inform research within the health and social care sectors and can clarify the impact of external factors on service provision (UN, 2016). It is important to note that the current study will not evaluate the homecare service and is aiming to capture the unique experiences of older people and homecare workers relating to homecare. However such frameworks will be considered within this part of the literature review, in order to establish if any one may be appropriate, from which to draw upon when devising data collection tools.

Humphreys and Waterman (2015) suggest that modifying existing healthcare evaluating frameworks and tools, can enable researchers to tailor data collection tools to the needs and attributes of the health issues of a particular cohort. Through attaining such specific data relating to the experiences of a specific community or group, future service provision in health and social care can be modified based on the distinctive findings of the evaluation (Humphreys & Waterman, 2015). Although the current study is exploring the experiences and perspectives of older people and homecare workers regarding homecare, as opposed to evaluating the service, consideration of some elements of healthcare evaluation frameworks, may enhance this research. The range of issues examined, depth of exploration and methods of measurement used within evaluation frameworks, may offer additional insight pertaining to the current study and how it will be approached.

Multiple frameworks, models and toolkits have been developed specifically for the purpose of evaluating social care service provision, three of which are discussed in more detail:

2.17 (1) The Adult Social Care Outcome Toolkit (ASCOT) was developed within the University of Kent in 2010. Netten et al. (2011) suggest that the ASCOT is designed to measure Social Care Related Quality of Life (SCQol) and to be flexible enough to be used across multiple social care settings. Evaluating the level of function and subsequent need, is further essential to the ASCOT. Outcome measurements consist of methods which aim to assess the SCQoL pre and post intervention, and methods which aim to assess estimated change to SCQoL, should social care not be provided. Furthermore, assessment may be based on social care need and ability to perform tasks of everyday living (post intervention/care provision) and finally, via measuring the potential capacity for benefit of the intervention (Netten et al. 2011). The domains within which social care service is assessed via the ASCOT are illustrated within Figure 2. (c) below:

Fig. 2. (c): The Adult Social Care Outcome Toolkit (Netten et al. 2011)

2.17 (2) The Primary Care Assessment Tool (PCAT) is a tool used to assess various aspects of primary care delivery, from both the systems of delivery and care received (Starfield, 2011). Starfield (2011) suggests that this is achieved through assessing the following domains and correlating subdomains presented in figure 2. (d):

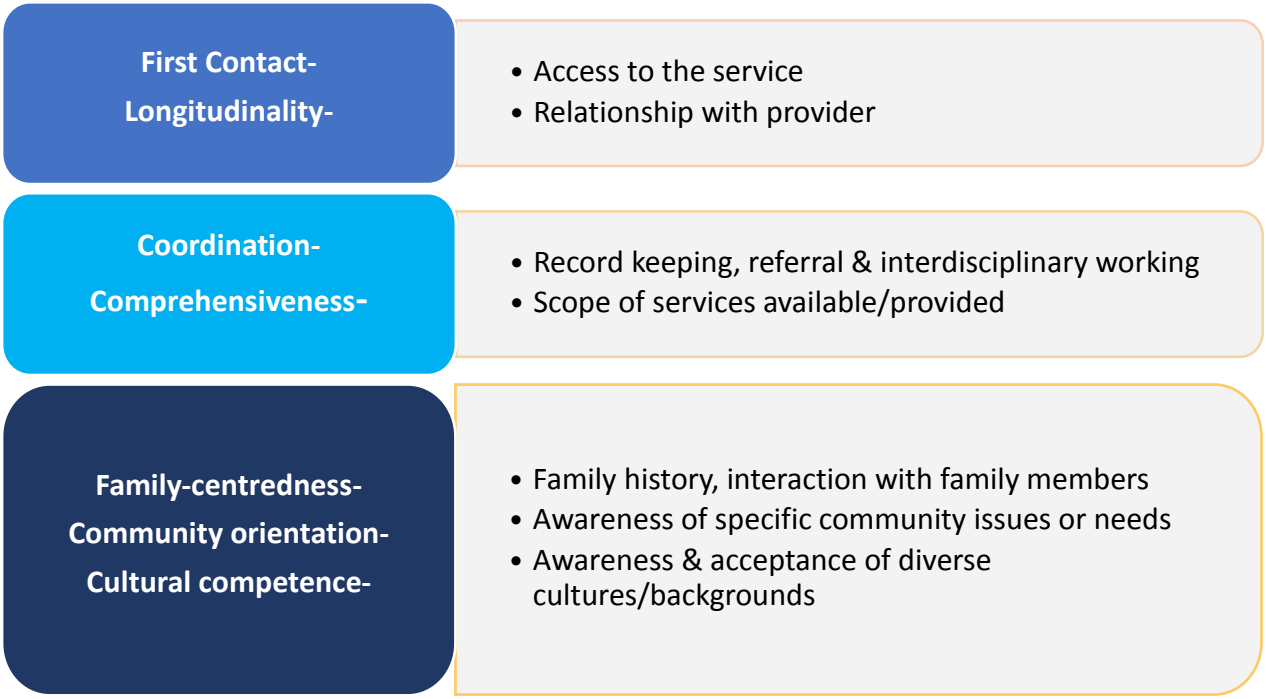


Fig. 2. (d): The Primary Care Assessment Tool (Starfield, 2011)

2.17 (3) The Donabedian Quality of Care Framework (DQCF) is a measurement tool used in health and social care and evaluates service provision based upon three specific domains:

- Structure
- Process, and
- Outcome (Mc Question, 2006).

Figure 2. (e) demonstrates the scope of each domain of the DQHF:

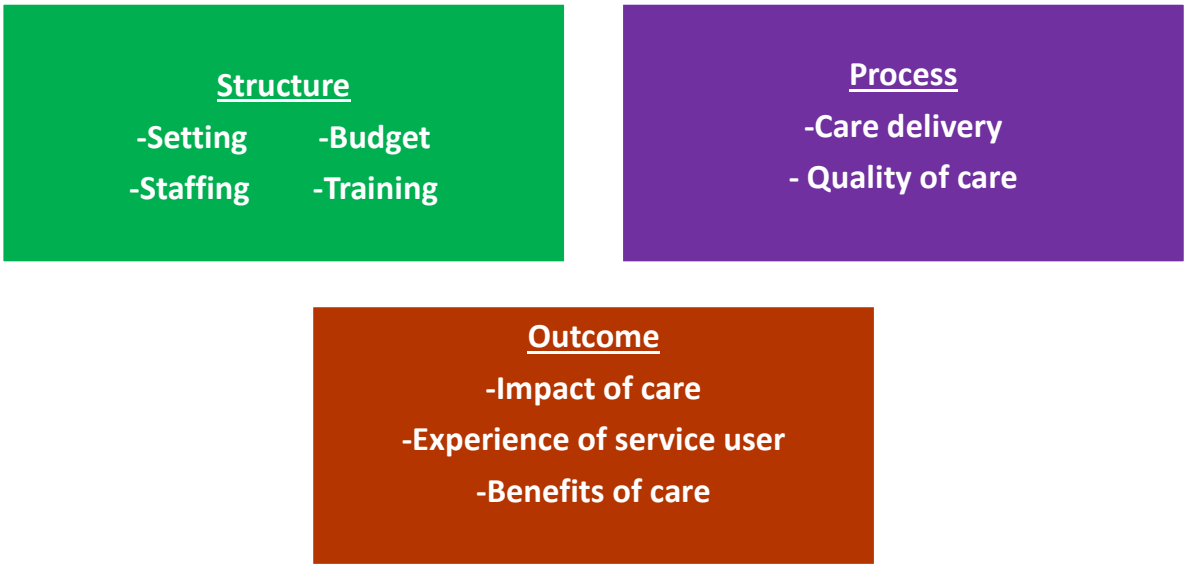


Fig. 2. (e): the Donabedian Quality of Healthcare Framework (Starfield, 2011)

The DQHF according to El Haj, Lamrini and Rais (2013, p. 17), is "universally accepted" and is useful for the development of quality standards. Created by Avedis Donabedian, the DCQF assesses the appropriateness of the care provided, in addition to the level of skill and expertise used to deliver such care. Outcomes may be identified as improved functioning, ability, health or quality of life, in addition to perceived satisfaction and the lack of negative consequences (e.g. inability to complete self-care tasks, poor psychological/physical health) (El Haj et al. 2013). Liu, Singer, Sun and Camargo (2011) argue that outcomes are the sum of the structure and process and may be impacted by issues such as time, person centeredness and effectiveness. Should the structure or process negatively impact the time, or comfort of the individual, this will consequently negatively impact the outcome for the older person (Liu et al. 2011).

Each of the assessment and evaluation methods discussed could be useful to apply to this study. Having an understanding of the factors which are examined in evaluating effectiveness, may further assist in creating data collection tools for the current research.

The criteria outlined within the ASCOT framework are quite general and therefore may not be useful to inform the current study. Equally the PCAT requires quite in-depth information on the impact of homecare and the availability and scope of the service overall. Yet this tool requires the examination of records relating to older people and proposes the investigation of community and cultural issues. Such a format is too broad given the aim of this research project: to ascertain the factors which affect homecare provision from both the perspectives and experiences of older people and homecare providers.

This study is seeking a much more intimate and specific data set derived from the experiences of older people and homecare workers. The key objectives of this study are to explore the experiences and perspectives of both parties within the homecare relationship. A more subjective outlook is central to this and consequently the DQHF appears the most appropriate evaluation framework which could potentially serve as a guide, when creating data collection tools for this study. The DQHF may serve as a compass to direct this study in presenting a holistic, yet comprehensive picture of homecare, from the perspectives of both parties involved in the homecare relationship.

Nevertheless, use of any framework is quite prescriptive and therefore potentially limiting, given the novel yet intimate picture of homecare experiences this research aims to ascertain. Consequently, this study will not adopt in totality any of the frameworks explored, as none appear to align sufficiently to the research aim and objectives. However, the domains of DQHF may be useful within the current study when developing data collection tools pertaining to the experiences of service users as homecare recipients, and structural issues which impact homecare worker's experiences within their roles.

2. 18 Summary

Part 6 of this literature reviewed explored the use of health and social care evaluation frameworks. Although the current study will not be concerned with evaluation of the homecare service in Ireland, the use of an evaluation framework may enhance the planning regarding areas of study. The DQHF appears the most appropriate framework from which to use to inform the current study. Examining

the domains of structure, process and outcome pertaining to homecare for older people in Ireland, will provide results which are comprehensive and multifaceted (El Haj et al. 2013).

2.20 Literature Review Conclusion

This chapter has examined the broad array of literature which explains homecare and the factors which impact this, for both older people and homecare workers. Exploration of fundamental concepts relating to ageing theories which will underpin the current study and the development of legislation and policy surrounding care of older people, will directly inform the methodology for this research. The moulding of the homecare worker's role from a societal perspective, combined with previous research on their experiences, further illuminate the precarious nature of their positions within the homecare sector. Such evidence will frame the current study and support the methodological approach.

The literature surrounding ageing in place concludes that the vast majority of older people wish to remain living in their own homes and communities, for as long as possible. Ageing in place has emerged within the gerontological discourse and elucidates the reasoning and emotions which people associate with staying at home, as opposed to entering long-term stay facilities. Ageing in place highlights the symbolic, interactional and experiential dimensions provided by a place considered home and what such spaces mean to older people. Such understandings inform the theoretical approach of this research as they align with the objectives of delivering homecare, to support and enable people to age in place.

Loneliness and isolation within the literature review were found to be particularly detrimental to the health and well-being of people as they age, and consequently may impact homecare service need and utilisation. The literature asserts that older people are disproportionately affected by social isolation, particularly those who live alone. Loss of family and friends through death causes isolation for some older people, while others may never have married and may be childless. Regardless of the rationale, loneliness and social isolation are a major cause of concern to the health and well-being of older people. Loneliness is often stigmatised by older people themselves or viewed as a private matter, which culminates in its maintenance over time. The concepts of isolation and loneliness are of particular importance in relation to this study, as both profoundly affect older people and consequently may impact their homecare experiences.

Health promotion as people age aims to increase their wellbeing for as long as possible, which is particularly relevant as people are now living longer. The idea of choice and control are fundamental to health promotion and should be evident in the experiences of older people pertaining to their homecare. Choice and control further enable older people to feel empowered and feature centrally within the international policy context on ageing. Yet the literature highlights that the educational and socioeconomic background of the older person, can significantly impact their level of empowerment. Choice theory within this vein implies that older people will make choices, in an effort to meet their most basic needs. Hence choices regarding homecare made by older people may be driven by this innate desire to have their needs of belonging and freedom realised, as they remain living at home.

The literature review explored ageism and found that ageism permeates multiple levels of society, from personal opportunities for individuals, to policy development. Ageism can be based on prejudices, stereotypes or a fear of ageing or dying, and is further proliferated within negative media images of older people. Ageism is of direct significance to the current study as the lack of development regarding legislation and policy to govern homecare to date, is possibly stemming from this.

Theoretical gerontological perspectives were examined within the literature review and will inform the current study from methodology, to data collection and analysis. Life course theory presents a lens from which to explore the older person's current needs or presentation, based on notable life events from their past. Encompassing theory enables a deeper comprehension of the depth and understanding concerning ageing and older people. Disengagement and activity theories further provided insight relating, to both the older person's and the societal interpretations of withdrawal or continuation from usual activities, as one ages. Such theoretical groundings provide a foundation for the current study and will underpin the methodological process.

Homecare workers and their initial and continued motivation to work in the homecare sector, were examined within this chapter. This care was historically provided within a voluntary capacity, by well-meaning neighbours within the community and with the intention of being charitable in befriending the sick and elderly. Vocation was a central theme within the literature and proposes that some homecare workers provide care instinctively and view their role as fundamental to their identity. Such an inherent motivation to care combined with gendered expectations of women as caregivers, culminates into a genuine yet sometimes guilt-ridden role of care provision, in the homes

of older people. However, neoliberalism has substantially transformed the homecare sector in Ireland, with privatisation of homecare delivery now commonplace. Such an evolution places a greater emphasis on cost reduction, which presents logistical and emotional challenges for homecare workers. Increasingly challenging working conditions, combined with a lack of job security, results in some homecare workers providing additional care without pay, in an effort to meet the needs of older people. Many homecare workers come from poor socioeconomic backgrounds and ethnic minority groups. Such an already marginalised workforce, alongside the poor working conditions of homecare workers, further maintains vulnerability and disadvantage for this hard to reach group. These notable findings within the literature review will be instrumental in guiding the current study and informing the analysis of data gathered, pertaining to homecare workers.

The literature review examined in detail the policy governing the care of people as they age both, within an international context and in Ireland. Choice and autonomy for older people appears enmeshed within the international policy regarding ageing. Yet Irish policy is more focused upon the expansion and standardisation of the current homecare service and enabling older people to remain living at home. The initial establishment of the home-help service and the development of this to date based on the recommendations of evolving health policy, illustrates the rationale for the current delivery of care in Ireland. Yet notably homecare in Ireland is operating in the absence of legislation. Although developments towards regulation are ongoing, to date they have not been realised. This lack of regulation results in the vulnerability of both homecare workers and older people and uncertainty concerning minimum standards of care. Furthermore, older people do not have a statutory right to receive homecare as this remains a discretionary service. In contrast, homecare policy and legislation in England is robust, yet operates in an increasingly privatised market, similar to Ireland. The literature review regarding policy and legislation, will place in context the current delivery of homecare in Ireland and how this has developed to date and will further inform the data analysis and discussion.

Finally, the literature review explored research tools used in the evaluation of health and social care services. Although the current study will not evaluate the homecare service, consideration of methods used to explore other comparable services was undertaken, in an effort to gauge if any elements could be applicable to ascertaining the experiences of older people and homecare workers. The DQHF offered some useful components which may enhance this study, in particular pertaining to user satisfaction and outcomes of service delivery.

This chapter identified gaps within the research concerning the voices of older people and homecare workers, regarding their perspectives on homecare provision in Ireland. Other scholars have identified the dearth in research concerning homecare to date (Kiersey & Coleman; Lundstrom & McKeown, 1994; Timonen 2012). Equally findings within the research undertaken on this topic have surmised that inconsistency within the current provision of homecare culminates in distress and ambiguity for both older people and homecare workers (Donnelly et al. 2016; Timonen & Doyle, 2008). Research to date further highlights the value placed on the homecare service by older people and the meaningful relationships they form with their homecare worker (Hasslett et al. 1998; Lundstrom & Mc Keown, 1994; Dempsey at al. 2016). Kiersey and Coleman (2017) surmise that consultation with relevant stakeholders pertaining to homecare should be of paramount importance. None of the previous research in Ireland to date has focused solely on ascertaining the factors which homecare workers and older people view as impacting their experiences of homecare provision. Hence the current study will aim to address the gap within the literature concerning the key factors both older people and homecare workers identify as impacting homecare, based on their unique perspectives and experiences.

In summary, the literature review explored the key concepts, theories, policy and research regarding homecare and older people. Findings illustrate the significance of further research to promote the protection and care of older people within their homes and to explore in more detail the experiences of homecare workers. The literature review has illustrated the hard to reach status and vulnerability of both groups, further accentuating the rationale for research which explores their experiences and perspectives pertaining to homecare.

Chapter 3: Methodology

3.1 - Introduction

The aim of this chapter is to both present and justify the methodological process undertaken within this research study (Oliver, 2014). Silverman and Patterson (2015) argue that the methodology within social research, can act as a tool for empowerment. Such empowerment occurs when the people living through and affected by the phenomenon being studied, are involved in and have access to the research process as participants (Silverman & Patterson, 2015).

This chapter will illustrate the consideration of various approaches, philosophical assumptions and research designs, in order to identify and explain the methods deemed most appropriate for this study (Neuman, 2014). Neuman (2014) contends that research which blends, yet acknowledges both objective and subjective understandings, can result in a comprehensive insight into phenomena being studied.

This chapter will describe the methods employed by this study, which enabled the study aims and objectives to be achieved. This chapter will initially present the philosophical positioning and methodological processes which informed the current study, within the 4 step framework proposed by Caelli et al. (2003). This framework aims to strengthen the rationale for a generic qualitative approach as an appropriate methodology, by illustrating clarity regarding the theoretical positioning of the research and enhancing credibility and rigour. Braun and Clarke (2022, p. 6) describe qualitative research as contributing to knowledge which is a “rich tapestry of understanding”, as opposed to aiming to establish a singular truth, or a complete understanding of the phenomenon being studied.

The rationale for the research design and methods which this study employed will be examined, within the context of the research aim and objectives. The sampling and recruitment processes undertaken pertaining to this study will be described, in addition to amendments and adjustments made to facilitate the initial low uptake of participants.

The data collection methods will be presented within this chapter, and a detailed discussion of the data analysis techniques employed within this study, will be described. Such discussions will focus on the comprehensive and cyclical procedures of data analysis undertaken, based upon Braun and Clarke’s 6 step process for thematic analysis. How each step was employed within the current

research will be considered, in an effort to illuminate how the key findings of this study were identified. Ethical considerations relevant to this study will further be examined and the key limitations within the methodology will be considered.

3.2 - Overall Methodological Approach

Caelli et al. (2003) identify 4 fundamental requirements from which to position a study undertaking a generic qualitative approach, in order to enhance rigour and credibility:

1. the theoretical positioning of the researcher;
2. the congruence between methodology and methods;
3. the strategies to establish rigor; and
4. the analytic lens through which the data are examined.

The current study will now be presented within Caelli's et al. (2003) framework:

3.2 (1) - The Theoretical Positioning of the Researcher

The philosophical underpinnings of this study will place in context the rationale for the subsequent research design, methods and analysis. A constructivist/interpretivist position informs this study, as the interpretation of the researcher is acknowledged as being critical to developing understanding of human behaviour (Denzin & Lincoln, 1998). A constructivist/interpretive paradigm, acknowledges the background and experiences of the researcher and how this may further impact their interpretation of the data and meanings they may assign to phenomena themselves (Creswell, 2003). As the primary researcher approaches this study from a background in the homecare sector, acknowledging this is important. Remaining self-aware, reflective and above all critical in data collection and analysis, are vital components of integrity within the research process. "Reflexivity can be defined as thoughtful, conscious self-awareness. Reflexive analysis in research encompasses continual evaluation of subjective responses, intersubjective dynamics, and the research process itself" (Finlay, 2002, p. 532). Finlay suggests that being reflexive prompts the researcher to scrutinize what they know and how they have come to know this (2002). Berger (2015) argues that reflexivity with qualitative research can be affected if the researcher has been part of the phenomenon being studied. Hence given that the primary researcher has practiced extensively within the homecare sector, it is essential that one continually engages in "careful self-monitoring the impact of biases, beliefs, and personal experiences on the research" (Bergin, 2015, p. 220). Dean (2018, p. 1) argues

that interpretivism explores a phenomenon as it is "co-constructed" both socially and through experiences.

Constructivists contend that the world is constructed by the interactions of humans with various phenomena and the meaning humans attribute to them. Constructivism attempts to explain the issues being studied, through the lens of participant's experiences (Mackensie & Knipe, 2006). Punch (2005) articulates that from a constructivist paradigm the researcher will build understanding and meaning about the topic being studied, based on their experiences with participants and their interaction with them. This may be viewed almost as a negotiation where the researcher observes, questions, reads and queries, based on their current research and past experiences (Punch, 2005). Rather than studying specifically the phenomenon of homecare, this research paradigm places exploration of the participant's experiences of homecare, as the key objective (Creswell, 2003). Based upon this constructivist/interpretivist paradigm, this study aims to:
Examine the current delivery of homecare to older people in Ireland from both older people's perspectives, and the experiences of homecare providers.

The key objectives of this research are to:

- Ascertain the views of older people relating to both positive and negative experiences of homecare provision, based on their individual perspectives
- Explore homecare worker's experiences of delivering homecare to older people and examine the factors which impact this care.

3.2 (2) - The Congruence between Methodology and Methods

Multiple research designs must be considered and evaluated based upon the study objectives, in order to reach an informed decision about the most appropriate design (Bechhofer & Patterson, 2000). The research design should enable the aims and objectives of the social research to be achieved. As the aim of this study is to examine the phenomenon of homecare based upon the experiences and perspectives of both older people and homecare workers, this study adopted a qualitative design (Bechhofer & Patterson, 2000). Bell, Waters and Waters (2014, p. 9) propose that qualitative research is concerned with ascertaining the "individual's perceptions of the world". Qualitative approaches oftentimes provide for less structured methods of gathering and analysing data, yet are flexible enough for researchers to incorporate various theoretical assumptions or measurement tools (Bell et al. 2014).

Flick (2006) argues that quantitative research provides for statistics relating to the frequency or prevalence, of a health condition or use of a service. Yet quantitative designs often omit findings which could impact the lives of individuals, such as relating to coping capacity in living with a disease, or factors which could alleviate the negative effects on quality of life for example (Flick, 2006). Gogtay (2010) suggests that quantitative designs are employed when the research needed will be numerically significant. Datallo (2008) argues that the large sample sizes within quantitative research designs, culminate into results which are statistically significant.

However statistical significance within findings was not relevant for the current study, based on the research aim and objectives. Qualitative methods enabled the researcher to better grasp the individual experiences and perspectives of older people and homecare workers, and consequently inform future service provision (Stuckley, 2013). Litchman (2014, p. 17) proposes that qualitative research enables a study to "focus on the nature of social reality" and address issues not easily addressed, through quantitative methods. People are most suitable for examining and interpreting phenomena which relate to the lives of participants (Merriam, 2009). Analysis within the social research arena should include researchers who are "sensitive to underlying meanings" (Merriam, 2009, p.2).

It is now widely accepted that stakeholder and patient involvement in the planning of health and social care services is paramount (Vahdat et al. 2014; Advocacy Unit HSE, 2010; Dept. of Health, 2020). Personal and Public Involvement (PPI), in Ireland, relates to consultation with service users, family members and other relevant stakeholders (Dept. of Social Services and Public Safety, DSSPS, 2007). A qualitative approach incorporates PPI and aims to promote inclusion and accessibility, while aiming to positively impact the provision of homecare for older people. PPI should be an integral aspect of all health and social care provision, with the key aim of improving the care recipient's experience of care, improving care quality and promoting health (DSSPS, 2007).

A generic qualitative approach was undertaken, as this study failed to fit within the confines dictated by traditional approaches within the qualitative field such as: phenomenology, ethnography and grounded theory. Caelli, Ray and Mill (2003) argue that consideration of such traditional approaches is necessary, however, prior to concluding that a generic qualitative approach is most appropriate.

3.2 (2) (1) - *Phenomenology*

Phenomenology attempts to describe things as experienced by people, as opposed to how they appear to other people or "are in reality" (Gallagher, 2012, p. 8). Finlay (2011) suggests that phenomenology does not aspire to generate theory or attempt to explain behaviour, but is rather concerned with what is occurring for the individual. The aim of this study is to ascertain the experiences of both older people and homecare workers, in an attempt to illuminate the issues surrounding the provision of homecare. Hence a phenomenological approach appears limited in facilitating the generation of understandings from which somewhat generalisable, conclusions and summations can be drawn.

3.2 (2) (2) - *Ethnography*

Ethnography utilises observation, documentary data and interviews combined, to create a detailed picture of the phenomenon being studied (Reeves, Peller, Goldman & Kitto, 2013). Jones and Smith (2017) report that ethnography requires the immersion of the researcher within the lives of participants, in order to observe the context and setting within which the issue being studied occurs. Yet potential ethical challenges may arise with an ethnographic approach, as many tasks undertaken by homecare workers are intimate and involve personal care (Jones and Smith, 2017). Hence ethnography did not appear to be a suitable approach from which to address the issue of homecare for older people.

3.2 (2) (3) – *Grounded Theory*

Grounded theory as an approach to qualitative research aims to derive a theory based solely on the data collected (Khan, 2014). An inductive strategy with the specific objective of developing a theory, a grounded theory approach contends that no preconceived ideas or experiences should exist or impact the development of a new theory (Mills, Boner & Francis, 2006). As this research was not aiming to generate a theory from the data analysis, grounded theory was inappropriate as a potential approach.

3.2 (2) (4) – *Generic Qualitative Approach*

A generic qualitative approach appeared as the most fitting approach from which to address this study, given that the more traditional approaches associated with qualitative research do not appear suitable (as discussed above). A generic qualitative approach adopts an interpretive and descriptive exploration of the phenomenon being studied (Cooper & Endacott, 2007). Cooper and Endacott (2007) argue that a generic qualitative approach should be employed when such an approach is

most suitable within which to achieve the aims and objectives of the study. A generic approach to research actively avoids allegiance to a specific established theory and instead aim to collect and analyse data which is "richly descriptive" and captures the experiences and perspectives of participants (Bellamy, Ostini, Martini & Kairuz, 2016, p. 672). Bradshaw et al. (2017) outline principles of a generic qualitative approach as encompassing the subjectivity of both participants and the researcher within both the data collection and analysis process, while being inductive in nature. Acknowledging the preconceptions of the researcher is a key attribute of a qualitative descriptive approach. Yet such an approach further "attempts to interpret the findings without moving too far from that literal description" (Bradshaw et al. 2017, p. 3).

A generic qualitative approach, is in essence a qualitative descriptive approach which aims to undertake qualitative enquiry, yet without the specific focus on ethnography, phenomenology or grounded theory (Bradshaw et al. 2017). A qualitative descriptive approach may be more appropriate within healthcare research, where the experiences of people are gathered to develop an understanding of the phenomenon being studied, though "not to provide evidence for existing theoretical construction" (Bradshaw et al. 2017, p. 2).

3.2 (3) - The Strategies to Establish Rigour

Kahlke (2014) proposes that rigour within a generic qualitative approach is particularly significant and researchers must be able to illustrate clearly, the methods they engaged in order to increase rigour throughout data collection and analysis. Probst (2015) found that reflexivity is particularly important for rigour, when research stems from an epistemological approach. The researcher constantly revaluates their standing in relation to the research, data collection and data analysis. Although most researchers agree that the process of consistent reflexivity is challenging, the benefits mean that the research is more transparent, honest and presents increased self-accountability (Probst, 2015).

3.2 (3) (1) - *Rigour within the Literature review*

Rigour was established within the review of the literature which informed the current study, via a clear process for inclusion and exclusion of data, and documenting of sources utilised. The literature review aimed to gauge what was already known and researched on the topic of homecare. Randolf (2009) argues that the literature review should focus on the problem being researched and gauge the extent to which this problem has been previously addressed.

Literature was initially reviewed, then re-reviewed, cross checked and included or excluded based on the relevance to answering the research question (Randolf, 2009). Stern, Jordan and McArthur, (2014) argue that within healthcare research, a singular approach to inclusion criteria is rarely sufficient. Broadening search criteria and consideration of multiple sources of evidence are necessary, to address the complexities of phenomena being studied (Stern et al. 2014). Booth (2016) reiterates such ideas and proposes that searching for meaningfulness within the literature reviewed, can contribute to producing an insight into current practices within the field of study.

The inclusion and exclusion criteria for the literature reviewed within the current, are outlined in table 3. 1 below:

	Literature Review
Inclusion criteria	-Legislation & policy/policy statements relevant to the health and wellbeing of older people -Quantitative & qualitative research findings re: homecare provision -Books, journal articles, Government publications, websites, reports
Exclusion criteria	-Articles not written in English -Articles not published in peer reviewed journals/Government websites/from reputable organisations
Search terms	Homecare, homecare research, homecare evaluation, older people at home, homecare workers, ageing, loneliness, stigma and loneliness, isolation older people, social exclusion, isolation, community care, homecare workers, gender and care work, hard to reach groups, legislation older people Ireland, legislation older people England, home-help service, homecare in Ireland, private homecare providers Ireland, evaluating health and social care.
Search engines and academic databases	Social care online; NICE Evidence search health and social care; Science direct; SAGE Journals online; SCOPUS; PubMed; Springer Journals (IRel); JSTOR, BMJ Database; Google Scholar; NUI Galway library.

Additional steps to enhance rigour	-Including and considering contrasting research findings -Review of literature review and discussion with PhD supervisor -Reviewing media for developments nationally regarding homecare -Continually reviewing emerging and developing policy and legislation in Ireland pertaining to homecare

3. 2 (3) (2) - *Rigour Within Data Collection and Analysis*

Finlay (2002) argues that researchers themselves impact the participants in qualitative research. Should two different researchers gather data from the same participants based on the same problem or issue, their findings would be different, based upon each researcher's individual impact on the participants within the data collection process (Finlay, 2002). Darawsheh (2014) proposes that reflexivity within the data collection process enables the research to adjust and make improvements to their approach, as they gather data. For example: having reviewed the transcripts as I collected data, and reflecting on my interview skills and style, I found that I was following up with subsequent questions too quickly and perhaps not allowing for silence in the room. As I progressed through the interviews in phase 1, I continually reflected and checked my performance, to ensure I was being as effective as possible in promoting the acquisition of participant's experiences. Also, I continually asked myself if I was in anyway influencing the participants in their reply, or projecting my views or experiences. The first 5 interviews were undertaken with a research assistant. This further increased reflexivity, as the assistant took field notes and gave me feedback on my interview skills. This enabled me to hone my skills and implement changes (such as pace, tone etc.), as I continued to collect the data (Darawsheh, 2014).

Smith and Noble (2015) suggest that rigour when undertaking qualitative research is crucial to ensure the quality and credibility of the findings, particularly if the data is to be used to inform practice. Smith and Noble (2015, p. 1) argue that "accounting for personal biases which may have influenced the findings" is essential, if rigour is to be increased. Tracy (2010) suggests that sincerity on the part of the researcher is crucial, to ensure rigour and quality in qualitative research. Tracy proposes that self-reflexivity concerning biases in addition to transparency relating to challenges, are both key attributes of sincerity within the research process (2010). I endeavoured to illustrate sincerity by consistently questioning my own biases and preconceived ideas about homecare and older people. In my own experience working in homecare I witnessed poor service provision at times

and also disparity relating to the allocation of hours and quantity of care. Hence I actively questioned myself to ascertain if my experiences were impacting the collection and analysis of the data. I took the time to re-analyse and code the data multiple times, to ensure I was capturing accurately and honestly, the experiences of participants as they portrayed them.

Koch (2006) contends that transferability is a key attribute of a qualitative piece of research which demonstrates rigour. Transferability relates to the ability of the findings to be applicable when in another comparable context. Reinharz (1983) argues that this is evidenced when the researcher provides "sufficient contextual information to make similar judgements possible by others" (as cited in Koch, 2006, p. 93). To increase the transferability of the findings of this research, the coding of data was reviewed and critiqued by both a peer lecturer with qualitative research experience and the primary researcher, in an effort to maximise robustness. The PhD supervisor further reviewed and critically discussed initial and subsequent codes, to ensure conclusions being draw were warranted and that the data were being appropriately interpreted. Critically examining findings of previous studies with similar aims and methodologies, further increased rigour, as the findings of this current study were somewhat consistent with previous comparable research studies.

Verification according to Morse, Barrett, Mayan, Olson and Spiers (2002, p. 17), is a process of "checking, confirming, making sure and being certain". Morse et al. (2002) argue that identifying and rectifying errors as they occur throughout the research process and continually assessing the suitability of methods, enables the researcher to increase rigor within their study. This is a method which was continually employed by the primary researcher throughout the research journey, in an effort to enhance rigour and certainty.

Analytical triangulation, or peer debriefing is concerned with the researcher discussing the methods, data analysis and interpretations of such with a colleague who is not directly involved in the research (Hadi & Closs, 2016). This enables the researcher to receive ongoing critique and feedback on their research practices and interpretations of findings. Hadi and Closs (2016) suggest that the PhD supervisor often supports students in debriefing, which is one method I continually engaged with throughout this research process. My PhD supervisor facilitated debriefing and discussed critically the methodological steps I was employing and the rationale for each. Presenting findings at conferences based on the methodology, data collection, interpretation and findings, further afforded me the opportunity to have each element critiqued and receive feedback upon.

A further process undertaken within this research journey to enhance rigour and promote continued critical reflection, was the use of an established analytical framework, for data analysis. This study employed Braun and Clarkes (2006; 2022) 6 step approach to data analysis, which provides a comprehensive recipe for researchers to utilise which will result in a reflexive and objective route to identification of themes. Questioning is a fundamental of this 6 step process of thematic analysis, with the researcher continuously driven to question the accuracy of their interpretations of the data, and whether such interpretations truly represent the meaning they attribute to the data (Braun & Clarke, 2006; 2022).

3.2 (4) - The Analytical Lens through which the Data are Examined

Thematic analysis was employed to examine the data within this study and identify themes which reflected accurately the meaning implied within the data. Thematic analysis is a method of data analysis which seeks to identify patterns of shared meaning, within the text (Herzog, Handke & Hitters, 2019; Braun & Clarke, 2006). Thematic analysis is common within healthcare fields and aims to capture a true sense of participant experiences, through the development of themes which help to explain the phenomenon being studied (Vaismoradi, Turunen, & Bondas, 2013). Vaismoradi et al. (2013, p. 401) argue that thematic analysis is "as an independent and a reliable qualitative approach to analysis".

Braun and Clarke (2022) conceptualise that thematic analysis should be approached using a plan or recipe to enhance rigour and reflexivity. They use the metaphors of following a recipe to bake a cake, or creating a guide prior to travelling, to contextualise the importance of utilising a framework for thematic analysis, which is more likely to produce a successful result (Braun & Clarke, 2022). Bradshaw et al. (2017) argue that the use of a named framework for data analysis is an essential component of qualitative approach. Analysis will often take multiple attempts where recordings are listened to repeatedly and data analysed and reanalyse and with sub-themes and themes identified through several iterations of these processes (Bradshaw et al. 2017).

Maguire and Delehunt (2017) postulate that reflective questioning on the part of the researcher can enhance rigour and further illustrate reflexivity on the part of the researcher, within the data analysis process of the research journey. Questions which prompt such rigour and reflexivity include: Are there any alternative interpretations or possibilities? Am I trying to make things fit too much into this theme? Does the data support this conclusion? Am I certain? Could it alternatively be X or Y? (Maguire & Delehunt, 2017, Yin 2011). Yin (2011) in addition to Bradshaw at el. (2014) concur and

advocate that the use of a systematic and documented approach to data analysis within a generic qualitative approach is essential. Yin proposes a detailed process of: compiling, dissembling, reassembling and interpreting the data (2011).

Byrne (2021, p. 9) contends that initial coding should capture and document "short, descriptive or interpretive labels for pieces of information that may be of relevance to the research question". Themes should not be "determined by numerical frequency, so much as salience and importance to addressing the research question" (Braun & Clarke, 2022, p. 102). Elliot (2018) contends that coding enables the researcher to deconstruct the data and create something new. Elliot describes the initial codes as being identified through the first round of data analysis, while codes become clearer or more certain during the second or even third cycle of analysis. Assigning meaning and identifying patterns within the codes, eventually culminate into themes, which are formed or constructed as a result of this cyclical analytical process. Saldana (2021) argues that coding is subjective and impacted by the experience and discipline of the researcher and based on a transactional process of decoding and encoding. Thus reflexivity is an essential component of the coding process (Saldana, 2021).

3.2 (4) (1) – Thematic Analysis

The process of theme development was cyclical in nature and involved repeated review of nodes, codes and themes, "until agreement between the coders as to what determined sufficient demonstration of a true representation of a theme" becomes evident (Roberts, Dowell & Nie, 2019). Braun and Clarke (2022, p.70) reiterate such ideas and suggest that thematic analysis should result in developing "themes robustly based on clusters of similar meaning" within the data. Theme development should further be concerned with meaning and significance to answering the research question, as opposed to relating specifically to numerical frequency (Braun & Clarke, 2022).
Braun and Clarke (2006; 2022) recommend six distinct and essential steps in thematic analysis which were rigorously adhered to within this study, to produce the themes identified. Byrne (2021) proposes that Braun and Clarke's 6 step approach to thematic analysis (Braun & Clarke, 2006; 2022) can enable researchers to categorise the methodological steps undertaken which culminated into the final themes derived from the data analysis. These 6 steps were utilised within the current study in order to identify the final themes presented within the results chapter.

These six steps are outlined in fig 3.a below:

Fig. 3.a: Braun and Clarke's (2006; 2022) 6 step approach to thematic analysis

An example of Braun and Clarke's 6 step approach as applied to the current study is outlined below:

1. Familiarising myself with the data: transcripts were typed on a rolling basis as interviews and focus groups were undertaken. Transcripts were uploaded to Nvivo, read and re-read. A break was taken for a period of one month. Transcripts were then read and re-read again. Post initial coding and subsequent theme generation, data were re-read and re-coded. This familiarity with the data resulted in the evolution of my understanding concerning what the data was saying, and greater confidence in my ability to analyse and accurately interpret this (Byrne, 2021). Familiarising myself with the data further provided for more accuracy in my framing of participant's views, based on my interpretation of these (Toby & Begley, 2004). This persistent and continued engagement with the data, enabled enhanced awareness and insight pertaining to meaning and relevance of key ideas (Nowelli, Norris, White & Moules, 2017).
2. Generating initial codes: data were analysed using Nvivo software and initial nodes were identified which appeared to be of significance within the data and relevant to the research question. Nodes were scrutinised and developed to create initial codes such as: "the same homecare worker" "lonely", "having a cup of tea", "careplan". Initial codes were also identified via pen and paper methods, postits, written notes and drawing of mind maps which highlight

emerging patterns within the data, relevant to answering the research question. Thematic mapping was employed to present visually the initial nodes as they emerged and their subsequent development to codes and into themes which addressed the research question. Examples of thematic development can be seen in appendix A.

3. Searching for themes: initial codes and transcripts were reviewed in a cyclical process to establish codes which represented "clusters of similar meaning" (Braun & Clarke, 2022). Initial themes included: "choice", "consistency", "social contact". Questions to enhance rigour and reflexivity throughout this process included: Am I sure this is a theme and not a code? Does the text support the meaning I have attributed to this theme? Is this theme useful in answering the research question? Is the breadth and scope of this theme sufficient to draw such conclusions? (Braun & Clarke, 2006). Codes were grouped to ascertain if patterns were evident and then synthesised where appropriate to build initial themes (Kiger & Varpio, 2020). Themes were re-reviewed and developed to enhance accuracy and ensure meaning was significant and contributed to answering the research question (Maguire & Delahunt, 2007).
4. Review of themes: themes were scrutinised, deconstructed and reconstructed. Could it be something else? Does this accurately reflect the meaning and context conveyed within the data? Does this theme represent connections and alliances between codes which are significant? (Braun & Clarke, 2022). At this point, themes were further scrutinised to ensure they were not too wide-reaching, sub-themes were ruled out within themes, or identified and extracted. A further examination of whether the data matched the themes identified was undertaken (Maguire & Delahunt, 2007). Thematic mapping enabled a visual presentation of themes and cyclical review of thematic development. This further enhanced accuracy and ensured appropriate interpretation of meaning was derived from the data.
5. Defining and naming themes: final themes were defined in scope and named, based on detailed cyclical examination, reflexivity and scrutiny of the data (Saldana, 2021). According Braun and Clarke (2006, p. 82) a theme identifies "pattern and meaning". Themes were defined and labelled based on the deductive process undertaken within the data analysis. Data were re-reviewed to establish with greater certainty if the themes derived from the data analysis, did in fact reflect the meaning implied (Kiger & Varpio, 2020). Data quotes were presented within the write up at this stage, to illustrate the context and significance of quotes within each specific theme (Braun & Clarke, 2022). The write up was reviewed and re-reviewed to ensure the quotes did in fact reflect the theme and the meaning interpreted.

6. Write up: this stage within the 6 step approach to thematic analysis, resulted in the presentation and explanation of the journey undertaken to arrive at the final themes. Clarity was provided to enable the reader to trace the specific process embarked upon which produced the key themes presented. Clear description of frameworks and critical reflexive methods were presented throughout the methodology chapter, to further evidence the cyclical analysis process and emphasise the structured and reflective development of final themes within this study (Braun & Clarke, 2006, 2022). The final report was presented within the results chapter, outlining final key themes and documenting text which was representative of these. Themes were then merged to create 3 overarching findings which explain the phenomenon of homecare, based on the data analysis of participant's perspectives and experiences (Braun & Clarke, 2006, 2022).

The process of theme development, stemming from initial nodes, was undertaken with support and guidance from the PhD supervisor. Nodes and themes were scrutinised and discussed in detail, before agreement was met indicating that such themes were truly representative of the meaning within the data. Double coding was further undertaken concerning a sample of the data, to strengthen the thematic conclusions drawn from the data analysis and to enhance rigour (Braun & Clarke, 2022; Roberts, Dwell & Nie, 2019; Stuckley, 2015).

The table **3. 2** below presents an example of the process of theme development, based on the current study:

Initial/ Potential code	**Sub-Codes**	**Possible alternatives**	**Notes**	**Theme**
The same homecare worker **Sample from data:** "I suppose having the same person all the time is great because you know who's coming in to you"	-Familiarity -Consistency	-Inconsistency -Routine	-Having the same HCW associated with positive experiences. -Multiple HCWs causes distress & uncertainty. -Inconsistency profoundly negatively impactful	Impact of inconsistency
Companionship needs	-Alone at home	-Isolated	-Isolation of older people and the impact	Impact of isolation

Sample from data: I think it's a lot of it is just maybe company. And to be able to sit down and have a cup of tea with them.	-Lonely -Tea	-Homecare needs	this has on the HCW in their role. -Social needs appear the most notable of all needs. -Older people are lonely & want social contact -Meeting social needs is significant, based HCW experiences.	experienced by older people

3.3 – Sampling

This section will describe the sampling methods undertaken for both phases 1 and 2 of this study respectively. Both initial sampling procedures and subsequent expanded sampling methods will be explained. Tables and charts will further be utilised to demonstrate the sampling mechanisms undertaken.

3.3 (1) – Sampling Phase 1

Older people are recognised as a hard to reach group and often underrepresented within research (Spong & Bianchi, 2017; Canvin et al. 2018). Health and mobility issues, combined with marginalisation and vulnerability, can dissuade some older people from participating in research studies (Sydor, 2013). Hence recruitment methods which engage such harder to reach participants were employed. Recruitment via recognised organisations already in contact with older people, have been cited as an effective method to increase participation (Inge, Gibbons, Bray & Gray, 2019).
The population being studied in phase 1 were older people in receipt of homecare. Initially inclusion criteria were people aged over 65 years currently in receipt of homecare. Sixty five years is the age accepted in most developed countries as old age or elderly, according to the WHO (2002). Exclusion criteria were people aged under 65 years. These inclusion criteria evolved as initial uptake was extremely low and consequently, older people interested in the issue of homecare were invited to participate in focus groups. Interview inclusion criteria evolved to include family members of people in receipt of homecare and this occurred for 2 of the 16 interviews (1 was a spouse of a homecare recipient and 1 a sibling, and both were older people themselves). This expansion of inclusion

criteria appeared a necessary step to gather sufficient data, which would illuminate the factors which impact homecare provision, based on the perspectives of older people.

As uptake continued to be low, ethical approval was sought to expand recruitment to include extending the invitation to participate with voluntary agencies in Galway, who provide services and information to older people. Consequently, meals on wheels (a meal delivery service to older people) were contacted and asked to disseminate the invitation to participate to their meal recipients (See appendix B). Equally, the Department of Gerontology in NUIG, disseminated the invitation to participate with contacts on their mailing lists (older people, active retirement groups, older person's advocacy groups). The role of both gatekeepers within the recruitment phase was instrumental in addressing the reluctance of participants initially. Browne (2005, p. 51) found that members of hidden groups in society may feel increased trust when considering participating in research, when the information has been shared by one of their peers who is in a similar position (in this case in receipt of homecare). Hence snowball sampling was indispensable relating to this population and was employed to reach those who chose to participate (Browne, 2005).

Fig. 3.b below details the recruitment process for phase 1, including the breath and scope of the reach within which invitations to participate were disseminated:

Fig. 3. b: Recruitment process phase 1

As uptake continued to be low within phase 1, the methodology was expanded to include an invitation to participant in focus groups with older people, to discuss more broadly the issue of homecare (See appendix C). Although such a decision deviated from the initial aim of seeking experiences of homecare participants, focus groups offered alternative perspectives on homecare views and experiences more generally. Furthermore it was hoped that focus groups may assist in demystifying the research process and result in a greater uptake in recruitment of participants for interviews. Based on such expanded recruitment criteria, 2 groups made contact and expressed an interest in participating in focus groups, to discuss the issue of homecare for older people. Both were active retirement groups. Focus groups facilitate the informal discussion and gathering of information, based upon the interactions between of a group of people relating to the topic of interest (Acocella, 2012). Two focus groups were undertaken with 7 and 8 participants respectively. Focus group 1 consisted of 6 female participants and 1 male, while focus group 2 consisted of 8

females. Hence participants within the focus groups were in fact sharing their perspectives on homecare more generally, as opposed to their individual experiences.

Table **3. 3** below, presents the inclusion, exclusion and expanded inclusion and exclusion criteria for phase 1:

	Inclusion Criteria	**Exclusion Criteria**	**Expanded Criteria**
Phase 1	-Aged >65 -In receipt of homecare via the HSE or a private provider	-Aged < 65 -In receipt of informal homecare/homecare not provided by the HSE or a private provider	-Older people in the community/ by proxy participants -Older people who had a family member in receipt of home care

Post data collection for both focus groups, additional older people in receipt of homecare made contact and expressed a wish to participate. Of the interview participants, 3 were male and 13 were female. Both family members of homecare recipients who participated were themselves older people aged over 65, and were female.

Table **3. 4** below outlines the participant profile in addition to the duration of each interview, for phase 1:

Interview	**Interviewee Profile**	**Duration of interview**
1	Male in receipt of homecare	38 minutes
2	Male in receipt of homecare	40 minutes
3	Female in receipt of homecare	24 minutes
4	Female in receipt of homecare	20 minutes
5	Female in receipt of homecare	16 minutes
6	Female in receipt of homecare	11 minutes
7	Female in receipt of homecare + family member to support	18 minutes
8	Female in receipt of homecare	10 minutes
9	Female in receipt of homecare	21 minutes

10	Female family member of person in receipt of homecare	18 minutes
11	Female in receipt of homecare	22 minutes
12	Female in receipt of homecare	48 minutes
13	Female in receipt of homecare	32 minutes
14	Female in receipt of homecare	17 minutes
15	Female family member of person in receipt of homecare	15 minutes
16	Male in receipt of homecare	23 minutes

Table. 3. 4: Participant profile table phase 1

3.3 (2) – Sampling Phase 2

The population relevant for phase 2 were homecare workers, currently employed by the HSE or a private homecare provider. Inclusion criteria were homecare workers, aged over 18 years currently in employment. Exclusion criteria were homecare workers under the age of 18 or those working independently and not employed by either the HSE or a private homecare company.
Similar to the sampling challenges within phase 1 of this study, recruitment of participants for phase 2 also proved quite difficult. Homecare workers are themselves identified within the literature as a hard to reach group, due to poor working conditions and low socioeconomic status (Bonevski et al. 2014). Furthermore, many homecare workers are from ethnic minority groups and precarity regarding work contracts and employment security, further marginalise this vulnerable group (Simoene et al. 2021; Green & Alayon, 2017).

Initially, all HSE offices in Galway and all private homecare providers were contacted with information about the study and were invited to participate (See appendix D). Managers emailed all homecare workers with information about the study and the invitation to participate. Uptake was quite low initially. Snowball sampling subsequently became instrumental in recruiting from this hard to reach group and was utilised with homecare workers sharing the invitation to participate with their colleagues and friends. Snowball sampling is useful when the population being studied is harder to reach yet can be enhanced via use of social networks, personal relationships and connections between people (Browne, 2005).

Table 3. 5 below outlines the inclusion and exclusion criteria for phase 2 participants:

	Inclusion Criteria	**Exclusion Criteria**
Phase 2	-Homecare workers employed by the HSE or a private homecare provider	-Homecare workers not employed by the HSE or a private provider

This resulted in a total sample of 20 homecare worker: 17 females and 3 males. The majority of participants being female is consistent with trends within health and social care in general (CSO, 2016; 2019). Table 3. 6 below illustrates the profile of each participant within phase 2 of this study and the duration of each interview:

Interview	**Interviewee Profile**	**Duration of Interview**
1	Female homecare worker	39 minutes
2	Female homecare worker	14 minutes
3	Female homecare worker	10 minutes
4	Male homecare worker	30 minutes
5	Female homecare worker	20 minutes
6	Female homecare worker	15 minutes
7	Female homecare worker	14 minutes
8	Female homecare worker	15 minutes
9	Female homecare worker	17 minutes
10	Female homecare worker	31 minutes
11	Female homecare worker	23 minutes
12	Female homecare worker	14 minutes
13	Female homecare worker	22 minutes
14	Female homecare worker	23 minutes
15	Female homecare worker	11 minutes
16	Female homecare worker	13 minutes
17	Female homecare worker	33 minutes
18	Female homecare worker	25 minutes
19	Male homecare worker	27 minutes
20	Male homecare worker	30 minutes

Table 3.7 below identifies the status of phases 2 participants regarding their homecare employers: HSE, a private provider, or both:

HSE	**1**
Private Provider	**17**
Both HSE & Private Provider	**2**

3.4 - Data Collection

This section will describe the data collection methods employed within this study for both phases 1 and 2 respectively.

3.4 (1): Phase 1 Data Collection

A pilot phase was undertaken with the first 3 participants and an interview assistant was employed for each pilot interview. The pilot interviews tested the data collection tool for feasibility and appropriateness (In, 2017). Pilot interviews further tested the capability of the researcher to capture all data (both recorded on dictaphone and via note taking). The interview protocol was modified only slightly post pilot (See Appendix E). Research assistants were no longer used post pilot as their presence was not needed (Teijlingen & Hundley, 2001). Due to the low uptake of participation and the lack of change relating to the interview protocol, pilot interviews were included as part of the main study (analysis and conclusions). Teijlingen and Hundley (2001) argue that within small scale studies and when the data collected within the pilot is seen as valuable to informing the study overall, that research can use this data as part of the overall study.

A focus groups guide (See Appendix F) was created under supervision of the PhD supervisor and with the aim of generating discussion more generally around homecare, as opposed to relating to specific experiences. Focus groups can provide an insight into beliefs, perspectives and attitudes relating to the phenomena being studied (Ochieng, Wilson, Derrick & Mukherjee, 2018). Ochieng et al. (2018) argue that the dynamics of pre-established groups such as those used for this study, can enhance the engagement of participants as they are already familiar with one another. Both focus groups were undertaken within existing pre-formed groups. Focus group 1 consisted of members of an advocacy group for older people. Focus group 2 consisted of members of an active retirement group. Ivey (2011) suggests that focus groups enable community members to discuss issues and problems, based upon their shared values as a group. The position and knowledge of the researcher relating to the phenomenon being studied, is central to the facilitation of focus groups and subsequent data analysis (Kook, Shalev & Yuval, 2019). The researcher comes from a practice background with older

people in homecare, which provided a sincere rationale for participants about the intentions of improving service provision.

Focus groups help to demystify the research process, particularly for vulnerable participants who may be apprehensive about partaking in a one to one interview (Kook et al. 2019). “Focus groups are planned to capitalize on the synergy arising from interactions of the members” (Carey, 2016, p. 731). Through their exchanges with one another, focus group members discussed homecare in more detail and further provided greater rationale for their views and experiences (Carey, 2016). Acocella (2012) argues that focus groups prompt participants to articulate in more detail their thoughts and experiences relating to the phenomena being studied, as the natural synergy of the group stimulates this.

Interviews for phase 1 were undertaken in the homes of older people in receipt of homecare. Health, mobility issues and vulnerability of older people, can reduce participation in research (Mody et al. 2008). Hence facilitating interviews in the homes of participants, aimed to increase accessibility and reduce barriers. One participant had a family member present due to a diagnosis of dementia and the need for additional support to participate. All other interviews were one to one, with the exception of the pilot interviews, which included the employment of a research assistant. Interviews were recorded and notes also taken by the interviewer throughout the interview. Field notes were further taken after each interview by the researcher, once they returned to the office.
Both Interview and focus group guides were created by the researcher under supervision and were expanded via consideration of the Donabedien Quality of Health Care Framework (DQHF). Although not utilised exclusively, consideration of the 3 domains of: structure, process and outcome, were used to promote the comprehensiveness of the data collection tools for phase 1.

3.4 (2): Phase 2 Data Collection

A pilot study for phase 2 consisted of 3 participants, currently employed as homecare workers. The pilot enabled the researcher to gauge the feasibility of the interview guide (see appendix G) and ascertain the effectiveness of the interview practicalities, such as timing and recording equipment (Williams-McBean, 2019). The pilot interview guide was amended slightly post pilot, as one question appeared repetitive. The final interview guide omitted this question (see appendix H). As the change from the pilot interviews of phase 2 were minor, these interviews were included within the overall study. If the data collection instrument was deemed not to be valid or apt, then the use of the pilot data should not be included within the main study (Williams-McBean, 2019).

Consistent with phase 1, interview guides for phase 2 were created by the researcher under supervision. The scope and breath of the data collection tools for phase 2 were informed (to an extent) by the Donabedien Quality of Health Care Framework (DQHF).

3.5: Reflexivity

Braun and Clarke (2022) emphasise the importance of active reflection on the part of the research throughout the research process. Braun and Clarke propose that reflexivity in thematic analysis is a "journey and not a destination" and consequently must be revisited continually before, during and after data collection and analysis. They further caution that truly reflective thematic analysis means that uncertainty, contradiction and ambiguity are a distinct possibility, and that a "nice tidy explanation" of the phenomenon is highly unlikely using this method (Braun & Clarke, 2022, p.7)

My own preconceptions of homecare are impacted by my experience as a homecare worker. This is something I have reflected on substantially and discussed with both my GRC and research supervisor. I have identified: what I thought I knew, my opinions and personal experiences, vs what the data illustrates, what the participants are communicating and what are the key themes emerging from the data. Yet acknowledging that my past experiences do shape my view of the current research project is further significant. I continually reflected on my time as a homecare worker and the broader beliefs I have based on my practice experience. I began my research journey thinking that the homecare service was not meeting the needs of older people, and that some older people were not receiving the amount of care they needed to have their needs met. I continually questioned myself regarding how my views may be impacting my analysis of the data. I viewed each interview and focus groups as a completely new experience and interpreted them within this same light. I used prompt questions such as: is this the only possible code? Could there be an alternative? Why? Am I viewing this from a clear lens and not based upon my preconceived ideas? (Yin, 2011; Braun & Clarke, 2022). I then stepped away from the data for a time, and then reanalysed this and used the same prompt questions, to be more certain that I was truly capturing the perspectives and experiences of the participants within my findings (Braun & Clark, 2022).

Equally important to recognise and acknowledge is the insight and appreciation I did bring to the data, based on my experience in homecare. My extensive experience in communicating with older people through my work, enabled me to detect subtleties in communication and gauge when a participant may have been hesitant in sharing additional information, or indeed expressing

dissatisfaction non-verbally. My experience further provided me with a more intuitive lens in discerning when further probing was appropriate within interviews with homecare workers, or if a prolonged silence was needed within interviews with older people. Hence although I actively aimed to reduce biases based on my previous practice experience, this undoubtedly enhanced my intuition in grasping non-verbal communication and issues unique to homecare, during the data collection and analysis for this study.

Nonetheless, I further remain aware of my position as a 39 year old living with no physical impairments, with no need for care provision and with a strong support network. This privilege means that I cannot truly understand the experiences of older people concerning homecare, as I myself have not been in their position as aged individuals and in receipt of homecare. Equally, my own privilege of having stable employment and job security, further made me reflect on the lack of job security experienced by some homecare workers and my lack of truly understanding how this must feel from their perspectives as research participants.

3.5 (1) Presenting Findings within the DQHF

The DQHF was subsequently used within the results chapter to frame and present the findings within the specific domains of: structure, process and outcome. Although the DQHF was not solely relied upon to inform the current study, its use was employed to further establish rigour and promote reflexivity (Darawsheh, 2014; Koch, 2016; Mc Question, 2006; Braun & Clarke, 2022). Although the aim of this study was not concerned with replicability or transferability of findings, employing the use of an established framework can assist in contextualising findings (El haj et al. 2016; Liu et al. 2011).

3.6 - Ethical Considerations

Both phases of this study received ethical approval from the Research Ethics Committee of the National University of Ireland, Galway. Consent forms were further provided to each participant in both phases 1 and 2 (See appendices I and J).

3.6 (1): Ethical Considerations Phase 1

Initially ethical approval was sought to undertake interviews with older people, which was approved on **July 16th 2016** (See Appendix K). An amendment was later sought to include focus groups with older people and this was granted on **April 11th, 2017**. Specific ethical considerations associated with older people in receipt of homecare related to:

- Should they become distressed due to perhaps recalling an upsetting experience or bereavement, permission was sought both verbally and in writing for the contact details of the public health nurse of each participant, in addition to permission to contact them should the participant become distressed. No participants became distressed during or after any of the interviews.
- Consideration of the vulnerability of participants was considered as due to health or status of living alone, some older people may feel pressure to partake or worry that their information may not be kept confidential. Participants were provided with information about the study, their right to withdraw participation, and confidentiality regarding the information they shared. Contact details for the researcher were provided and potential participants were advised to contact the researcher should they wish to participate.
- Upon meeting participants and prior to commencing interviews, participants were advised verbally of the purpose of the research, that their name or any identifying information would not be made public and also that they had the right to end the interview or withdraw their consent to participate, at any time and without repercussions.
- Ethical considerations relating to capacity should a potential participant be living with a diagnosis of dementia were addressed, as recommended by the REC at NUIG. Older people in receipt of homecare with a diagnosis of dementia would be supported to participate in this study if they so wished, with the support of a family member. This was the case for one participant, whose son supported her for the duration of the interview.

3.6 (2): Ethical Considerations Phase 2

Ethical approval for phase 2 of this study was obtained by the Research Ethics Committee at NUI Galway on: **December 21st 2017** (See Appendix L). Specific ethical considerations associated with ethical approval for phase 2 related to:

- Participants were advised that although highly unlikely, there may be a minor risk to their emotional well-being should they become upset, when recounting a difficult experience from their work or recall experiences with an older person who has passed away.
- Participants were advised of their right to withdraw their participation at any time, prior to, during, or after interviews took place.
- Participants were assured confidentiality, with each being assigned a letter to protect their identity when interviews were transcribed.

- Participants were informed that any information which may identify an individual homecare worker or homecare company would not be included, within any publications which may be created based upon this data.

3. 7: Limitations within the Methodology

Notable within the methodological research process for the current study as a potential limitation, was the use of a specific question within phase 2, which asked directly about the issue of loneliness. This question was derived from the data analysis undertaken for phase 1, which identified the social contact element of the homecare service as significant, based on the perspectives of older people. Hence including a question on loneliness appeared appropriate. However this may have been perceived by participants in phase 2 (homecare workers) as a leading question. Equally, such a specific question on loneliness may have inflated findings surrounding isolation and loneliness within the data analysis for phase 2.

3. 8: Conclusion

In summary, this chapter has examined the methodological journey undertaken within this research project, based on the specific aim and objectives of this study. This chapter has presented justification and clarity regarding the research design, sampling, data collection and analysis. The used of established frameworks and analytical mapping were drawn upon within this chapter, to demonstrate the critical consideration employed and efforts to enhance rigour consistently throughout the research process.

Caelli et al. 2003 framework was utilised to demonstrate comprehensively the key steps undertaken in designing and completing this study, including rationale for each. The theoretical positioning of the researcher which informed this study was a constructivist/interpretivist research paradigm. Such a paradigm adopts the belief that people construct and impact the world around them. People's experiences can be articulated to the researcher and the experience and knowledge of the researcher on the phenomenon of homecare, can contribute to the attribution of meaning and interpretation of experiences.

The congruence between methodology and methods were examined and the rationale for a generic qualitative approach was explored. The efforts to increase rigour undertaken were outlined in detail. The sampling and recruitment of participants for both phases of this study have been documented

and justification for sampling methods outlined. A table outlining the initial sampling and subsequent expanded recruitment of participants, explaining inclusion and exclusion criteria as they evolved were provided. The data collection process of focus groups and interviews for phase one, and interviews for phase 2 were explained and rationale considered for same.

The strategies to establish rigor within this research project were further explained within this chapter. Analytical triangulation, critical reflection and continued verification were employed throughout each stage within the research journey, to enhance rigour and reduce the likelihood of bias or the views and experiences of the researcher impacting the conclusions drawn from the data collected. Illustration of how continuous review, questioning and critical consideration were instrumental throughout the research process, were discussed.

The analytic lens through which the data are examined were described carefully, with a specific focus on Braun and Clarke's (2006; 2022) 6 step approach to thematic analysis. This approach was rigorously applied to the current study and further enabled eventual certainty with conclusions drawn from the data and a robust process of justification for how such findings were derived. Ethical considerations for this study were also presented within this chapter. Particular focus was given to the potential vulnerability of participants in receipt of homecare, and how these may be addressed.

Chapter 4: Results

4.1 Introduction

This chapter will present the results from both phases 1 and 2 of this study, in answer to the research question. Findings from the data analysis will be discussed within this chapter and how such findings address the research question will be clearly described. Results based on phase 1 data analysis will address objective 1. Findings from phase 2 will be presented in response to addressing objective 2. The primary aim of this chapter is to clarify how the results from the current study address the research question:

To examine the current delivery of homecare to older people in Ireland, from the perspectives and experiences of older people and homecare workers.

Both phases of the current study contributed equally to presenting an insight regarding the primary research question.

The key objectives of this study were concerned with:

1. Ascertaining the views and perspectives of older people relating to both positive and negative experiences of homecare provision, and
2. Exploring the homecare worker's experiences of delivering homecare to older people and examining the factors which impact this care.

Phase 1 consisted of 2 focus groups with 7 and 8 participants respectively. Focus group participants expressed their perspectives on homecare, as opposed to experiences, as not all had themselves experienced receiving homecare. Phase 1 further consisted of 16 one to one interviews with older people. Fourteen of the 16 participants were in receipt of homecare themselves, and the remaining 2 participants were family members of an older person who received homecare (1 a spouse and 1 a sibling).

Phase 2 consisted of interviews with 20 homecare workers, currently employed in the homecare sector in Ireland. 17 of the participants in phase 2 worked for a private homecare provider. 2 participants worked simultaneously for both the HSE and a private homecare provider. One participant was employed by the HSE.

Three key themes and one sub-theme were identified from the in-depth data analysis for phase 1, based upon the perspectives of older people within focus groups and 1-1 interviews. Three key themes were identified within the data analysis from phase 2, deriving from the 1-1 interviews with homecare workers.

The structure of this chapter will commence with an explanation of each key theme and sub-theme, based on both phases 1 and 2 of this study, respectively. The meaning, context and rationale for development of each theme will be provided and examples from the transcripts which support the thematic development will included.

Subsequently, the overarching findings derived from the totality of the data analysis will be presented in answer to the research question. The three fundamental findings will then be considered within the context of the Donabedian Quality of Health Care Framework. This will further contextualise the overall findings of this study within a framework created to evaluate and attribute meaning to specific the practices and nuances of healthcare settings (Haj et al. 2013).
Interview participants will be identified by a letter for phase 1, and numerically for phase 2. Focus group participants will be differentiated to enhance clarity, and identified using the prefix FG for focus group, and subsequently with a number to identify whether the quote stemmed from focus group 1, or focus group 2 (FG.(1)/FG.(2)). Finally a letter to represent the individual focus group participant will be provided, eg. FG. (1) .E.

4.2: Results Phase 1

Phase 1 findings identify the key issues which older people expressed as relevant in impacting their views of homecare, based upon their individual experiences and perspectives. The data indicate that 3 primary themes of: building rapport, the impact of inconsistency and social needs, as significant in influencing perceptions regarding homecare service for older people. A subtheme of ethnicity of the homecare worker was further identified, as a factor which impacts the perspectives of older people concerning homecare provision. Although the frequency of this subtheme within the data was less apparent compared to the three crucial themes which were identified as central to addressing the research question and objectives, this subtheme of ethnicity did emerge as meaningful to participants, which consequently equally warranted inclusion within the presentation of findings. Elicited from the perspectives and experiences of older people regarding homecare, phase 1 data analysis resulted in the following 3 themes and 1 subtheme, which address the research question

and specific objectives. Phase 1 themes and subtheme are presented in figure 4 (a) below within the context of answering the research question:

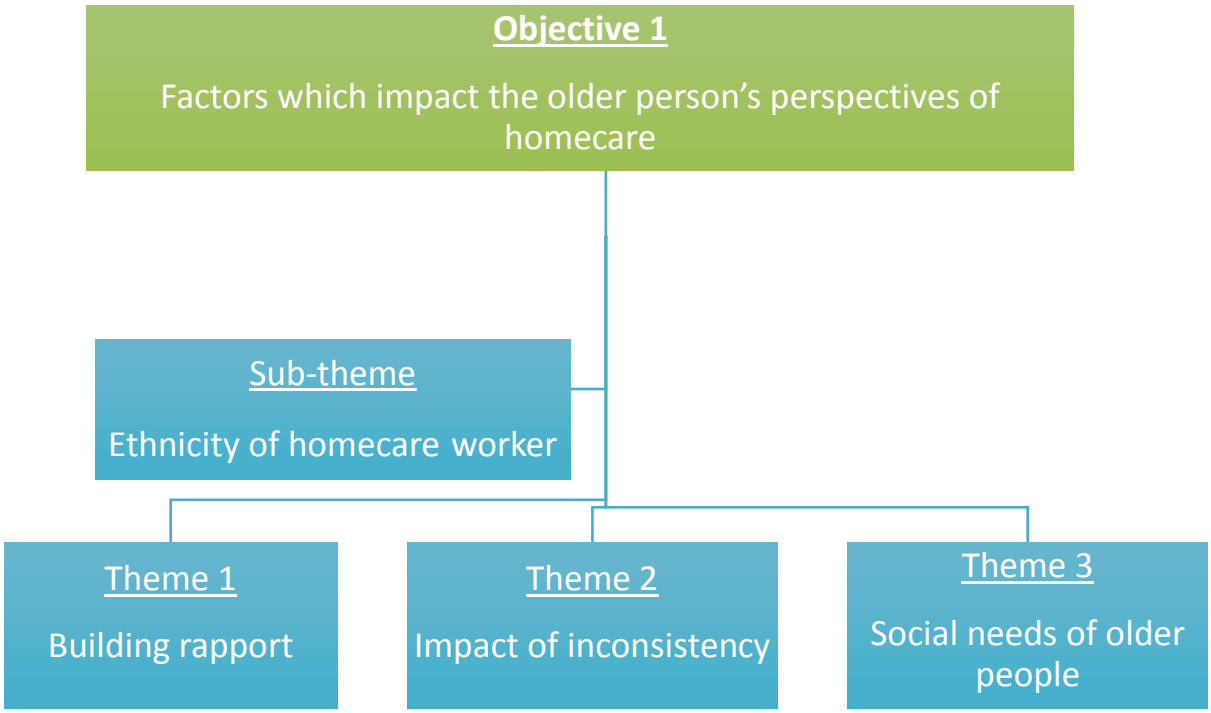


Fig. 4 (a): Phase 1 Themes and Sub-themes

4. 2 (1) Phase 1 Theme 1- Building Rapport

It was clear from the data in this study that building rapport was a positive and essential factor impacting homecare provision, based on the perspectives of older people. Participants placed substantial meaning on becoming familiar with their homecare worker, and their homecare worker becoming familiar with them. The findings supported the notion that building rapport, results in greater satisfaction with homecare, based on the perspectives of older people. Participants reported that their regular homecare worker can pre-empt their needs and they can gradually build a relationship with them. The data indicated that when both parties build rapport, this culminated into homecare provision where the older person feels understood by their homecare worker and continuity of care is enhanced. A sense of certainty regarding knowing what will happen and what to expect from the homecare visit, was identified as notable within this context:

"So you… know that they know what's going to happen" FG. (2). A

“Whereas Helen* knows exactly what I need, what I need having done. And as well as that, when you get to know somebody, you ask how their grandchild is, if they’ve been ill or if they’ve started school how are they getting on and… they almost become a part of your extended family. So it makes it a much nicer thing” (B)

“If you had one person…who knows you… knows your needs, your shopping, keep you up to date” (H)

“I think if you don’t have a click, well it just doesn’t work then you know? Either the carer or the client. I think you have to click with the person and I do have that with *Carol” (L)

“What I would like to have I think for me would be to build a personal relationship with somebody” (N)

That data further denoted that the building of rapport can only be developed when both parties became familiar with one another over time, and a reassuring routine developed. Participants described the advantages of building rapport with the homecare worker, as knowing what to expect when they receive their homecare visit, and having care which is tailored to their unique needs. Participants agreed that building rapport enhanced the effectiveness of the homecare visit, as communication between the parties was clearer. Participants further proposed that this rapport subsequently culminated into a more positive experience of homecare:

“And it was just a great experience having *Mary. I think from the minute I saw her I knew that we’d click and get on fine, which we did” (L)

“Between us… we worked out a thing” (P)

“I mean *Patricia will even warm my underwear on the radiator for me, on the electric fire she’s great” (A)

“Ahh well 2 or 3 mornings a week, one or two… you would build up a relationship with them over time” (H)

“But knowing now that the lady will come in, we have a great routine” (K)

4.2 (2): Phase 1 Theme 2 - Impact of inconsistency

Inconsistency was identified as an important in terms of negative experiences concerning homecare provision, elicited from the perspectives of participants in phase 1. Inconsistency in which homecare worker visits, or indeed when multiple different homecare workers visit the home of 1 older person, were reported as ensuing into a more negative experience of homecare for older people. The data suggest that inconsistency can result in distress for some older people. Participants consistently expressed feelings of dissatisfaction and unease concerning unexpected changes in personnel. All participants within both the focus groups and interviews conducted within phase 1 of this study, agreed that inconsistency in homecare provision, is undesirable for older people:

"My cousin had 5 different people came. And he was only after coming out of hospital. And you know he was very upset" (FG. (2). D)

"Not knowing what time they were going to come, having different people when you go up to the door, and you haven't seen this person before. And they don't know what to do for you and you have to start up again and tell them what you need done" (D)

"Chopping and changing personnel knocking at your door. I find myself now, I've noticed myself actually that when I go to the door to open it I'm a little bit more weary" (L)

"It was one of the things that annoyed me about the agencies was because there were several people coming" (K)

"Well a colleague of mine has a carer coming twice a week. And….a… sometimes it's a female; sometimes male… sometimes it's a person that has language…. difficulties. And there isn't any continuity" (FG. (1). M)

Participants reported feelings of discomfort and discontent regarding not knowing who would be visiting them. The data denoted that older people felt apprehension about opening the door and allowing someone into their home, whom they didn't know. The health needs of the older person were further emphasised within this theme of the impact of inconsistent, with participants further expressing the fundamental the need for consistency within homecare provision. Concerns regarding

the physical vulnerability of older people in receipt of homecare and subsequent safety concerns, were discussed by participants:

“My problem was there’s so many different people” (D)

“Oh you would you would have new people yes… regularly…. So you adjust to whatever the agency sends you…..l…. you have to really” (H)

“And a……. they seem to be quite disorganised at first. Cause I was getting all different people and I never knew the time, it was all different times. And I said I need to know the time when… Now this girl that comes sometimes she’s late as well” (M)

“It was not the same person all the time” (F)

“Because they weren’t professional for sending people in to strange places and a stranger accepting them at the door. They could be a tyrant and somebody coming in could hit them with something” (D)

“There were… up on 5 or 6 different people. Due to her condition being dementia… the regular.. to have somebody regular coming in .. the same person would be more helpful” (O)

“Last week, so private homecare workers were coming. So last week I had 3!” (N)

“Well the first month I think I must have had about 6 different people. Including foreign people” (M)

Participants described inconsistency in terms of the homecare worker not knowing their needs or what tasks should be undertaken. Knowing what time the homecare worker would arrive and when to expect them, were identified as important to participants in promoting a more positive experience of being in receipt of homecare. Participants reported that inconsistency in the care workers visiting them, presented problems relating to issues such as the duration of the homecare visit varying, the time of arrival of the homecare worker changing and a general sense of uncertainty with exactly what to expect:

“And then there’s a difficulty with time. If they were supposed to be here at 10, and came at twenty past 10… they still left at 11. And it was wrong, they should have stayed ‘til 20 past 11” (D)

“The amount of times I was due a visitor, by the time they come in and have taken off their coat said hello to the person, because they don’t know the condition of the person at that stage” (FG. (1). F)

“There’s an odd lady that comes particularly on a Sunday now because I have the odd ones then, they mightn’t be great you know” (A)

“I’m sure she said her name and out of a sense of kindness… shock or both! I let her in. And she must have been *Sarah or somebody wasn’t available… sick or something I forget” (L)

“Sometimes she comes and stays for…an hour. An hour I’m allowed. But sometimes she doesn’t stay the hour do you know?” (M)

4.2 (2) (1): Phase 1 Subtheme 2. 1- Ethnicity of Homecare Worker

Results from both the interviews and focus groups undertaken within phase 1 of this study, indicated that participants viewed ethnicity and language as notable in impacting homecare provision. Common ways of reporting the relevance of the matter of ethnicity were expressed by participants in terms of communication issues relating to English language, or via referring to homecare workers as “foreign”. Participants did not express dissatisfaction per se pertaining to the nationality of homecare workers, but rather conveyed the challenges presented by language barrier and feelings of discomfort regarding different cultures. Findings illustrated that some participants were perhaps not familiar with people from other cultures and this presented feelings of uncertainty and miscommunication:

“You know it’s nothing to do with being foreign. Now I’ve got this girl coming regular she must be coming for 5 or 6 months now that girl.. or even more. And she’s a Nigerian person but you see she’s a younger person and she makes a great job of the bed. But I personally and again it’s not because of race or colour or anything. I was doing fine with her. It’s because of … on my own level kind of thing that I could maybe get somebody to do some cooking” (M)

“And like, there might be something like say that I use the wrong term in wash down something when we’re not allowed to wash things. But they are allowed to clean the surface. It’s the wrong use

of precise wording especially if it's a foreign person who's more precise in the use of language who suddenly thinks you want to get the whole house polished from top to toe or something. If you have an Irish person coming in there's a little more leeway" (C)

"*Sarah or somebody wasn't available… sick or something I forget. And she had one of these scarves on, of the muslim….type. And…ah… I… she came in to the kitchen. And she stood with her scarf and coat on. And she was a nice little one, inoffensive and all that. So I said will I take your coat? Thinking she might feel awkward or something. And she said Oh no… (laughs)…" (L)

Further expressions of such meaning regarding English language and nationality were expressed by participants within the focus groups. Participants expressed the importance of English language proficiency in terms of a prerequisite for effective homecare. The narrative concerning ethnicity was further emphasised regarding feelings of fear, inconsistency and uncertainty regarding different cultures and the impact this potentially had, on the older person in receipt of homecare. Interestingly, some participants struggled with finding the words to use to convey discomfort relating to ethnicity and appeared conscious of how their views would be perceived. This was evident within focus groups when participants paused, shifted uncomfortably within their seats, and stated that isn't necessarily a negative issue, but rather a notable one which impacts perceptions of homecare:

"Sometimes it's a female; sometimes male… sometimes it's a person that has language…. difficulties" (FG. 1. B)

"That they are friendly and caring… and that they speak English" (FG. 1. A)

"Some older people who are getting help I know… are more scared of a person who doesn't have … I don't want to start considering you know… country wise. They wouldn't have been as exposed to…a mixture of nationalities…. the way to an extent we are at this stage you know… yeah… yeah" (FG. 2. F).

"And not understanding maybe the language……barrier you know and not understanding… as I would call them.. the patient… they would get upset and they don't know what's going on" (FG. 2. A)

“That would be a negative experience… and again.. language… ammm… (pauses)… where the person isn’t able to understand what is being asked of them” (FG.2. B)

“Not that’s there’s anything wrong….. I’m not saying…. But it can be frightening” (FG. 2. C)

“And different cultures as well you know… And if you could understand what they’re saying that’s the biggest issue you know. I mean somebody coming in with broken English and they can’t understand what they’re saying… and if the person is deaf… the person is misinterpreting what they’re saying” (FG. 2. E)

“Ammm… a lot of the Philippino women… the problem is that a lot of them aren’t legal in the county” (FG. 2. B)

The data further depicted a sense of positive prejudice and stereotyping relating to homecare workers from different ethnicities and cultures. This positive prejudice was expressed via participant expression relating to positive care provision and ethnicity. Such perspectives were however limited to focus group participant’s perspectives:

“You know the ones I found that were gifted were the Filipinos and they were absolutely brilliant” (FG. 1. B)

“The best thing for us is some of them are really cheerful especially the African girls. They almost dance around and it’s great. But they very willing and very caring” (E)

“Oh I’ve heard that… they’re meant to be very nice, they’re very caring” (FG. 2. A)

4.2 (3): Phase 1 Theme 3- The Social Needs of Older People

Results asserted that the social contact needs of older people were significant, regarding their homecare experiences and possibly a factor which motivating factor for seeking homecare initially. Within the data, a sense of longing for social contact was expressed by participants. The term loneliness was not articulated specifically within the data for phase 1. Yet the social need of participants was a consistent pattern identified within the data analysis. The significance of homecare in meeting this social need, was further evident. Findings indicated that older people

value the opportunity for socialising and communicating with someone, which is presented by their homecare visit. Ultimately the data analysis indicated that some older people's social needs, were being inadvertently met via their homecare visit. Participants reported that they view the social element of their homecare visit, as a significantly positive aspect associated with the homecare service:

"The fact that you can talk to someone, tell them that such a thing happened in town yesterday, and oh that interesting kind of thing you know? In other words I suppose human contact" (A)

"You could have a day otherwise and you mightn't see a friendly face you know?" (P)

"And the other thing is they're so glad to **see** somebody you know, because again my brother in law, the daughter rings every morning to make sure he's alright. He's living on his own you know… that's important to for the patient… for the carer coming in. Just someone to communicate" (FG. (1). A)

"You would be looking forward to them coming…. Yeah. Cos if you're here,… I was here all day and you would be waiting for someone to come" (J)

"On a down day maybe all you need is somebody to talk to you know" (M)

"The biggest thing I find with it is that it's a cheerful face coming in really" (P)

"And I think that's important as well. I think the social side of things is overlooked. But perhaps we're lucky that we don't need that much material help you know" (E)

"I like to have someone come and talk to me" (N)

"And one week nobody came at all.. it really was upsetting, I mean I was watching the door. No phone call nothing, no…no" (D)

In contrast, some participants were more subtle in expressing their need for social contact, or indeed in conveying the significance of homecare for addressing isolation or social need. This was evident with statements relating to feeling grateful for their homecare visit, and more generally when discussing the significance of having someone to talk to:

“No the home-help is a bit of fulfilment for me you know. I’m grateful for it, it gives me… you know a thing for older people” (B)

“It does sort of give you a quality of life” (H)

“I’m not abandoned, but at the same time it’s nice to have someone you can talk to regularly and that’s very important” (A)

“She used to come and sit and have a cup of coffee with me and talk” (N)

“And you get all sorts of news about their families and sometimes they’ll have a cup of tea” (E)

“The person that they’re with might just need talking you know? Or some reassurance” (M)

Bereavement and loss were further notable within the data regarding social need and homecare. The narrative reflected that the need for social contact met via homecare, may be impacted by a previous bereavement. Participants shared intimate details about their loss of loved ones in their lives and emphasised how this has impacted them. This is significant as no interview questions directly asked about bereavement or loss. Hence bereavement was identified as significant to participants, relating to their perspectives and experiences of being in receipt of homecare:

“I looked after my husband before he died as well…. Cancer and emphysema” (M)

“I used to go out much more. I used to go to church in the morning but someone took me along all the time…but he died. I miss it so much. I only go one Sunday now” (N)

“Aaa… she committed suicide, I found her dead. About three months ago, still at the start of the journey. Her sister sent me her ashes. We both had two different places but we done everything together like” (B)

“On the night my husband died I left that place at 9 o’ clock. And I said if I had a chair I’d stay the night. And they said you should go home and have your night’s rest. And next thing they rang me at 3 o’clock in the morning and told me he died at 1am” (F)

4.3: Results Phase 2

Phase 2 consisted of one-to-one interviews with 20 homecare workers. Seventeen of these participants worked for private homecare companies. Two homecare workers were employed by both the HSE and a private homecare provider. And the remaining participant worked for the HSE. The primary objective for phase 2 was to determine the factors which homecare workers viewed as impacting their provision of homecare to older people. The key themes derived from the detailed data analysis from phase 2 were related to the: emotionally difficult role, feelings of genuine care and finally the impact of isolation experienced by older people. These themes are depicted below in figure 4 (b):

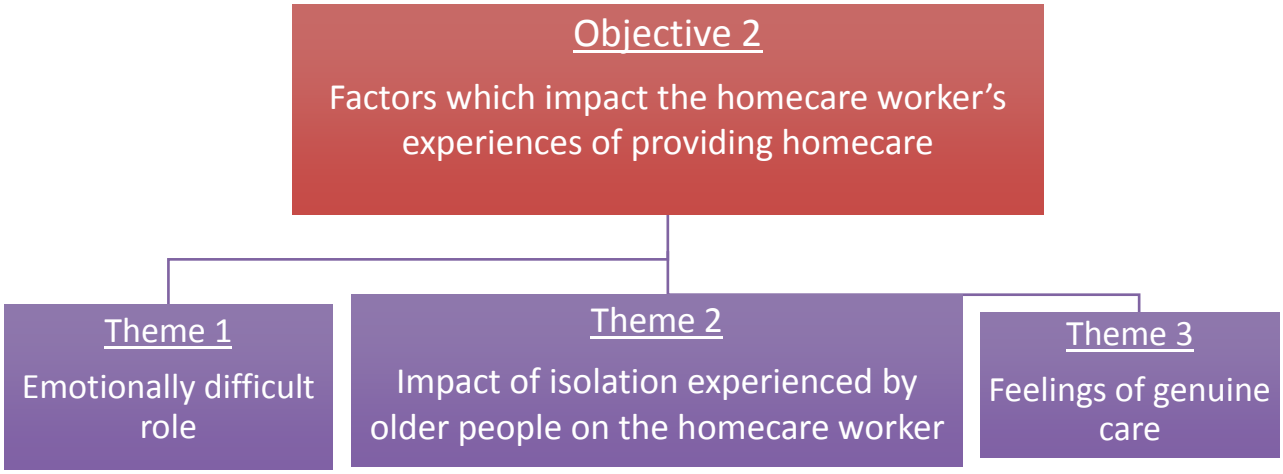


Fig. 4.(b): Themes phase 2

4.3 (1) Phase 2 Theme 1- Emotionally Difficult Role

Participants explained that their role's as homecare workers were often challenging emotionally. Participants expressed feelings of sadness and heartbreak regarding the older people they provide care to who were often alone and isolated. The data indicated that such emotions are experienced by homecare workers both during and after the homecare call and sometimes when they are at home with their own families. The narrative indicates that participants accept some level of an emotional toll as expected within their role as a homecare worker:

"It's sad like their lives really are like just sitting around watching telly or just waiting for the carer to come in and they probably might not see anybody maybe the odd niece or nephew. It's horrible… it's hard looking at people like that" (2)

“It’s soul destroying for me as a carer to go in to someone that you know hasn’t seen anyone… and you know hasn’t had a proper conversation all day. It’s just literally being sat in their chair or their bed just watching tv. It’s because there’s nothing else to do. There’s nowhere to go… there’s nothing to do… they’re just sat around… just existing” (17)

“You know some of these calls are social calls … and.. it’s sad enough” (9)

“The most difficult part I’m finding in the last couple of weeks is … there’s one particular lady that we’re going to… that I’m going to that’s after starting palliative care. And for me it’s just watching her go downhill so quickly. That’s what I find difficult. Apart from that… apart from the rest I’m enjoying it. But it’s to watch them decline so rapidly like” (8)

“When they’re looking for their loved one that’s already passed. I did find a situation where I had to… I felt like I was lying… but I had to we’ll say play along… that he was gone shopping but it was heart breaking. But it kept **her** happy and that was my goal to keep her happy” (13)

“It will break your heart… I mean you could go home thinking about them. You could spend Christmas day thinking about them. But you can’t go to them, you know? Because they expect it and when you don’t do it later on then you’re the one letting them down. Happily I will stay if I can” (11)

Further strengthening the evidence that homecare workers are impacted by the emotional toll of their role, participants discussed the emotional impact they experience, when leaving the home of the older person they are providing care to. Participants used language such as “hard” and “heart-breaking” when describing the feelings and thoughts they experience, when trying to leave the home of some older people:

“They don’t want you to go. And what they do is they constantly ask you to do something when you’re heading out the door and it’s so difficult. So there’s probably 2 calls I might have that they’d say you know you wouldn’t just do this .. you wouldn’t just do that. And it’s not even that they want it done it’s because they don’t want you to go” (10)

“Some days they might need a bit more extra care. If it’s someone you’re very friendly with sometimes it’s hard to get away. You don’t want to be like: I have to go I have to go!” (4)

“Like my …the 96 year old she lives completely on her own. No husband, no family, no children. She’s awful lonely. And like in the last week she’s been quite ill. And when we’ve gone in, she’s got 3 different carers that go in she’s in bed. And she goes: please don’t leave me, please don’t leave me I don’t want to die on my own” (15)

“And it’s hard as a carer to leave. And it’s so bad you see their face just fall…as you’re leaving. And they kind of just go back to sort of… a sunken version of themselves. And… it’s just… I don’t… it’s just one of those things it’s hard to describe and you just kind of get used to” (17)

“Am…would break your heart. Yeah…having to leave. You know, I’ve been in calls before and when you’re going.. oh is it that time already? You know…like if I have nowhere else to go, I will do my log out and I will stay. But you can’t do it all the time” (11)

The narrative further implies that loss through bereavement, impacts homecare workers as an integral part of their role. Findings indicated that homecare workers are negatively affected by the deaths of the older people they provide care to. Participants reported feeling “devastated” and further visibly looked upset when describing an older person they provided care to, who had passed away:

“Now I’ve had a lot of very regular clients and I’ve had one that passed away and I was very upset by it …but I’m definitely happy I had that person all the time, do you know?” (5)

“And when she passed away on me… I was devastated! I mean it was like I had lost one of my own family… it was horrific. And then…they’re gone. You’re 9 to 10 call in the morning is gone…that’s it! (appears a little teary eyed).Yeah it’s difficult… it’s not an easy job…but I do love it …but these parts I don’t like too much” (4)

“And it was only recently she passed away so it was….. it was hard. Cause you know I didn’t realise that I had gotten attached to her. And am… yeah I was actually off for my holidays…cause the last time I saw her I was off for my holidays and when I got back she was in the hospital. And .. you know obviously she passed away there and … just that.. I never got the closure that I needed” (7)

“I said it’s awful sad that she’s gone. And I said I missed her terribly” (13)

"And she only lasted 6 weeks in the nursing home. Yeah… she went very quickly and she was in a wheelchair but she was so independent… so independent" (9)

4.3 (2): Phase 2 Theme 2 - Impact of Isolation Experienced by Older People

One of the most prominent findings within the thematic analysis for phase 2 was the theme of impact of isolation as perceived by homecare workers, as experienced by older people. This perceived isolation was identified as significant in terms of the negative effect this has on the homecare worker within their role. The issue of loneliness was evident within the majority of interviews with homecare workers and this was expressed in terms of the older person's need for social contact and companionship. Results proposed that the isolation experienced by homecare recipients was the most substantial issue homecare workers identified as impacting them in their provision of homecare. Findings further suggested that the isolation experienced by older people may be a catalyst in their seeking of homecare:

"Like companionship is a big part of being a home help and a home carer. Like…you know I've been in houses where they've got no family around. You know they're all off in Australia or America or wherever and they're all alone. So I might be the only face that they see that day. And I might only be in there maybe once maybe twice a week" (17)

"A lot of them it's just companionship. It's just people living on their own and like… just making them a cup of tea and you can see a smile on their face" (8)

"You know some of these calls are social calls … and.. it's sad enough. That's all they might be getting that day that half hour call. And you could be the only person they're seeing that day" (9)

"And to be able to sit down and have a cup of tea with them. Communication is a big thing. They just like to see a friendly face coming in the door and someone to have a bit of a laugh and have a joke with them and have a cup of tea with them. You know?" (12)

"It's not even about cooking the best dinner or making the best cup of tea…it's just someone being there with them. I think that's what's really important to **them**. It's just someone being there and socialising" (13)

“A lot of people I go in to don’t have anybody else or their families are living far away so you might be the only person that they see all day every day” (4)

“Apart from going in and helping them a lot of them need the company” (6)

“Sometimes they just need a companion” (7)

“We just sit down and it might be just watching the television with her. But it’s just the companionship” (8)

“Sometimes they live by themselves so they don’t really have anyone there to support them other than us the carers” (7)

Participants reported that isolation as experienced by older people and its impact on homecare workers, was further expressed in terms of the importance of having a “chat” with the older person. Participants further acknowledged the impact of isolation and their response to this, in terms of having a cup of tea with the older person they are providing care to:

“A lot of them just need company and a chat…and to know that they’re wanted” (4)

“So just being there and having the chat and a cup of tea with them” (7)

“I think some older people… even if they didn’t need any physical help could do with a companionship call” (5)

“Just making them a cup of tea and you can see a smile on their face that would make **you** smile like” (8)

“And they mightn’t see anybody all day long you know?” (10)

“I think it’s a lot of it is just maybe company. And to be able to sit down and have a cup of tea with them” (12)

Homecare workers reported on the social isolation of older people and how this subsequently impacts them within their roles, via reporting on the needs of older people. Participants identified their perceptions of the older person's needs, versus expected or documented needs. The social needs of older people were identified as the most prominent need according to the homecare workers:

"Say in the case of that man now he was down for a light wash or to the commode. And it was literally sit down and talk" (11)

"And they said next of kin… and he said nobody. Absolutely nobody" (1)

"There was one or two who lived on their own and hadn't children or partners that died or husbands or wives had dies. It's sad like their lives really are like just sitting around watching telly or just waiting for the carer to come in" (2)

4.3 (4): Phase 2 Theme 3 - Feelings of Genuine Care

The data suggests that of feelings of genuine care are commonplace among this sample of homecare workers and that their role is more than just a job. The majority of participants described feeling close bonds with older people they provide care to and the data reflects a sincerity in demonstrating genuine care and affection:

"These people become a part of their lives. You can say no I don't care then you stop going there. But once you continue going there over and over again you find that you too yourself become very vulnerable. Because the attachment that forms (laughs)… an attachment problem comes in. You find yourself very protective of them" (14)

"We have a nice relationship too.. but because he's so vulnerable and so lonely I try to… I care about him you know? Because nobody is there for him you know except care workers and some other services" (1)

"And it turned out… he'd dead now 2 years… we got so close. And we used to have the best of laughs" (10)

The data further reflect the theme of feelings of genuine care on the part of homecare workers, in their descriptions of additional care provision without pay, and caring tasks they performed. Such tasks are often far beyond the remit of their professional role. Participants described examples of a genuine wish to meet the unmet needs of some older people, particularly when the older person in receipt of care has chronic health issues, and lives alone:

"And when I started to visit her over the weeks I began to realise she was on her own. And she had no… she was very physically handicapped with arthritis. She couldn't walk without her wheelchair… she could walk very little. So I ended up that I would collect her pension and do her messages and things like that.. for her bits and pieces. I did a bit more than other cases where people wouldn't need me as much. And that's how I became close to her" (6)

"Well one of the regulars would be one of the people who always need something extra done. Or help with something. But she's eighty something…eighty seven years of age and lives alone and doesn't have family around her. So if you don't help her…nobody can. She physically wouldn't be able to do it herself, she uses a rollator, she has ulcers on her legs, she gets very short of breath. And she'd very much depend on the carers" (5)

"Or in the summer the two of us… I would go up to the garage where he lives and get 2 ice creams. And he loved it! I'll never forget the first day I came in with the 2 ice creams cones for him. He lit up like a little boy. He hadn't had one in so long. No one had gotten him one…and it was scorching! He was like a little boy his 2 eyes were like this (makes shocked expression)" (11)

"But I suppose … I was with her 6 years. And she became a friend yeah. It used to be… I'd bring her up to my house and had her for Christmas because she had no family" (9)

Participants further implied that they feel a sense of responsibility to the individual older people they care for. The living alone status of some older people, combined with feelings of genuine care, culminate into an ongoing sense of obligation to be there for them and meet needs when they have no one else to do this for them:

"It's a lot of responsibility in some places where you might be the only person that person has seen all day long. So you just want to make sure they're okay" (2)

“And you know…it’s just……being that attached … the care… that you tend to render to these people is just .. you can’t explain it. And you feel so bad if it’s not given. I think you become very… too responsible for them sometimes to a fault. You know because they’re so vulnerable. They’re so vulnerable I don’t just want anybody to help them. It actually affects me sometimes. If for some reason somebody wasn’t able to go in and do what they’re supposed to do I get very upset. I feel very responsible for them now” (14)

“And those are the two that I’m with for years now and I’ve always said when I’m finished with those …when they’re gone, I’m going to move on and do something else. That’s the only reason I’m staying on (laughs) is for those 2” (15)

The theme of feelings of genuine care towards the older people they provide homecare to, was further expressed with participants describing the satisfaction they derive from their roles. Participants used phrases such as: looking forward to seeing the older person, and feeling fulfilled in their roles:

“Just literally delighted to see you. So I feel I have fulfilled my …you know hour there or whatever length of time I’d be there” (12)

“It’s rewarding. It’s very rewarding cause you tend to find that you’re making a difference in somebody else’s life. It’s very rewarding” (14)

“It’s the satisfaction you get out of doing the job really. It’s funny I’ve been working in homecare a year and I have never compared my wages to my hours you know? I never looked at am I getting enough or stuff like that. So I think it’s just the satisfaction of the job. It’s being able to make a difference you know? “(20)

“I like working with people I just like helping people. Especially if… when I feel that they need help. I just… I just like doing that really. I like to see people happy” (18)

“Do you know you look forward… I don’t consider it work. I look forward to going in to see them in the morning. There’s always a smile and when there’s not a smile you can create a smile somehow you know? They’re great like. So..that’s what keeps me going” (11)

4.4: Summary of Findings

The key findings of this study, derived from the combined data from both phases 1 and 2, present a picture of homecare which is impacted by:

- The isolation of older people
- The importance of continuity of care, and
- The established care relationship

4.4 (1): The isolation of older people

A common narrative within this study was the issue of isolation as experienced by older people, and this impact this had on the homecare visit, and indeed the lives of older people. Phase 1 data alluded to the social needs of some older people, while emphasising the social and emotional benefits of the homecare visit. Older people, although reluctant to use terms such as isolation or loneliness, expressed a distinct acknowledgement of the social impact their homecare visit afforded them. Equally significant, participants from phase 1 expressed the negative impact that not having their homecare visit, had on them.

Homecare workers were much more direct and certain in their perspectives on the social isolation of older people. Participants in phase 2 of this study expressed the ongoing impact of the isolation experienced by older people on the homecare visit, and the emotional impact of this on the homecare worker themselves. Homecare addressing social isolation perhaps indirectly, further emerged as a significant factor which impacts older people. Social isolation was further identified as notable in impacting homecare workers in the delivery of the homecare duties, for example: when trying to leave the home of the older person who is feeling socially isolated, to the tasks they undertake during the homecare visit. Interestingly, the data indicate that sometimes older people need a chat and a cup of tea, as opposed to the more traditional or noted tasks of personal care or domestic duties.

4.4 (2): Continuity of care

The findings support the notion that continuity of care and consistency, are fundamental prerequisites for a positive experience of homecare, particularly based on the perspectives of older people. Results indicate that inconsistency such as having various different homecare workers providing care to 1 older person, causes distress and results in recipients having a more negative homecare experience. Having multiple homecare workers resulted in older people feeling unease, uncertainty and reporting more negative views concerning being in receipt of homecare. Not knowing the time of the homecare visit, the duration that the homecare worker would stay for, or which homecare worker would visit them, negatively impacted the overall homecare experience, based on the findings of this study. Findings demonstrate that inconsistency adversely impacts the perceptions and experiences of homecare. Results implied that continuity of care provision is desirable to promote more positive experiences for older people.

4.4 (3): The established care relationship

The findings of this study indicated that the established relationship which develops between older people and their homecare worker, has been identified by both parties a significant factor which impacts their experiences and perspectives of homecare provision. Both phases of this study surmised that with consistency and continuity of care, both older people and homecare workers are enabled to build rapport with one another. The data asserted that once this rapport is constructed over time, an established relationship develops between older people and homecare workers. This established relationship is one built upon genuine care and one which emotionally impacts homecare workers, and addresses quite uniquely, the social needs of the older person.

The results imply that the relationship between the older person and their homecare worker, is dependent upon the prerequisites of building rapport and maintaining continuity of care. This relationship is simultaneously fuelled by the isolation experienced by the older person, and the emotional impact of this isolation on the homecare worker. Figure 4. (c) below represents the cyclical process of achieving the established care relationship which the data suggests, results in positive experiences of homecare:

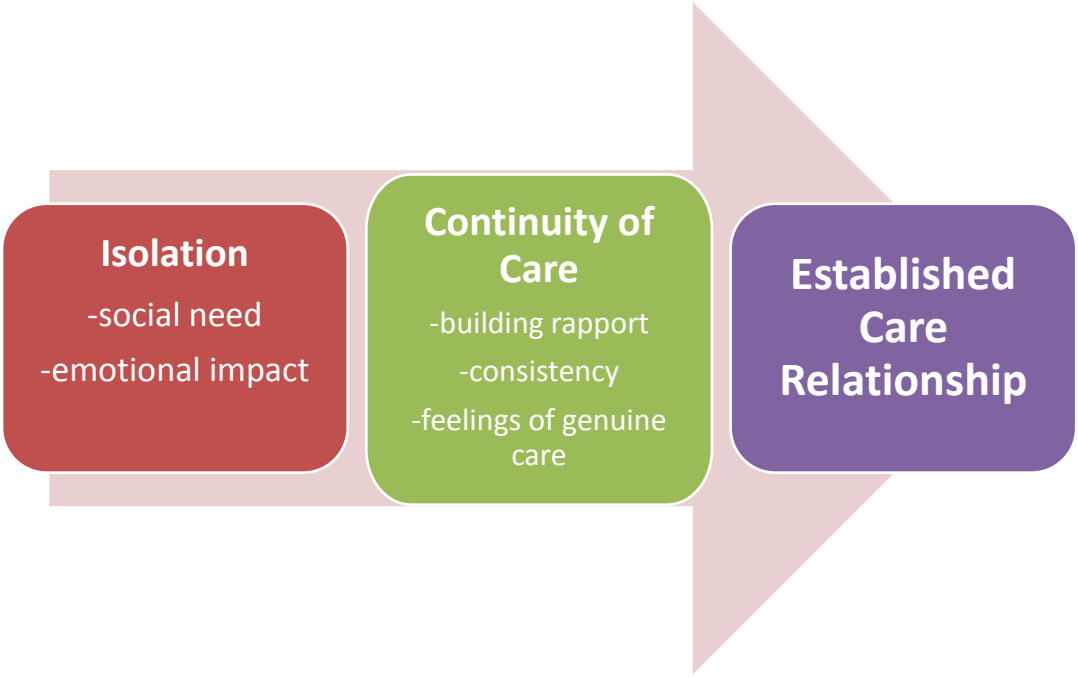


Figure 4 (c) the Process of Homecare

4.4 (4): Findings within the context of Donabedian Quality of Healthcare Framework

The Donabedian Quality of Healthcare Framework DQHF (Haj et al. 2013) was used to inform the scope and breadth of the data collection tool for both phases 1 and 2 of this study. Consequently, the findings of the current study will be the presented within the context of the 3 key domains of the DQHF: structure, process and outcome. Although the DQHF was not prescriptively used within the methodology of this study, it did inform the interview protocol. The DQHF provides a somewhat comparable framework from within which to consider the factors which both homecare workers and older people identify as significant within their experiences and perspectives of both parties. Such ideas presented within the boundaries of the DQHF, will further offer insight pertaining to the homecare service from both an organisational and healthcare lens. Table 4. 1 below presents the key findings of this study which have been found to impact homecare provision, within the context the 3 domains of the DQHF:

Structure	The key finding of: continuity of care appears to be a structural feature of homecare agencies, and culminating in either consistency with older people receiving consistency in care provision, or inconsistency which was identified as a significant issue which impacts older people as recipients of homecare. Inconsistency in care provision was identified as: having multiple homecare workers providing care to one older person, and a lack of clarity from the older person's perspective about what to expect from their homecare visit.
Process	The key finding of: the isolation of older people, impacts the process of homecare provision in an ongoing fashion. The data suggest that older people in receipt of homecare experience isolation, and that homecare offers some respite to this isolation. Homecare workers are continually impacted by the isolation of the older people they provide care to, as they administer their homecare duties. Isolation is an ongoing substantial issue which impacts the process of homecare provision, from the perspectives of both parties within the homecare relationship.
Outcome	The key finding of: the established care relationship between the older person and their homecare worker, represents the outcome, based on the data analysis. Older people and homecare workers identified the relationship they build with one another, through consistency and building rapport, presents a desirable outcome of satisfaction and enjoyment, based on the perspectives of both parties. This comforting, consistent and caring relationship, presents both older people and homecare workers with a sense of success concerning the impact of the homecare visit.

4.5: Summary

This chapter has presented the key findings from this study elicited from the in-depth thematic analysis process. The research question aimed to ascertain the factors older people identify as impacting homecare, based on their unique perspectives. The views of homecare workers regarding issues they view as significant in impacting homecare based on their individual experiences, were further sought.

Findings from phase 1 culminated into 3 key themes which older people view as significant to contributing to both positive and negative experiences of homecare provision: the social needs of older people, inconsistency in care provision, and building rapport. An additional sub-theme of: ethnicity of the homecare worker, was further identified as pertinent to answering the research question and closely related to the theme of inconsistency in care provision.

Results from phase 2 were developed and presented within 3 key themes: the emotionally difficult role, the impact of isolation as experienced by older people, and feelings of genuine care. The data indicated that homecare workers are negatively affected by the emotional toll associated with their role. Findings propose that the social isolation experienced by older people, presents challenges both practically and emotionally for homecare workers as they administer their duties. Finally, the genuine care homecare workers feel towards the older people they provide care too, was identified as a significant factor which impacts homecare workers within their role.

Findings indicated that the social need and isolation of older people, impacts homecare, as established from the experiences and perspectives of both older people and homecare workers. The data further submitted that continuity of care and building rapport are pertinent to a positive experience of homecare according to the participants in phase 1. Findings asserted that homecare workers feel genuine care for the older people they provide homecare to. This study concluded that a culmination of these factors, results in more positive experiences for both parties within the homecare relationship.

Chapter 5: Discussion and Conclusion

5.1 - Introduction

Homecare enables older people to remain living in their own homes and communities as they age (Murphy et al. 2015; Browne 2016). Homecare workers provide practical essential care in the home via the provision of tasks such as assistance with washing, dressing and getting in and out of bed (Kiersey & Coleman, 2017; HSE, 2019). The home as a setting for care is unique and presents both homecare workers and older people with an atypical environment for care delivery, when compared to residential settings (Parks, 2003; Abrams et al, 2019; Herber & Johnston, 2012).

This study aimed to gauge the experiences and perspectives of both older people and homecare workers, pertaining to the homecare service. The voices of older people and homecare workers are central to truly understanding what homecare means at the personal interactional level, as experienced by both groups. It is widely acknowledged that service user and patient feedback is crucial to gain an authentic insight into a service its effectiveness in practice (Nolan et al. 2007; Kenney, 2011; CQC, 2013). Yet the low status of homecare workers within the helping professions (Boris & Klein, 2006), combined with potential health and mobility needs of older people, has resulted in both groups being underrepresented in research to date and considered hard to reach (Sterling et al. 2020). Hard to reach groups are oftentimes marginalised by society due to issues such as age, ethnicity and social class. Yet non-participation in research further maintains such marginalisation, as the experiences and perspectives of these hard to reach groups are often not represented within the evidence base concerning health and social care (Airth & Oelke, 2020: Boris & Klein, 2006).

This study aimed to:

Examine the current delivery of homecare to older people in Ireland from both older people's perspectives, and the experiences of homecare providers.

The key objectives of this study were to:

- Ascertain the views of older people relating to both positive and negative experiences of homecare provision, based on their individual perspectives
- Explore homecare worker's experiences of delivering homecare to older people and examine the factors which impact this care.

A qualitative methodology was employed, with both focus groups and interviews undertaken in phase 1. Focus group participants included older people aged over 65 (7 and 8 participants respectively). Phase 1 further entailed 1-1 interviews with older people in receipt of homecare (14) and family members of homecare recipients (2). Phase 2 consisted of 1-1 interviews with homecare workers currently employed the HSE, a private homecare provider or both (20).

The findings from this study present a picture of homecare based exclusively on the experiences and perspectives of the 2 key parties involved in the homecare relationship. Phase 1 results indicate that the social contact afforded via the homecare visit contributes to meeting the social contact needs of older people, while building rapport with a regular homecare worker is important for them. Participants reported that inconsistency in the homecare worker providing their care, causes distress. Phase 2 data contend that isolation can have a devastating effect on the older person and further presents challenges for homecare workers both emotionally and in the in the administration of their duties. The data from phase 2 suggests that homecare workers feel genuine care for the older people they provide care to and many provide additional care and support in an unpaid capacity.

This discussion chapter will address the primary issues presented by the findings of this study, in the context of answering the research question. The results of this study will be examined and contextualised within the existing evidence base and literature previously undertaken on this topic. The meaning and significance of findings will further be explored within this chapter. The fundamental issues for discussion identified by both older people and homecare workers as impacting their experiences and perspectives of homecare are:

1. Isolation and loneliness
2. The unique nature of the homecare worker role, and
3. Continuity of care

5.2 - Isolation and loneliness

Isolation as experienced by older people in receipt of homecare, arose as a substantial finding within both phases one and 2 of this study. Findings propose that isolation, reported as loneliness, is a fundamental issue which both older people and homecare workers report impacting their experiences and perspectives of homecare provision. Older people expressed how their need for social contact is met within the interactions afforded via their homecare visit. Building rapport and

getting to know their regular homecare worker, was reported by older people as resulting in greater levels of satisfaction with their homecare service, and a sense of having a connection or relationship with their homecare worker. Phase 2 data presented a picture of isolation from the homecare worker's perspectives and illuminated both the practical and emotional impact of this on the homecare workers.

The issue of isolation as experienced by older people was reported and expressed quite differently, by both older people and homecare workers. Participants in phase 1 alluded to experiencing isolation through sharing experiences of bereavements they had suffered and in reporting their wish for greater social contact in their lives. Older people further articulated the positive impact the social contact element of their homecare provision, presents for them. Findings suggest that for some older people, their homecare visit is their only form of social contact. Many participants reported looking forward to seeing their homecare worker and having someone to talk to.

In contrast, homecare workers in phase 2 were much more direct in their interpretation of isolation experienced by the older people they provide care to. The data submit that the social contact need of many older people in receipt of homecare is substantial and that many recipients of homecare within this sample, spend the majority of their time alone. Findings propose that homecare workers find the isolation experienced by older people quite a distressing and emotionally challenging aspect of their role. Homecare workers report that having a cup of tea and taking the time to sit and talk to the older person, is a significant necessary element of their role. Yet the social contact needs of older people are not considered within the homecare remit, and consequently homecare workers spend additional time in an unpaid capacity, to address this.

The most prominent novel idea stemming from this data, relates to the notion that isolation profoundly impacts both older people and homecare workers, within the context of homecare provision. Findings suggest that homecare is addressing social isolation and fulfilling the need for social contact exhibited by older people. Availing of homecare presents an opportunity to address the social contact needs of older people, without them having to definitively express feeling isolated or lonely. Evidence pertaining to an increase in frequency of visits to emergency rooms and GPs, in an effort to alleviate loneliness for older people, further substantiates the findings within the current study (Gerst-Emerson & Jayawardhana, 2015; Cheng, 1992). Some older may people feel little options are available to them in attempting to address their loneliness, so may seek opportunities to

access services which meet this for social contact indirectly. Health and social care services present such opportunities (Blayzer & Ryerson, 2020; Gerst-Emerson & Jayawardhana, 2015).

Considering the significance of isolation as it pertains to older people in receipt of homecare, previous literature has identified that social isolation is indeed more prevalent for people as they age (Menec et al. 2019). The findings from both the Irish and Canadian longitudinal studies on ageing suggest that older people who live alone and older older people, are particularly at risk of experiencing social isolation (Ward et al. 2019; Menec et al. 2019). The methodology of the Irish study was mixed methods in nature and consisted of interviews and questionnaires. The TILDA data were gathered at intervals of 2 years and 8504 participants were included (Kenny, Turner & Donoghue, 2018). The Canadian study adopted a qualitative methodology consisting of telephone and in-person interviews with 50,000 participants, and with intervals between follow ups of 3 years (Menec et al. 2019).

Consistent with the findings of the current study, Ivanova and Dykstra (2015) argue that older people without family members are more likely to rely on homecare services to enable them to age in place. Life events such as bereavement, loss of social opportunities and retirement from the job market, can culminate in social isolation for some older people, based on a systematic literature review by Bekhet, et al. (2008). Nicholson (2012) in their systematic literature review found that health issues such as incontinence and hearing loss can further contribute to the social isolation experienced by older people. Hence the literature to date supports the notion that older people in receipt of homecare may be more socially isolated due to the aforementioned issues of health, bereavement, childlessness or other circumstances, which mean they are living far away from family members (Carr, 2018; Bekhet et al. 2008; Ivanova and Dykstra, 2015).

Equally the literature concerning what it means to be isolated and lonely are important in the context of the current study. Isolation is defined as lack of social connectedness or the opportunity to feel socially supported and engaged (Zavaleta et al. 2017; Hawthorne, 2006). Zavaleta et al. 2017 argue that isolation is quantifiable and concerned with the measurement of the frequency of contact with other people. Indeed this was the method employed to measure isolation within the largescale CLSA, which examined the frequency of contact with family, friends, community/church gatherings, in addition to marital and living alone status (Menec et al. 2019). Contrastingly, Victor et al. (2007) contends that social isolation is somewhat subjective, similar to loneliness, and based upon the individual's expectation of their social need, in the context of the frequency of their social

interactions. In essence, this will be very distinct from person to person, and based on their unique needs and expectations (Victor et al. 2007).

While the terms isolation and loneliness are often used interchangeable, there is a clear distinction between these terms within the literature (Klinenberg 2016; Fischer, 2009). Loneliness is described as the negative feelings and emotions which arise, when the individual's wish for social contact and closeness with another person are not met (Tilvis et al. 2011 Berg-Werger & Morley, 2020; Taylor, 2020). The theme of building rapport which emerged within phase 1 based on older people's experiences, could be construed as their attempt at making a connection and building a relationship with their homecare worker. Such a relationship may serve to perhaps alleviate the social isolation they face and mitigate the negative emotions associated with this.

Loneliness may be felt when one's desire for social contact and connection is less than that available (Dahlberg, 2009). Such understandings of loneliness propose that the individual must express to some extent that they are feeling lonely for it to be perceived or understood externally, as it's subjective to the individual. Whereas isolation is more objective and may be measured externally, based on the frequency of opportunity for social contact (Gierveld et al. 2018, Pettigrew et al. 2014). Loneliness was the term used most frequently by homecare workers when discussing the social contact need and isolation experienced by the older people they provide care to. For example: within phase 2 the data contend that some older people ask directly for the homecare workers to stay as they don't want to be alone. Or the older person may request additional tasks to be undertaken, as the homecare worker is trying to leave. Such instances were construed as expressions of loneliness by homecare workers, as opposed to social isolation. It could be argued that much like the literature concerning isolation and loneliness, that homecare workers may have used the term loneliness as a synonym for isolation (Fischer, 2009; Klinenberg 2016; Tilvis et al. 2011). Within this study homecare workers when using the term lonely, made reference to the older person being alone without social contact, as opposed to describing negative emotions or feelings expressed by the older person concerning this lack of social contact.

Findings suggest that older people value immensely the social contact element of their homecare visit and indicated that this also meant someone would be coming to visit with them. Such findings could be interpreted as an expression of feeling lonely or socially isolated and wanting or needing more frequent opportunity for social interaction and connection. Although indirectly, the older person is communicating their need for a greater level of social interaction. The value older people

placed on their homecare worker taking the time to sit down and talk to them or have a cup of tea, further indicates their wish for social contact.

In Ireland, there are services specifically aimed at addressing loneliness experienced by older people in the form of visiting services either in the home or via a phone call (Friends of the Elderly, 2020; ALONE, 2020). Yet availing of such a service requires the older person to self-disclose their desire for greater social contact or feelings of loneliness. The stigma associated with loneliness may dissuade some older people from self-disclosing their social isolation, as this may be perceived as a social failure (Olds & Schwartz, 2009; Perlman & Joshi, 1987).

5.2 (1) - The changing homecare role

The evolution of the homecare worker's role over the past 5 decades since the inception of the home-help department, is further notable within the context of understanding isolation and loneliness as it pertains to homecare. Having been historically provided by the Catholic Church via voluntary organisations, the establishment of the home-help department in the 1970's signified the shift from charitable provision, to a more streamlined and formal service provision (The National Council for the Aged, 1983). Yet at the inception of the home-help service, the remit of the homecare worker very much incorporated the social and companionship needs of older people. This was evident with a publication by Deevy in 1983, which described the home-help as housewife who could provide a listening ear to an older person in her care. Deevy (1983) described the home-help service a good neighbour approach based on love and understanding. The companionship element of homecare provision remained throughout the 1980s and 1990s and in fact this befriending element of the homecare remit, was widely accepted as a niche within the spectrum of services for older people in Ireland (NCAOP, 1994; Haslett et al. 1998).

Yet as the homecare service evolved, gradually the social and companionship element of this service dissipated (HSE, 2020, Kiersey & Coleman, 2017; HSE, 2019-b, Citizen's information, 2013). The remit of homecare workers evolved to become much more specific and associated solely with essential tasks relating to personal care or indispensable domestic duties, according to the scoping review regarding the feasibility of the regulation of homecare in Ireland, undertaken by Kiersey and Coleman (2017). Equally the impact of neoliberalism on the homecare market in Ireland is significant, concerning the scope and boundaries of the homecare role (Hudson, 2016). The current quasi market system means that private homecare providers are competing for HSE contracts for out-sourced homecare hours (Phealan et al. 2018). This results in the most efficient and cost-

effective tenders being successful, which at the coal face of service delivery, means who can get the most done in the least amount of time possible (Mercille, 2017; England et al. 2007). Neoliberalism promotes the increased privatisation and financialisation of the homecare market, veering away considerably from the good neighbour approach which initially informed the establishment of formal homecare services, to a profitable and competitive sector within Irish society (Mercille, 2017; England et al. 2007). The neoliberalist approach to homecare in Ireland has likely contributed to the isolation experienced by older people, as this may have influenced the extent to which homecare workers can meet the social needs of the older people they provide care to, within their official homecare role (Donnelly et al. 2016; Garrett, 2017).

Yet notably, findings of the current study suggest that many homecare workers do provide additional care in an unpaid capacity, in an effort to meet the unmet social contact needs of the older people they provide care to. The findings within this study suggest that homecare workers go the extra mile despite their limited job description, and perceive themselves to provide the companionship and time, older people in receipt of homecare may need. Such findings have been previously identified within the literature (Abrams et al. 2019; Turner et al. 2018). Indeed Lundstrom and Mc Keown (1994) in their cornerstone study of the home-help service in Ireland, found that many homecare workers provided additional care and support in an unpaid capacity, out of genuine concern for the welfare of the older people they provided care to. More than half of the 194 participants within this study reported the significance of the social contact their homecare visit afforded them, and further used familial terms in describing their homecare worker (Lundstrom & Mc Keown, 1994).

5.2 (2) - Ageism

Ageism as a contemporary social issue which impacts older people and the societies within which they live and interact, may further contextualise the findings of the current study concerning the isolation experienced by older people. Ageism is the prejudice or unfair treatment of an individual or group, because of their age (Officer et al. 2016). Ageism at the macrosystem is manifested in the unfavourable treatment of older people within society more broadly, and within the government and societal response to ageing and the care of older people (Darling 2007; Bettis et al. 2020; Bronfenbrenner, 1979). Concerning the findings, ageism may be a causal factor in the lacklustre response to date concerning the regulation of the homecare sector in Ireland and in responding to the social isolation experienced by older people. Ageism within the context of the significance of isolation for older people in receipt of homecare, could manifest in a collective acceptability of

isolation for older people as they age and a consequent lack of societal and governmental action to address this (Officer et al. 2016). Previous research supports such ideas and Chew-Graham et al. (2012) propose that older people themselves expect a reduced quality of life and an increase in suffering as they age. Chew-Graham et al. (2012) conducted secondary data analysis utilising a new conceptual framework concerned with access to services for older people. The research team included a primary investigator from both original studies which adopted qualitative methodologies and consisted of 31 semi structured interviews with older people. Data were reanalysed based on these 2 qualitative studies, using this newly developed analytical lens (Chew-Graham et al. 2021). Pikhartova et al. (2016) reiterate such sentiments and contend that the normalisation of loneliness for older people is problematic, based on the English Longitudinal Study of Ageing (ELSA). This study adopted a qualitative methodology and used computer assisted interviews to collect data from 4465 people aged over 50. Due to the longitudinal nature of the ELSA, subsequent data collection revealed that 8 years later, 95% of participants who expected to feel lonely as they aged, reported actual loneliness (Pikhartova et al. 2016). Pikhartova et al. (2016) report that expecting loneliness as one ages, substantially impacts the likelihood of future loneliness for older people.

Indeed it could be argued that the normalisation of isolation and loneliness experienced by older people is Ireland, is further maintained within to the absence of a governmental response to combat this. The Loneliness Taskforce established in 2018 in Ireland called for the Government to appoint a minister with specific responsibility for loneliness. They further called for action from the government to address loneliness via funding and the development of appropriate supports, to adequately respond to this contemporary social issue affecting older people (Loneliness Taskforce, 2018). At the time of writing, neither of these recommendations have been realised. ALONE (2020) assert that insufficient funding and resources have culminated into the social contact needs of some older people remaining unmet. It is plausible to suggest that this may result in some older people accessing homecare services, in an attempt to have their need for social contact met.
Schrimer and Michailakis (2015) propose that loneliness is a consequence of societal impact on the individual and is socially constructed. From such a perspective, society has a moral responsibility to respond to this issue. Irish policy however, is largely devoid of acknowledgement concerning loneliness as a social problem and lacks any strategies which address this specifically (DOH, 1994; DOHC, 1998; DOHC, 2001). Indeed Ward (2019) via examination of TILDA data asserts that isolation levels in Ireland, for older people did not decrease over a 6 year period. Such inaction to date from the Irish Government in essence, communicates an acceptability of the isolation experienced by older people and further maintains the existing circumstances found within the current study.

5.2 (3) - Life course theory

The literature pertaining to life course theory further assists in appraising the finding concerning the building rapport and the social needs of older people. Life course theory which initially developed by Elder (1988), postulates that early life events result in cumulative advantage or disadvantage as we age. Life course theory offers a lens from which to view the development of the individual across the lifespan, based on the premise that major life transitions (marriage, having children, level of education) can enable us to estimate correlating trajectories or occurrences later in life. Life course theory further provides theoretical understanding and insight pertaining to isolation and loneliness as experienced by older people in receipt of homecare. Life course theory contends that previous life transitions culminate into somewhat predictable trajectories or outcomes later in life (Crosnoe & Elder, 2002; Elder, 1998). Elder (1998) alongside Mc Donald and Thomas (2013) argue that advantages or disadvantages at each stage in the life course, enable the estimation of cumulative outcomes with greater certainty.

Based on a life course perspective, older people may find themselves isolated due to earlier life events such as whether or not they married, had children, educational attainment or employment history. Concerning loneliness, TILDA found that lower educational attainment was a risk factor for isolation in later life (Ward et al. 2019). Ward et al. (2019) found that 36.1% of 6, 686 participants who completed only primary school education, were in the “most lonely” category, compared to 32% of participants to had completed secondary school. Such findings strengthen the use of life course theory to understand how previous life events culminate to impact people as they age. This is relevant to contextualising findings from the current study, as homecare workers reported that many of the older people they provide care to, live alone. The issues of social isolation and loneliness are particularly problematic for many of the older people in receipt of homecare. Findings from the current study suggest the impact of social isolation of older people on the homecare worker, was a significant factor which impacted their experience of homecare provision. Results further suggest that older people in receipt of homecare value and need the social contact their homecare visit provides.

The linked lives principle of life course theory in particular, may assist in presenting understanding for why some older people find themselves in need of formal homecare supports as they age. This could be useful from both a service planning and policy perspective, in addition to presenting homecare workers with a greater insight into the lives of the older people they provide care to.

Linked lives asserts that individuals are intrinsically linked and impacted by their relationships with other people, eg. grandparent status, spouse etc. (Elder, 1998). An interdependency develops whereby individuals are impacted by the life occurrences of those they share their lives with, and such interdependency creates meaning and purpose (Gilligan et al. 2018; Setterson, 2015). For example: an older person with adult children or grandchildren living nearby, will likely be positively impacted by these relationships and potential care provision, hence may not need to utilise homecare services to remain living at home. Conversely an older person with no family members or friends, will undoubtedly be more dependent on formal homecare services. Hence the relationship with their homecare worker may be much more meaningful and purposeful, as they have no existing familial links. Based on life course theory, an earlier life transition has set in motion a series of events which has culminated into the current presentation of the older person, ageing alone and without family members (Elder, 1988). An example of such transitions may be not marrying, due to one's sexuality and the acceptability of same sex relationships within society at that time. Or an older person who lost a spouse due to an illness which wasn't treatable due to the timing of their lives such as Tuberculosis. A final example could be an older person who was orphaned at a young age, and the impact this subsequently has on them across their lifespan.

However there are also criticisms of life course theory and its accuracy. Both Hendricks (2012) and Thornton (2005) argue that life course theory is far too broad and results in generalisations which can culminate into prejudice or stereotyping. Hendricks (2012) contends that life course theory is unreliable and should be considered with caution, as opposed to being accepted as absolute. Nonetheless, life course theory does offer plausible ideas for the significance of the relationship and connection presented via homecare, for older people who live alone (Elder, 1998).

5.4 - Unique Nature of Homecare Worker Role

The findings of the current study emphasise the unique nature of homecare work. The experiences and perspectives of older people within phase 1, combined with findings from phase 2, present a picture of the quite distinctive nature of homecare provision. Results highlight the uniqueness of the homecare worker role, due to the feelings and emotions this evokes, in addition to the genuine care they express towards the older people they provide care too. Results indicate that care provision in terms of additional and specific tasks, places homecare work in an unprecedented realm concerning its comparability to other health and social care roles and often the boundaries are blurred. The HSE (2019) describe the homecare worker's role as completing tasks concerned with personal care, washing, dressing and assisting the older person to get in/out of bed. Yet it is the intimacy of such

tasks, combined with the home as a setting and the needs of the older person, which make this role unique. Other professionals provide care in the home such as nurses, occupational therapists or social workers, are governed via specific regulation and requirements for registration with both the Nursing and Midwifery Board of Ireland and CORU, the health and social care regulator (Nursing and Midwifery Board of Ireland, 2022; CORU, 2022). Homecare workers are unique within those who provide care in the home, as the sector is unregulated (Kiersey & Coleman, 2017). It is plausible to suggest that the omission of regulation and regulation requirements for homecare workers to date, may be a factor in differentiating them from other professionals who also provide care within the home as a setting.

5.4 (1) - Additional care

Findings propose that the unique and distinctive nature of homecare indeed impacts the experiences and perspectives of both older people and homecare workers. Results indicate that the genuine care homecare workers feel towards the older people they care for, is sometimes expressed via the provision of additional care in an unpaid capacity. Patterns were evident within data which suggest that many homecare workers undertake additional tasks for older people, particular those living alone without family members. Examples of additional care and support within the data include: being available outside of their regular homecare hours and doing things that family members would do such as buying an ice-cream for the older person or inviting them to Christmas dinner. Such examples within the data emphasise the flexibility of boundaries within homecare work, based on the needs of the older person.

Such findings mirror those of Haslett et al. (1998) in their Irish study. This study's aim was to consult with the public concerning the feasibility of regulation for the homecare sector. Haslett et al. (1998) employed a qualitative methodology consisting of interviews and focus groups with 100 homecare workers and 64 older people in receipt of homecare, in addition to: 114 public health nurses, 40 home-help organisers, 68 informal carers and 144 other health and social care workers. This study found that older people develop an attachment to their homecare worker and value this relationship immensely. Parks (2003) concurs and argues that the home as a setting creates additional challenges for homecare workers as such meaningful relationships occur. Park's book is based on her own practice experience as a homecare worker, and she argues that unpaid additional work is commonplace in homecare, yet is often unnoticed and undocumented (Parks, 2003). Kihlgren et al. (2013) reported similar findings within their qualitative research, consisting of 30 interviews with older people in receipt of homecare. They concluded that the relationship which develops between

the older person and their homecare worker, contributes to a meaningful life from participant's perspectives (Kihlgren et al. 2013).

Equally the findings propose that homecare workers and older people build meaningful relationships and describe one another with terms of endearment such as: like a mother, daughter or friend. The issue of responsibility towards the older person in receipt of care, arose frequently within the findings and particularly for homecare workers visiting older people who were living alone. Within the literature, Boener et al. (2017) through the qualitative study with 200 homecare workers, found that meaningful relationships develop between older people and homecare workers. Such meaningful relationships and close relationships are discouraged in more professional environments, yet culminate into greater job satisfaction for homecare workers (Boener et al. 2017).

5.4 (2) - Emotionally difficult role

The findings of the current study pertaining to the emotionally difficult role of the homecare worker, further substantiate the unique nature of the homecare worker's role within the health and social care sector. Participants in phase 1 reported homecare giving them a quality of life, giving them something to look forward to and providing someone to talk to and have a cup of tea with. Such impacts are not typical of health and social care service provision and further illuminate the uniqueness of homecare work. Findings propose that the homecare worker and older person build familiarity, and this further contributes to the unique value placed on this relationship by older people. Many homecare workers provide care because they want to, they feel a sense of responsibility to meet the needs of the older people they care for and it's much more than just their job.

These findings concerning the uniqueness of the homecare worker's role are consistent with previous research by Lundstrom and Mc Keown (1994) who found that older people in receipt of homecare often used familial terms when describing their homecare worker. Interestingly Lundstrom and McKeown's study was undertaken almost 30 years ago, yet these two distinctive findings pertaining to the uniqueness of the homecare worker role remain consistent between these 2 studies.

Previous Irish research by both Haslett et al. (1998) in their public consultation and Dempsey et al. (2016) via their mixed methods study, acknowledge the social contact and companionship element of the homecare service as unique, which is consistent with the findings of the current study.

Interestingly the study by Donnelly et al. (2016) which conducted focus groups with 23 older people in receipt of homecare and questionnaires with 242 homecare workers, reported that should additional time be allocated to homecare visits, homecare workers would use this time to talk to the older people they care for. Such findings substantiate the unique nature of the homecare worker's role concerning companionship. Mc Donald et al. (2019) with their study also conducted in Ireland, found that key stakeholders within the homecare sector feel that getting to know the older person and forging a companionship between the two parties, is an aspect of the role which is not factored into the ridged timelines and scheduling of the homecare visit. Their study was qualitative in nature and consisted of focus groups with 104 participants, 58 of whom were relevant stakeholders (family members, homecare workers, voluntary agencies, nurse and social care managers and policy planners) and 46 older people in receipt of homecare (Mc Donald et al. 2019).

5.4 (3) - Boundaries

Literature on home as a setting in comparison to the more traditional boundaries of health care settings, further provides possible insight and understanding pertaining to the unique nature of homecare work. The intimacy of the home as the setting for care provision has previously been documented by Parks (2003) and Abrams et al. (2019). Both contend that the unique challenges and opportunities are presented for homecare workers by this very distinct setting for care. A greater flexibility regarding boundaries is necessary within the non-typical setting of the home as the place of care provision (Parks, 2003). The literature asserts that when compared to the more traditional boundaries which exist in more typical health and social care settings, boundaries within the home as a setting are often more diverse or even omitted (Parks, 2003; Abrams et al. 2019; Nasol & Franscisci-Menchaves, 2021). Parks (2003) contends that women as caregivers face moral and ethical challenges within homecare, as they both want and feel the need to meet the needs of those looking to them for care. Parks (2003, p. 58) describes homecare as "exploitation of women's sense of responsibility for others" and argues that she herself as a homecare worker spent additional time with older people in an unpaid capacity. Boundaries are much less clear when this moral sense of responsibility is present and women feel both internal and societal pressure to provide care seamlessly (Parks, 2003). However, Park's argues that this is often at their own expense both financially and emotionally (2003).

Research by Guarnizo and Rodriguez (2017) further substantiate the findings of the current study with their research, which was qualitative in nature and examined the experiences of people who had employed someone for domestic help in their home (Guarnizo and Rodriguez, 2017). Through

interviews with 227 participants, Guarnizo and Rodriguez (2017) found that the greater the intimacy of tasks undertaken, the greater the level of informality which occurs between the older person and their homecare worker. They concluded that domestic help in general, and any help provided within the home (as opposed to outside) resulted in greater levels of informality between staff and family members (Guarnizo & Rodriguez, 2017).

The MCRI (2015) report that the blurring of lines between the formal and the informal is common within the homecare sector, due the unique nature of the home as a setting. Such ideas further contextualise the current findings relating to genuine care on the part of the homecare worker, towards the older person they are providing care to, and the unique nature of their role. The literature supports the idea that the blurring of boundaries is quite unique to the homecare worker's role, consistent with results from this study.

5.4 (5) - Gender and relationships

The literature suggests that women feel an inherent sense of obligation to provide care and society reinforces such expectations of care provision from them (Ruiz & Nicolas, 2017; Esplen, 2009). At a macro level the societal gendered expectations of care provision by women, undoubtedly contributes to the unique nature of the homecare worker's role. Rubio-Marin, (2016), Epslen (2009) and Sharma et al. (2016) report that women are socially and culturally expected to provide care based on their gender, and such norms are further evident within the statistics concerning women and men employed within the health and social care sector (Block et al. 2019; CSO, 2016; 2019).

Such societal pressure to provide care can manifest in caregivers feeling guilt and providing additional care and support, in an effort to try to meet any unmet care needs (Gill-Monte, 2012). Delp et al. (2010) alongside Moore and Hayes, (2017) corroborate the findings of this study arguing that homecare workers often spend additional time, unpaid, in the home of the older person. This was based on their qualitative research via 1-1 interviews with 14 homecare workers. Previous research by Abrams et al. (2019) gathered via interviews with 30 homecare workers and 14 homecare managers, is consistent with the current findings regarding the emotionally onerous role of the homecare worker. Abrams et al. (2019) contend that the societal and gendered expectations on women concerning care provision, normalises the emotionally challenging element of the homecare worker's job. They further argue that flexibility concerning boundaries is essential when providing care in non-typical workplace settings such as in the home (Abrams et al. 2019).

Francis and Netten (2003) found similar results within their study regarding the genuine care many homecare workers report and illustrate within their roles. Previous studies identify the vocational element of choosing homecare as employment, as a momentous factor which culminates into the genuine care homecare workers demonstrate within their role (Witter et al. 2018; Atkinson et al. 2016). Vidman and Stromberg, (2018) reiterate such ideas and surmise that homecare workers derive satisfaction from feeling like their work is having a positive impact, and such satisfaction further motivates homecare workers to continue providing this care. Some homecare worker's "personal values may predispose them towards caring for others regardless of material rewards" (Turner at al. 2018, p. 2). Such findings were further evident within the current study, with homecare workers describing attachment and closeness with the older people they provide care to. The predisposition to caring was equally evident via homecare worker's expressions of their role not feeling like a job and of deriving satisfaction from helping people.

The vulnerability of both older people and homecare workers, combined with the informality of the home as a setting for care, may be a catalyst in the development of a relationship between the parties. Previous research suggests that both older people and homecare workers may be marginalised and disadvantaged due to their ethnicity, socioeconomic status and health needs (Woolhead et al. 2004; Nasol and Franscisci-Menchaves, 2021). Such vulnerability and marginalisation, combined with the inimitable setting of the home of the older person as the place of care provision, lends greater opportunity for close bonds to develop between the parties, and consequently for the emotionally challenges this may present (Abrams et al. 2019). Homecare workers may actively aim not to form attachment to the older people they care for, in an effort to maintain boundaries and protect themselves emotionally. Yet this result is inevitable for some as they engage daily in this "emotional labour" (Abrams et al. 2019, p. 1976). This reiterates findings from the current study which suggest that homecare workers feel additional responsibility and protectiveness towards the older people they care for, when they become close. This study found that this closeness and sense of responsibility felt by the homecare worker, is often expressed via additional tasks of care being provided.

In contrast to the findings of this study pertaining to the uniqueness of the homecare worker role and the impact of this role on the lives of older people, the literature reviewed cites the formal remit of the homecare worker as solely concerned with essential tasks (Kiersey & Coleman, 2017, Government of Ireland, 2020; HSE, 2019). The HSE (2019) outline the role of the homecare worker as meeting the personal care needs of older people and give the examples of providing showers,

assisting with getting dressed and with assisting the older person with getting in and out of bed. Yet research by Austin et al. (2006) and Ayalon and Roznier (2017) are consistent with the current findings and they report that the homecare worker often meets the relationship needs of older people in their care, and that such closeness and meeting of needs results in satisfaction. Kihlgren et al. (2014) in their findings argue that homecare can present meaningfulness to the lives of older people. Kihlgren et al.'s (2014) findings mirror those of the current study and contend that the relationship between the homecare worker and older people is indeed a unique one, where the homecare workers knows the needs and preferences of the older person like no one else. Although notable is the small sample size of their study which consisted of interviews with 15 older people (Kihlgren et al. 2014).

5.4 (6) - Ageing in place

Literature concerning ageing in place, further assists in contextualising the current findings regarding the unique nature of the homecare worker role. Ageing in place relates to the older person remaining in a place of familiarity, where they find meaning and where they feel connected, as they age (Barrett et al. 2011; Stones & Gullifer, 2014). Ageing in place relates to not just the home of the older person, but also the wider community where they live and feel connected to (Wiles et al. 2012). The literature asserts that the home is a place where rituals and routines occur and a sense of belonging is felt (Lengen & Kistemann, 2012; Clarke et al. 2018). Ageing in place is often seen as a key expression of choice and control for older people in choosing to remain in their own home and maintain their connection to this place of familiarity and comfort (Cutchin, 2013). Yet ageing in place is highly dependent upon the availability of support and assistance and consequently, may not be choice based for older people without a support network (Cutchin, 2003). Indeed the role of informal carers has been identified as substantial in enabling older people to age at home (McGarrigle & Kenny, 2020).

The IPH (2018), Ambrugo et al. (2020) and Kuzuya, (2011) concur with such findings and reiterate the significance of having informal care from family, friends and neighbours, in facilitating the older person to remain at home and avoid admission to long-term stay settings. Pertaining to the findings of the current study, ageing in place and the literature surrounding this concept, illuminate the role of informal care in the enablement of older people to remain at home. Yet for many of the older people both interviewed, and discussed via homecare worker's interviews, such informal care provision is non-existent. Many of the older people interviewed and in receipt of homecare provision, live alone and rely solely on formal homecare provision. Nonetheless this place of

meaning, rituals and belonging is where this formal care provision is occurring. Hence such profound meaning and connection is maintained and to an extent enabled, during and via the homecare visit. This enablement to remain living at home offered by homecare support, combined with the sense of place and belonging presented by ageing in place, could cumulatively contribute to the unique nature of the homecare work.

5.4 (7) - Choice and control

The literature pertaining to choice and control, further illuminate the findings of the current study regarding the uniqueness of homecare work. Choice and control are key facets of health promotion which aims to support individuals to increase autonomy over their own lives (WHO, 1986). Relating to older people, choice and control relates to decisions about care and having sufficient support and enablement to make such decisions (Coulton et al. 2006; Netten et al. 2011). Within this vein, choice theory coined by Glasser (2004), asserts that people adapt their behaviours, in an effort to maintain choice and have their most essential needs met. Lecei and Leoicnik, (2014) alongside Glasser (2014;2020) contend that love and belonging are the most primitive of needs and that individuals will actively seek relationship building, in an effort to meet this need. Based on this premise, it could be argued that such a need for love and belonging on the part of the older person, could be a catalyst in creating the unique nature of homecare work. The older person may be adapting their behaviours to establish a bond or closeness with their homecare worker, in an effort to feel this sense of belonging and should they not experience such a relationship within their own family and social network.

5.5 - Continuity of Care

Results from this study highlight the significance of consistency and continuity of care for older people, as a key issue which impacts their experiences of homecare. Findings indicate that older people both want and need consistency regarding their homecare provision, in terms of having the same homecare worker providing their care. Findings emphasise the negative impact of inconsistency on the older person in receipt of homecare. Results suggest that inconsistency creates and maintains uncertainty for the older person and a lack of clarity concerning what to expect from their homecare visit.

5.5 (1) - Staying at home

The results further demonstrate the crucial role of continuity of care, as it pertains to building rapport between the older person and their homecare worker. Findings suggest that older people

value this element of homecare provision immensely and that having continuity in terms of the same homecare worker, enables this building of rapport to develop. The results propose that continuity of care affords the consistency necessary for a relationship to develop between the older person and the homecare worker, and this is an issue older people deem especially important in creating a positive experience of being in receipt of homecare. It is plausible to suggest that continuity of care further offers reassurance for older people concerning their capacity to continue receiving homecare and remain living at home. Research undertaken in Ireland supports the notion that informal care provision and support is a vital prerequisite to enable older people to remain living in their own homes and communities as they age (Timonen & Doyle, 2008; Donnelly et al. 2016). Hence older people who lack such informal support networks often find themselves more dependent on formal homecare supports services, to age at home for as long as possible. The risk of nursing home admission is higher for these older people relying solely on formal homecare provision according to Sage Advocacy (2020).

The NESC (2012) conducted stakeholder research concerning homecare in Ireland and interviewed 13 stakeholders representing managers and staff from the public, voluntary and private homecare sectors. The NESC (2012) found that some older people had unmet care needs, due to the availability of homecare where they live. This lack of availability of homecare services is problematic in Ireland and does indeed culminate into premature nursing home admission (Sage Advocacy, 2020). Consequently, the need of continuity of care and greater consistency in care provision as identified within the findings of the current study, may be related to the reliance and dependence of older people on homecare support. Homecare support enables older people to remain living at home and avoid long-term stay settings (Kiersey & Coleman, 2017; Lundstrom & Mc Keown, 1994; Houses of the Oireachtas, 2019). This may further accentuate the need for continuity of care for older people who are more reliant on homecare, when they lack family and informal support with their care needs. Indeed the evidence base supports this idea and unequivocally contends that most older people fear nursing home admission, while those who live alone in particular, express a fear of nursing home admission (Quine & Morel, 2007). Quine and Morel's (2007) research was based on a sample of 500 community dwelling older people in Austraila and was based on a qualitative methodology. Participants were community dwelling older people aged over 65 years and computer assisted telephone interviews were used to collect data (Quine & Morel, 2007).

The Loneliness Taskforce (2018) contend that loneliness and isolation directly impact premature nursing home admission for older people in Ireland. Equally notable within the literature concerning

policy and legislative developments in Ireland regarding the need for consistency and continuity of care within the current findings, is the disparity between the statutory right to avail of homecare, in comparison to nursing home care. The homecare service remains discretionary in nature and consequently older people have no statutory right or entitlement to avail of this service (Timonen et al. 2011; Wright, 2020; NESF, 2009; Haslett et al. 1998; Donnelly et al. 2016). Yet nursing home care is a statutory entitlement which older people are legally obligated to be provided, under the nursing home support scheme (Government of Ireland, 2009: Government of Ireland, 2021).

5.5 (2) - Regulation and policy

Uncertainty and a lack of consistency are further visible within the evolution of policy in Ireland, concerning the homecare sector to date (Kiersey & Coleman, 2017; Timoney, 2019; Timonen et al. 2009). It is plausible to propose that such ambiguity and uncertainty concerning homecare entitlement, could impact older people in receipt of homecare, concerning their need for consistency in care provision. The Care of the Aged Report (1968) initially highlighted the need for resources to be allocated to enable the maintenance of older people at home, via the provision of homecare (Government of Ireland, 1968). Interestingly even at this primitive point in the development of homecare, the Care of the Aged Report recommended the creation of legislation to govern the home-help service (Government of Ireland, 1970). The Health Act of 1970 subsequently made provisions for care at home for older people and is to date the only piece of legislation in Ireland, pertaining specifically to homecare (Government of Ireland, 1970). However the terminology used within the Health Act has resulted in ambiguity as it states that the health board "may" provide care to enable older people to remain living at home, rather than identifying a statutory right or entitlement to such care (Office of the Ombudsman, 2010; Murphy et al. 2015). Subsequent policies such as the Years Ahead Report (1988), Shaping a Healthier Future (1994), Adding Years to Life and Life to Years (1998) and Quality and Fairness a Health Strategy for You (2001), further made recommendations for the regulation and development of the homecare sector via training of staff and the allocation of adequate resources (The Working Party on Services for the Elderly, 1988; DOH, 1994; DOHC, 1998, DOHC, 2001).

However, progress regarding the recommendations set out within these policies has been inconsistent, with the regulation and legislation of homecare in Ireland still being debated within Government (Houses of the Oireachtas, 2020). Given that the primary recommendation for the regulation of homecare emerged within Irish policy in 1988 and this has yet to come to fruition, it is plausible to suggest that such a delay contributes to and maintains the lack of uncertainty

concerning entitlement to homecare services for older people, and ultimately their potential capacity to remain at home (Government of Ireland, 1988).

Timonen and Doyle (2008) conclude that the emergence of the quasi market system of public and private providers of homecare in Ireland, has inadvertently promoted the regulation of the homecare sector, as private homecare providers have lobbied consistently for this to happen. Timonen and Doyle (2008) further surmise that inconsistency in care provision is a notable feature of homecare in Ireland. Timonen and Doyle (2008) conducted a detailed desk review of policy development in Ireland, in addition to examining the implementation of such policy. They further aimed to ascertain the impact of such policies at the coalface of service delivery, using qualitative interviews with 125 homecare workers, managers and those responsible for planning and policy (Timonen & Doyle, 2008). Indeed such inconsistency in homecare provision, is a widely known problem which continues to discussed and debated within the Dail (Butler; 2015, Houses of the Oireachtas, 2012; 2020; Boyle, 2011; Dempsey at al. 2015).

Yet further notable is the issue of legislation development more broadly pertaining to vulnerable populations in Ireland. The Law Reform Commission's Issue Paper of 2019, emphasises the necessity to enact the Adult Safeguarding Bill (2017). The Law Reform Commission (2019) contend that existing legislation in the guise of the Capacity Act of 2015, although a welcome development in terms of enhancing rights, is not sufficient in terms of safeguarding. The enactment of the Safeguarding Bill (2017) would further enhance Ireland's compliance with the Charter for Human Rights. This report highlights the broader issue of legislative development in Ireland relating to older and vulnerable groups and illuminates that this issue is not limited to the homecare sector (Law Reform Commission, 2019).

5.5 (3) - Continuity of care for older people

Results propose that continuity of care results in much more positive experiences of homecare. Findings suggest that when the homecare worker knows the needs and preferences of the older person, this culminates in a homecare visit which is much more predictable for the older person and one which results in greater satisfaction. Continuity of care further results cumulatively in the building of a relationship between the older person and the homecare worker, based on the findings from this study. Continuity of care has been identified as particularly significant concerning the care of older people, within the previous literature on this topic (Settersten, 2015; Aspinal et al. 2012). Settersten's article was based on a detailed literature review pertaining to relationships and their

significance across the lifespan. Aspinal et al. (2012) undertook a qualitative methodology within their study, which consisted of interviews with 71 adults with long term health conditions in receipt of out-patient care.

Continuity of care could further be particularly relevant to homecare, due to the intimate nature of the care provided ie. personal care, in addition to the unique nature of the home as a setting. Previous research by Delp et al. (2010) suggest that the vulnerability and isolation of the older person, contributes to the blurring of boundaries in terms of relationship development within homecare. Delp. et al. (2010) utilised regression analysis pertaining to qualitative data gathered via telephone interviews with 1614 homecare workers employed in Los Angeles, in 2003. Delp et al. (2010) surmise that even the provision basic domestic duties, often culminates into meaningful conversations and connections between the homecare worker and the older person they are providing care to.

Continuity of care is further considered within the evaluation of health and social care provision (Starfield, 2011). It is plausible to suggest that continuity of care is even more significant for older people without family members or close friends. Findings suggest that the homecare relationship affords a greater level of certainty to the older person, in terms of the care they receive. While results indicate that the older person in receipt of care places significant value on their unique relationship with their homecare worker.

Further literature which assists in contextualising the findings from this study regarding the significance of continuity of care, is that presented by Guthrie et al. (2006). Guthrie et al. (2006) propose that continuity of care between a health care professional and patient may be understood within 3 distinct domains, which will be examined here within the context of the homecare worker and the older person:

- Informational continuity relates to the homecare worker's knowledge and familiarity with the older person's values and preferences regarding their care.
- Management continuity is concerned with the homecare worker following up on agreed tasks and understanding concerning the homecare worker's responsibility.
- Relationship continuity relates to the development of the relationship between the homecare worker and older person over time, and the positive impact of this on the older person.

Findings from the current study mirror in particular relationship continuity as propose by Guthrie et al. (2006) concerning the relationship between the older person and their homecare worker and the positive impact of this for the older person.

Previous literature by Facchinetti et al. (2020) relating to the importance continuity of care for older people further contextualise the current findings. Facchinetti et al. (2020) conducted a meta-analysis of randomised control trials relating to older people aged over 65, who had been discharged from hospital and examined readmission rates. The framework provided by Guthrie (2006) was used to evaluate continuity of care based on the 3 domains of: management, informational and relationship continuity. Thirty studies were included and these pertained to 8920 participants. Facchinetti et al. (2020) reported that participants who were provided with care based on continuity and consistency, were less likely to be readmitted to hospital. The large-scale nature of this study strengthens the findings and presents a strong argument for the substantial impact of continuity of care provision to older people in the community (Facchinetti et al. 2020).

Ohta et al. (2020) in their Japanese study contend that continuity of care reduces hospital admission for older people and enables the earlier identification of health decline. Ohta et al. (2020) conducted a qualitative study and undertook both interviews with 12 participants and focus groups comprising of 109 participants. All participants were with people aged over 50 years, and 80% self-rated their health and care needs as high. Results from the study by Ohta et al. (2020) propose that continuity of care concerning homecare, enabled greater understanding between older people and their care providers, as they became more familiar with one another. Findings further highlighted the issue of privacy and the importance of getting to know the person providing your care, prior to sharing sensitive information with them (Ohta et al. 2020). Within the context of the current study, such findings substantiate the need for continuity of care expressed by older people.

Equally Dostalova et al. (2022) report that continuity of care within homecare provision, reassures older people with a sense of certainty regarding their care and an opportunity to positively anticipate the social aspect of their homecare visit. Dostalova et al. (2022) adopted a qualitative methodology within their study and conducted semi-structured interviews with 15 older people in receipt of homecare.

It is plausible to suggest based on the results of this study, and within the context of the literature to date, that the lack of consistency and continuity of care offered via homecare entitlement more

generally, contributes to a sense of uncertainty for older people. Hence older people in receipt of homecare want and need certainty, consistency and ultimately continuity of care, from their individual homecare provision. Policy and legislative developments concerning the regulation of homecare have been inconsistent (Timonen & Doyle, 2008; Kiersey & Coleman, 2017). Such inconsistency has maintained a sense of ambiguity regarding the entitlement of older people to avail of the homecare service (Houses of the Oireachtas, 2020). Older people without an informal care support system (ie. from family members, friends or neighbours) are at an increased risk of early nursing home admission, should they not have sufficient homecare to meet their needs (Working Group on Long-term Care, 2008; HSE, 2019; The Loneliness Taskforce, 2018: Ivanova & Dykstra, 2015). Continuity of care provides a greater sense of dependability and reassurance to older people in receipt of homecare regarding the continued delivery of care and what they can expect from this care (Ohta et al. 2020; Guthrie et al, 2006). In essence, the homecare service continues to operate on the periphery of other professional health and social care provision in the home (eg. nursing, social work or occupational therapy) in a somewhat Cinderella capacity, in the absence of the regulation of this service (Lundstrom & Mc Keown, 1994).

5.6 - Implications

This study has found that 3 fundamental issues impact both older people and homecare workers concerning their experiences and perspectives of homecare:

- This unique nature of homecare work
- The isolation and loneliness as experienced by older people, and
- Continuity of care

5.6 (1) - Implications for older people

This study found that older people both want and need continuity of care concerning their homecare, and very much value the opportunity for social contact their homecare affords them. Such findings have previously been identified in Ireland (Lundstrom & McKeown, 1994; Haslett at al. 1998; Donnelly at al. 2016), which emphasises the longitudinal nature of the problem concerning the need for the regulation of the homecare sector. Equally, the social needs of older people identified within this study, are further consistent within the research undertaken in 1994, by Lundstrom and Mc Keown. This presents a picture of homecare for older people where their views and experiences are not be addressed via sufficient policy and legislation.

This study found companionship and relationship element of homecare are particularly important for older people, especially those living alone. These findings suggest that loneliness and social isolation are problematic for some older people in receipt of homecare. Interventions aimed at addressing social isolation as experienced by older people would help older people to feel less alone and to have a dedicated and targeted service aimed at meeting their social contact needs. An example of such a service may be social prescribing. Social prescribing is a service with aims to address the holistic and wellbeing needs of people in their own communities (WHO, 2022). The process for referral comes from the person's GP and they are then assigned a link worker, who will work closely with them to assess their needs. The link worker then connects the person with organisations and groups in their community, which can help them to improve their health and wellbeing. The link worker also supports the person to develop behaviour change, based on their individual needs and wellbeing (WHO, 2022). Relating to older people experiencing social isolation, they could be supported to join local groups, engage with befriending services or to participate in outings and events.

Social prescribing has just recently become available within 30 locations throughout Ireland, partially in response to the isolation and negative impact of Covid 19 on mental health and wellbeing (Crowley & Ni Bhriain, 2022). The services prescribed are delivered by existing community and voluntary organisations and are funded through the HSE. Conducting a social prescribing needs assessment when a referral is made for homecare, may identify previously unmet social contact needs for older people. This is an optimal opportunity to comprehensively examine the holistic and wellbeing needs of the older person.

5.6 (2) - Implications for homecare workers

Findings from this study suggest that the homecare worker's role is a truly unique one and that they often provide additional care and support to older people who live alone. This finding is particularly significant as it has not been previously identified within the Irish context. Findings propose that the social isolation of the older people they provide care to, is an issue which impacts homecare workers emotionally. Previous research has identified the emotionally difficult nature of the homecare worker's role, and further acknowledges the gendered nature of homecare provision and the guilt which often accompanies this (Mottaghi et al. 2019; Gill Monte, 2012).

The additional hours of unpaid care provision identified within this study appear to be directly related to older people who live alone and appear socially isolated, who present with unmet need

after the homecare visit. Much of the additional care and support provided relate to the social and companionship needs of older people. The evolution of the homecare worker role from initially being concerned with companionship to addressing only the most essential tasks of personal hygiene and getting in and out of bed, has been previously documented (Deevy, 1093; HSE, 2019). The impact of neoliberalism on the homecare market in Ireland, further contributes to understanding of the issues which homecare workers identified as significant to impacting them in their role (Mercille, 2017). The increased competition within the homecare market culminates into a service which aims to keep costs to a minimum and consequently results in unmet needs for older people (Garrett. 2017; Hudson, 2016). Findings from this study suggest that some homecare workers feel responsibility to meet this unmet need and this culminates in the provision of additional care in an unpaid capacity.

The literature pertaining to gendered societal expectations on women to provide care, in addition to the genuine feelings of care and responsibility homecare workers report, further substantiate the current findings (Gill-Monte, 2012). Indeed findings by Rubio-Marin, (2016) mirror those of the current study concerning the vocational element of homecare and homecare workers having previously cared for family members. Such predisposition towards caring, combined with gendered and societal pressure to provide care, results in many homecare workers facing exploitation in their roles and the acceptability of working for little reward (Green and Alayon, 2017; Palmer & Eveline, 2012; Lundstrom & Mc Keown, 1994). Ultimately, homecare workers are often undervalued and may themselves be marginalised due to race/ethnicity, income and the low status of their roles within the broader health and social care sector (MCRI, 2015; Boris & Klein, 2006; Sterling et al. 2020). Such understandings contextualise the findings of the current study pertaining to the unique role of the homecare worker and the provision of additional care in an unpaid capacity. The marginalisation of homecare workers, combined with gendered societal expectations of seamless care provision, culminates into the acceptance of providing care in excess of what they are being compensated for and meeting the social and companionship needs of older people living alone (Green & Ayalon, 2017; Gill-Monte, 2012; Abrams et al. 2019).

Finings point to a need for greater resources to be provided to compensate homecare workers for the additional care they provide. Regulation of the homecare sector with the enactment of the 2020 Professional Homecare Bill will undoubtedly alter the role of the homecare worker in terms of meeting the social contact and companionship needs of the older person.

Part 6 (1) a of the Professional Homecare Bill (2020) stipulates that homecare must encompass the companionship needs of older people. Examples provided within the Homecare Bill include: supporting the older person to visit with friends and neighbours, and supporting the older person with meal preparation and medical appointments. The 2020 Professional Homecare Bill further stipulates that companionship needs should not only be derived from assessment, but also based on the needs and preferences expressed by the older person.

Consequently, when the Professional Homecare Bill (2020) is enacted into law, homecare workers will be in a position to address the companionship needs of the older person within the remit, scope and boundary of their role, and consequently reduce the need to provide this care in an unpaid capacity. Equally the emotional impact of isolation and loneliness of older people which homecare workers identified as impacting them in their role, would further be reduced.

5.6 (3) - Implications for policy

Findings from the current study relating to continuity of care, isolation of older people and the unique nature of the homecare worker's role, point to the need for the regulation of the homecare sector in Ireland. Results suggest that homecare workers are providing additional care in an unpaid capacity, to meet the unmet needs of older people they deliver homecare to. Findings suggest that additional care and support outside of the official homecare worker's remit are more common, when to within the older person in receipt of care is living alone. The scope and extent of the homecare worker's role is largely dictated by the HSE, as the primary public homecare provider and the organisation responsible for funding private providers, as part of the current quasi market system (Mercille, 2017; HSE, 2012; 2019; HCCI, 2019). Yet both public and private homecare providers have to date been delivering care in an unregulated capacity, in the absence of legislation to govern minimum standards or present certainty concerning the scope and depth of the homecare worker's role (Kiersey & Coleman, 2017; Conyard et al. 2020).

Within their scoping review, Kiersey and Coleman (2017) indicate that such regulation would require minimum training standards, the registration of homecare providers and a substantial cost input from Government. Yet Deputy Colm Burke in his address to Dail Eireann highlighted that the Homecare Bill has been brought before the Oireachtas on multiple occasions since 2014, was first discussed in 2009 and was reported on by the Law Reform Commission in 2011 (Houses of the Oireachtas, 2020; Law Reform Commission, 2011). Deputy Burke argued that the discussion and debate surrounding the need to enact the Professional Homecare Bill into law, has occurred for long

enough and that the time for action for the protection of older people in receipt of homecare is urgent. The ongoing discussion and delay with enacting the Professional Homecare Bill presents questions as to the priority being placed on the needs of older people in Ireland. Phelan (2008, p. 324) asserts that ageism manifests in the abuse or neglect of older people, where their needs are "ignored or overlooked simply because of the older person's age and possible dependency". The Governmental response to recommendations to regulate the homecare sector in Ireland from as early as 1988 within the Years Ahead Report, to the present day within the Dail, indeed communicates a sense of overlooking the needs of older people (The Working Party on Services for the Elderly, 1988; Houses of the Oireachtas, 2020).

5.7 - Limitations

This study has 3 main limitations. Firstly the sample size of this study was quite low. The hard to reach status of older people in particular, resulted in the necessity to undertake focus groups in an effort to demystify the research process and generate interest in participation. Consequently, the data gathered within phase 1 represented experiences of older people in receipt of homecare, in addition to the perspectives of older people on homecare more generally. This could be interpreted as a weakness within the current study.

The second limitation is concerned with the depth of information gathered within the data collection process for phase 1. The marginalised status of older people in receipt of homecare, combined with the lack of a statutory entitlement to receive homecare, may have culminated into a reluctance to disclose dissatisfaction with their homecare service provision. The opportunity to revisit older people and further build rapport, may have yielded richer data and greater depth in data analysis.

The third and final limitation within the methodology of this study is that of the limited geographical location of the data collection. Due to resource and time limitations, the geographical location of the study was limited to Galway City and County. Consequently, the findings of this study may be not be truly represented of homecare more generally in Ireland. Equally given the variation in terms of service delivery from one HSE area to another, it is possible that patterns evident within the data in Galway, are not typical of homecare in Ireland more generally.

5.8 - Recommendations

The findings of this study and subsequent discussion have culminated into the following recommendations:

- Initiatives specifically targeting the social isolation experienced by older people in Ireland are much needed. Such initiatives should be deriving from a broad needs analysis of older people in receipt of homecare. This would assist in streamlining services and meeting the social contact needs of older people in receipt of homecare.
- Greater public and government understanding of isolation and loneliness for older people is necessary. More open discussions and understanding regarding the impact of social isolation, combined with tangible methods of addressing this, would help to destigmatise this contemporary social issue. It should be normal and acceptable for an older person to express feelings of loneliness and ask for help in combatting this.
- A mechanism for homecare workers to identify and flag older people in receipt of homecare who are experiencing social isolation, would be useful. This would enable more targeted responses and signposting/referral, to services specifically aimed at promoting social inclusion.
- Appointing of a government minister with specific responsibility for loneliness is crucial. Such an appointment would promote clear public accountability for addressing loneliness and social isolation, with the creation of specific goals and objectives. A minister for loneliness would further prompt greater fiscal investment in addressing this issue.
- A large and detailed evaluation of the homecare service in Ireland and exactly how this is delivered and received is necessary. To plan effectively to meet the needs of older people appropriately, it is essential to first establish the complexities, strengths and weakness of current delivery. Older people's voices should be front and centre in any conversation concerning their reality, service needs and preferences.
- Finally, enacting legislation to govern and regulate the homecare sector in Ireland is essential and should be progressed as a matter of urgency. Homecare affords older people with a unique service which unequivocally enables them to remain in the own homes and communities. The passing of the Homecare Bill will provide greater levels of certainty to older people concerning entitlement to service provision, and consequently less ambiguity and inconsistency in service provision. Most importantly, the Homecare Bill when enacted, will result in companionship being addressed within the remit of the homecare worker.

5.9 - Conclusion

The primary aim of this study was to examine the phenomenon of homecare. The key objectives were to ascertain the factors which older people and homecare workers identified as impacting their experiences and perspectives of homecare provision.

A qualitative methodology was employed and interviews and focus groups were undertaken with older people in phase 1. Phase 2 consisted of interviews with homecare workers. The DQHF was used to guide the framing of the current study within the 3 domains of: structure, process and outcome. Braun and Clark's (2022) 6 step process of thematic analysis was utilised to examine, critique, consider and extract the final themes derived from the data.

Findings propose that the unique nature of homecare is a notable factor which both parties recognise as significant in impacting the provision and receipt of homecare in Ireland. Unique attributes of homecare include the home as a setting for care, the building of rapport and relationships and the genuine care expressed by homecare workers for the older people they provide care to. Results contend that additional care provision and the undertaking of tasks outside of the official remit of their role, are particularly unique within homecare and more evident for older people who live alone.

Findings propose that the isolation experienced by older people is substantial in impacting both homecare workers and older people, in the context of homecare provision. Older people rely and depend upon their homecare visit as a source of social interaction. Yet isolation impacts homecare workers in terms of the care they provide, the emotional impact of their role and the sense of responsibility they feel towards older people who are isolated. Indeed the issue of isolation experienced by older people has further been illuminated during the recent impact of Covid 19 (WHO, 2021). Although the problem of social isolation for older people is widely known as detrimental to health and well-being, this issue became more salient as a result of the pandemic (WHO, 2021).

Results indicate that continuity of care is of the utmost importance for older people. Consistency in terms of personnel enables older people to know what to expect from their homecare visit, and to become familiar with their homecare worker. Findings contend that older people are negatively impacted by the omission of continuity in terms of the homecare they receive.

Ultimately, findings from this study reiterate the extent and impact of social isolation for older people in Ireland and illuminate the impact of this for homecare workers in their care provision. The social contact element of the homecare visit is significant for older people. The unique attributes of homecare when compared to more traditional health or social care provision, emphasises the truly momentous value of this service on the lives of the older people who receive it. The familiarity between older people and homecare workers enables the building of rapport and development of a caring relationship. Hence continuity of care is an essential prerequisite for this relationship to occur, based on the perspectives of older people.

Recommendations based on the findings from the current study, in the context of the previous literature and policy pertaining to older people and homecare, unequivocally propose that the Homecare Bill (2020) should be enacted as a matter of urgency. Two of the 3 key issues identified within this study: continuity of care, the isolation experienced by older people in receipt of homecare, would be addressed immediately via the enactment of this legislation. The unique nature of the homecare worker's role is something truly distinctive and very much valued by both parties within the homecare relationship. Having a cup of tea and a chat will likely never appear on a care plan, yet is often the most significant part of the homecare visit.

Bibliography

Abrams, R., Vandrevala, T., Samsi, K., & Manthorpe, J. (2019). The need for flexibility when negotiating professional boundaries in the context of home care, dementia and end of life. *Ageing and Society, 39* (9), 1976-1995. doi:10.1017/S0144686X18000375

Achenbaum, W., & Bengtson, V. (1994). Re-engaging the disengagement theory of aging: On the history and assessment of theory development in gerontology. *The Gerontologist*, *34* (6), 756–763. https://doi.org/10.1093/geront/34.6.756

Adams, W. L., McIlvain, H. E., Lacy, N. L., Magsi, H., Crabtree, B. F., Yenny, S. K. & Sitorius, M. A. (2002). Primary care for elderly people: Why do doctors find it so hard? *The Gerontologist, 42*, 6, 835–42. DOI: 10.1093/geront/42.6.835

Advocacy Unit HSE. (2010). *Service user involvement methods: A guidance document*. Retrieved: https://www.hse.ie/eng/services/yourhealthservice/documentation/methodsresource2010.pdf

Age Action. (2012). *Age Action welcomes HSE homecare package standards*. Retrieved: https://www.ageaction.ie/age-action-welcomes-hse-homecare-package-standards

Age Action. (2022). *Human rights of older people*. Retrieved: https://www.ageaction.ie/how-we-can-help/campaigning-policy/human-rights-and-older-people

Age Action. (2014). *Overview of the human rights of older people in Ireland*. Retrieved: https://social.un.org/ageing-working-group/documents/fifth/OverviewofthehumanrightsofolderpeopleinIreland.pdf

Age Action. (2017). *Submission to the department of health consultation on homecare services.* Retrieved: https://www.ageaction.ie/sites/default/files/attachments/021017_final_homecare_consultation_submission.pdf

Age Platform Europe. (2020). *United Nations: 140 countries jointly call for respect of the rights and dignity of older people and global solidarity*. Press Release. Retrieved:

https://www.age-platform.eu/press-releases/united-nations-140-countries-jointly-call-respect-rights-and-dignity-older-people-and

Ahn, M. (2017). Introduction to special issue: Aging in place. *Housing and Society, 44* (1-2). DOI: 10.1080/08882746.2017.1398450

Airth, L., & Oelke, N. (2020). How neoliberalism, ageism and stigma drive the lack of policy for older adults' mental health. *Journal of Psychiatric and Mental Health Nursing, 27* (6), 838-843. https://doi.org/10.1111/jpm.12618

ALONE. (2019). *Alone calls for demand led budget for homecare scheme*. Retrieved: https://alone.ie/alone-calls-for-demand-led-funding-for-home-care-scheme/

ALONE. (2013). *Alone urges government to regulate home-help*. ALONE Summer Newsletter. Retrieved: http://alone.ie/alone-urges-government-to-regulate-home-help/

ALONE. (2020). *Support and befriending*. Retrieved: https://alone.ie/what-we-do/befriending/

Ambugo, E., de Bruin, S., Masana, L., MacInnes, J., Mateu, NC, Hagen, T.,P. (2021). A Cross-European study of informal carers' needs in the context of caring for older people, and their experiences with professionals working in integrated care settings. *International Journal of Integrated Care, 21* (3):2. DOI: http://doi.org/10.5334/ijic.5547

Anderson, B. (2015). Migrant domestic workers: Good workers, poor slaves, new connections. *Social Politics: International Studies in Gender, State & Society*, *22* (4), 636-652. https://doi.org/10.1093/sp/jxv040

Anderson, G., & Westgaard, R. (2015). Discrepancies in assessing home care workers' working conditions in a Norwegian home care service: Differing views of stakeholders at three organizational levels. *BMC Health Services Research, 15* (1), 1-13. DOI 10.1186/s12913-015-0945-6

Andrews, G., & Clark, M. (1999). The international year of older persons: Putting aging and research onto the political agenda. *Journal of Gerontology, 54* (1), 7-10. DOI: 10.1093/geronb/54b.1.p7

Anton, C., E., & Lawrence, C. (2014). Home is where the heart is: The effect of place of residence on place attachment and community participation. *J. Environ. Psychol., 40*, 451-461. https://doi.org/10.1016/j.jenvp.2014.10.007

Asiamah, N. (2017) Social engagement and physical activity: Commentary on why the activity and disengagement theories of ageing may both be valid. *Cogent Medicine, 4*:1, DOI: 10.1080/2331205X.2017.1289664

Aspell, N, O'Sullivan, M, O'Shea, E., Irving, K., Duffy, C., Gorman, R., & Warters, A. (2019). Predicting admission to long-term care and mortality among community-based, dependent older people in Ireland. *Int J Geriatr Psychiatry, 34*, 999– 1007. https://doi-org.libgate.library.nuigalway.ie/10.1002/gps.5101

Aspinal, F., Gridley, K., Bernard, S., & Parker, G. (2012). Promoting continuity of care for people with long-term neurological conditions: The role of the neurology nurse specialist. *Journal of Advanced Nursing*, **68**(10), 2309– 2319. https://doi.org/10.1111/j.1365-2648.2011.05928.x

Ataguba, J., Bloom, D., & Scott, A. (2021). A timely call to establish an international convention on the rights of older people. *The Lancet. Healthy Longevity, 2*(9), E540-E542. DOI:https://doi.org/10.1016/S2666-7568(21)00178-1

Atkinson, C., Crozier, S., & Lewis, L. (2016). *Factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of domiciliary care.* Welch Government. Retrieved: https://gov.wales/sites/default/files/statistics-and-research/2019-07/160317-factors-affect-recruitment-retention-domiciliary-care-workers-final-en.pdf

Austin, A. G. (1989). Becoming immune to loneliness: Helping the elderly fill a void. *Journal of Gerontological Nursing, 15* (9), 25–30.

Australian Human Rights Commission. (2013). *Fact or fiction? Stereotypes of older Australians*. Research Report. Retrieved: https://humanrights.gov.au/sites/default/files/document/publication/Fact%20or%20Fiction_2013_WebVersion_FINAL_0.pdf

Ayalon, L. & Roziner, I. (2015). Satisfaction with the relationship from the perspectives of family caregivers, older adults and their home care workers. *Ageing and Mental Health, 20* (1), 56-64. doi.org/10.1080/13607863.2015.1020412

Ayalon, L., Tesch-Römer, C. (2017). Taking a closer look at ageism: Self- and other-directed ageist attitudes and discrimination. *Eur J Ageing 14, 1–4*. doi.org/10.1007/s10433-016-0409-9

Bandari, R., Khankeh, H., Shahboulaghi, F., Ebadi, A., Keshtkar, A.m, & Montazeri, A. (2019). Defining loneliness in older adults: Protocol for a systematic review. *Systematic Reviews, 8* (1), 26. https://doi.org/10.1186/s13643-018-0935-y

Barrett, P., Hale, B., & Gauld, R. (2012). Social inclusion through ageing-in-place with care? *Ageing and Society, 32* (3), 361-378. doi:10.1017/S0144686X11000341

Barry, U. (2010). Elderly care in Ireland. Provisions and providers. *UCD School of Social Justice Working Papers Series, 10* (1):1-34. Dublin: University College Dublin.

Bechhofer, F., & Paterson. L. (2000). *Principles of research design in the social sciences*. London; New York: Routledge Social Research Today.

Bekhet, A., Zauszniewski, J., & Nakhla, W. (2008). Loneliness: A concept analysis. *Nursing Forum (Hillsdale), 43* (4), 207-213. DOI: 10.1111/j.1744-6198.2008.00114.x

Belloc, N.B., & L. Breslow. (1972). Relationship of physical health status and health practices. *Preventive Medicine*, (1), 409-421.

Bell, S., Waters, J., & Waters, S. (2014). *Doing your research project: A guide for first-time researchers* (6th ed.). Maidenhead, Berkshire: McGraw-Hill Education.

Bellamy, K., Ostini, R., Martini, N., & Kairuz, T. (2016). Seeking to understand: Using generic qualitative research to explore access to medicines and pharmacy services among resettled refugees. *International Journal of Clinical Pharmacy, 38* (3), 671-675. doi: 10.1007/s11096-016-0261-1

Bennett, R., & Zaidi, A. (2018). Three challenges in realising the MIPAA in developing regions. *International Journal on Ageing in Developing Countries, 2* (2), 76-81.

Benoit, C., & Hallgrimsdottir, H. (2017). *Valuing care work: Comparative perspectives*. Toronto: University of Toronto Press.

Berg-Weger, M., Morley, J.E. (2020) Loneliness and social isolation in older adults during the COVID-19 Pandemic: Implications for gerontological social work. *J Nutr Health Aging 24*, 456–458 (2020). https://doi.org/10.1007/s12603-020-1366-8

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15* (2), 219-234. https://doi.org/10.1177/1468794112468475

Bernard, M., Ray, M. & Reynolds, J. (2020). *New directions for gerontology*. In (1st ed., p. 213). Bristol: Policy Press.

Berkman, L., & Syme, L. (1979). Social networks, host resistance and mortality: A nine year follow up study of Almeda County residents. *American Journal of Epidemiology*, 109, (2),186–204. https://doi.org/10.1093/oxfordjournals.aje.a112674Berk

Bettis, J., Kakkar, S., & Chan, C.D. (2020). Taking access to the community: An ecological systems framework for in-home counselling with older adults. *Adultspan Journal, 19*: 54-64. https://doi.org/10.1002/adsp.12087

Black, B. P., Holditch-Davis, D., & Miles, M. S. (2009). Life course theory as a framework to examine becoming a mother of a medically fragile preterm infant. *Research in Nursing & Health, 32* (1), 38–49. https://doi.org/10.1002/nur.20298

Blanchard-Fields, F. (1986). Reasoning on social dilemmas varying in emotional saliency: An adult developmental perspective. *Psychology and Aging, 1,* 325-333. https://doi.org/10.1037/0882-7974.1.4.325

Block, K., Croft, A., De Souza, L., & Schmader, T. (2019). Do people care if men don't care about caring? The asymmetry in support for changing gender roles. *Journal of Experimental Social Psychology, 83*, 112-131. https://doi.org/10.1016/j.jesp.2019.03.013

Bluebird Care. (2015). *Homecare.* Retrieved: http://bluebirdcare.ie/care-services/home-help/

Bonevski, B., Randell, M., Paul, C., Chapman, K., Twyman, L., Bryant, J., & Hughes, C. (2014). Reaching the hard-to-reach: A systematic review of strategies for improving health and medical research with socially disadvantaged groups. *BMC Medical Research Methodology, 14* (42), 1-29. doi/10.1186/1471-2288-14-42

Booth, A. (2016). Searching for qualitative research for inclusion in systematic reviews: a structured methodological review. *Syst Rev* **5,** 74. https://doi.org/10.1186/s13643-016-0249-x

Bound Alberti, F. (2018). This "Modern Epidemic": Loneliness as an emotion cluster and a neglected subject in the history of emotions. *Emotion Review, 10* (3), 242-254. /doi.org/10.1177/1754073918768876

Bor, J. (2015). Among the elderly many mental illnesses go undiagnosed. *Health Affairs*, *34* (5), 727-731. https://doi.org/10.1377/hlthaff.2015.0314

Boris, E., & Klein, J. (2006). Organizing homecare: Low-waged workers in the welfare state. *Politics and Society, 34* (1), 86-107. DOI: 10.1177/0032329205284757.

Bowers, B. (2020). Improving practice and informing policy development: The impact of gerontological nursing research. *Geriatric Nursing, 41* (1), 32-37. DOI: 10.1016/j.gerinurse.2020.01.010

Boyle, G. (2004). Facilitating choice and control for older people in long-term care. *Health and Social Care in the Community, 2* (3), 212-220. https://doi.org/10.1111/j.1365-2524.2004.00490.x

Boyle, M. (2011). *One for all. Age friendly health and social care: Principles and experience.* Older and Bolder. Retrieved: http://www.olderandbolder.ie/sites/default/files/One%20for%20All%20-%20Feb%202011.pdf

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research*, *4*, 1-8. doi:10.1177/2333393617742282

Braun, V., Clarke, V.: Using thematic analysis in psychology. *Qual. Res. Psychol. 3*(2), 77–101 (2006). https://doi.org/10.1191/1478088706qp063oa

Braun, V. & Clarke, V. (2022). *Thematic analysis. A practical guide*. London, Los Angeles: SAGE.

Bronfenbrenner, U. (1979). *Ecology of human development. Experiments by nature and design.* Cambridge MA: Harvard University Press.

Browne, K. (2005). Snowball sampling: Using social networks to research non-heterosexual women. *International Journal of Social Research Methodology, 8* (1), 47 - 60. DOI: 10.1080/1364557032000081663

Browne, M. (2016). *Responding to the support and care needs of our older population. Shaping an agenda for future action*. Sage: Support and advocacy for older people. Retrieved: https://www.sageadvocacy.ie/media/1460/report_of_forum_on_ltc_for_older_people_final.pdf

Buckley, J., & Linehan, C. (2005). *Innovation in the provision of home-help services in the southern health board area.* Publin Report No. D12-6 Irish case study WP4. University

Burger, J., Mc Ward, J., & LaTorre, D. (1989). Boundaries of self control. Relinquishing control over adversive events. *Journal of Clinical Psychology, 8* (2), 209-221.

Butler, S. (2015). The undervalued work of the homecare aide. *Women's Health Bulletin, 3* (2), 1-3. doi: 10.17795/whb-33105

Byrne, D. A. (2021). Worked example of Braun and Clarke's approach to reflexive thematic analysis. *Qual Quant*. https://doi.org/10.1007/s11135-021-01182-y

Bwiza, C., Son, J., & Lee, C. (2022). Integrated theories of biological aging. *Oxford Research Encyclopedia of Psychology.* Retrieved: https://oxfordre.com/psychology/view/10.1093/acrefore/9780190236557.001.0001/acrefore-9780190236557-e-334

Cacioppo, J., & Hawkley, L. (2009). Perceived social isolation and cognition. *Trends in Cognitive Sciences, 13* (10), 447-454. DOI: 10.17795/whb-33105

Cacioppo, J., Hawkley, L., Norman, G., & Berntson, G. (2011). Social isolation. *Annals of the New York Academy of Sciences, 1231*(1), 17-22. doi: 10.1111/j.1749-6632.2011.06028.x

Caelli, K., Ray, L., & Mill, J. (2003). "Clear as mud": Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods, 2* (2), 1–24. https://doi.org/10.1177/160940690300200201

Canvin, K., MacLeod, C., Windle, G., & Sacker, A. (2018). Seeking assistance in later life: How do older people evaluate their need for assistance? *Age and Ageing, 47* (3), 466–473. https://doi.org/10.1093/ageing/afx189

Care Alliance Ireland, (2014). *Care Alliance Ireland: Comments on the Health (Professional Homecare) Bill 2014 (as introduced by Sen. Colm Burke).* Retrieved: http://www.carealliance.ie/userfiles/file/Care%20Alliance%20comments%20on%20the%20Health%20(Professional%20Home%20Care)%20Bill.pdf

Care Alliance Ireland. (2022). The future of homecare. A report by the Homecare Providers Alliance. Retrieved: https://www.homeinstead.ie/docs/default-source/freedownlaods/the-future-of-home-care-report-march-2022.pdf?sfvrsn=2

Caremark. (2015). *What kind of services can care and support workers provide*? Retrieved: http://www.caremark.ie/faqs/

Care Quality Commission. (2005). *Guidance on common induction standards.* Retrieved: http://www.google.ie/url?sa=t&rct=j&q=&esrc=s

Care Quality Commission. (2015*). Regulations for service providers and managers*. Retrieved: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers

Care Quality Commission. (2019). *Regulations for service providers and managers*. Retrieved: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers

Care Quality Commission. (2013). *Review of homecare services*. Retrieved: http://www.cqc.org.uk/content/review-homecare-services-0

Care Quality Commission. (2015-a). *Services in your home*. Retrieved: http://www.cqc.org.uk/content/services-your-home

Care Quality Commission. (2015-b). *What standards you have a right to expect from the regulation of agencies that provide care in your own home*. Retrieved: http://www.cqc.org.uk/sites/default/files/documents/standards_to_expect_homecare.pdf

Carey, M. (2016). Focus groups—What is the same, what is new, what is next? *Qualitative Health Research, 26* (6), 731-733. doi: 10.1177/1049732316636848.

Carey, S., Carroll, B. (1986). *Patch work. Establishing the needs of the elderly at the local level. A report of the Joint Working Group on the Needs of the Elderly*. Dublin: Glendale Press. Retrieved: https://www.lenus.ie/handle/10147/559426?show=full

Carr, D. (2018). The linked lives principle in life course studies: Classic approaches and contemporary advances. In: Alwin D., Felmlee D., Kreager D. (eds.) *Social networks and the life course*. Pensylvania*:* Springer, Cham.

Carstensen, L., L. (2006). The influence of a sense of time on human development. *Science, 312,* 1913–1915. doi:10.1126/science.1127488

Carter L, O'Neill S, Keogh F, Pierce M, O'Shea E. (2021). Intensive home care supports, informal care and private provision for people with dementia in Ireland. *Dementia, 20* (1):47-65. doi: 10.1177/1471301219863580. Epub 2019 Jul 26. PMID: 31349753.

Cash, T., Moyle W. & O'Dwyer S. (2017). Relationships in consumer-directed care: An integrative literature review. *Australasian Journal on Ageing*, *36* (3), 193-204. DOI: 10.1111/ajag.12444

Central Statistics Office. (2007). *Ageing in Ireland 2007*. Retrieved: https://www.cso.ie/en/media/csoie/releasespublications/documents/otherreleases/2007/ageinginireland.pdf

Central Statistics Office. (2019). *Census of population 2016 - Profile 3 An age profile of Ireland*. Retrieved: https://www.cso.ie/en/releasesandpublications/ep/p-cp3oy/cp3/agr/

Central Statistics Office. (2019). *Women and men in Ireland in 2019*. Retrieved: https://www.cso.ie/en/releasesandpublications/ep/p-wamii/womenandmeninireland2019/work/

Central Statistics Office. (2016). *Men and women in Ireland in 2016*. Retrieved: https://www.cso.ie/en/releasesandpublications/ep/p-wamii/womenandmeninireland2016/health/

Central Statistics Office- a. (2016). Census of population 2016 - Profile 3 an age profile of Ireland. Retrieved: https://www.cso.ie/en/releasesandpublications/ep/p-cp3oy/cp3/agr/#:~:text=In%20Census%202016%2C%2094.7%20per,rate%20of%2076.2%20per%20cent.

Chambers, D., & Thompson, S. (2009). Empowerment and its application in health promotion in acute care settings: Nurses' perceptions. *Journal of Advanced Nursing, 65* (1), 130-138. doi: 10.1111/j.1365-2648.2008.04851.x

Cheng S-T. (1992). Loneliness-distress and physician utilization in well-elderly females. *J Community Psychol. 20* (1), 43–56. https://doi.org/10.1002/1520-6629(199201)20:1<43::AID-JCOP2290200107>3.0.CO;2-3

Chew-Graham, C., Kovandžić, M., Gask, L., Burroughs, H., Clarke, P., Sanderson, H., & Dowrick, C. (2012). Why may older people with depression not present to primary care? Messages from secondary analysis of qualitative data. *Health & Social Care in the Community, 20* (1), 52-60. Doi 10.1111/j.1365-2524.2011.01015.x

Citizen's Information. (2013). *Home-help service.* Retrieved: http://www.citizensinformation.ie/en/health/care_in_your_community/home_helps.html

Clarke, D., Murphy, C., & Lorenzoni, I. (2018). Place attachment, disruption and transformative adaptation. *Journal of Environmental Psychology, 55,* 81-89. https://doi.org/10.1016/j.jenvp.2017.12.006

Clarke, M., & Ravenswood, K. (2019). Constructing a career identity in the aged care sector: Overcoming the "taint" of dirty work. *Personnel Review, 48* (1), 76-97. https://doi.org/10.1108/PR-08-2017-0244

Cleland, J., Hutchinson, C., McBain, C., Walker, R., Milte, R., Khadka, J., & Ratcliffe, J. (2021). Developing dimensions for a new preference-based quality of life instrument for older people receiving aged care services in the community. *Qual Life Res* **30,** 555–565 (2021). https://doi.org/10.1007/s11136-020-02649-5

Coffey, A. (2004). Perceptions of training for care attendants employed in the care of older people. *Journal of Nursing Management, 12* (5), 322-328. DOI: 10.1111/j.1365-2834.2004.00442.x

Convery J. (2001), ''Ireland'', in: Blackman, T., Brodhurst, S. and Convery, J. (Eds.) *Social Care and social exclusion: A comparative study of older people's care in Europe*. Palgrave: Basingstoke and New York, NY, pp. 83-95.

Cooper, S., & Endacott, R. (2007). Generic qualitative research: A design for qualitative research in emergency care? *EMJ, 24* (12), 816-819. doi:http://dx.doi.org.libgate.library.nuigalway.ie/10.1136/emj.2007.050641

Cortese, C., Truscott, F., Nikidehaghani, M., & Chapple, S. (2020). Hard-to-reach: The NDIS, disability, and socio-economic disadvantage. *Disability & Society*, 1-21. Doi 10.1080/09687599.2020.1782173

Cosgrove, L., & Karter, J. (2018). The poison in the cure: Neoliberalism and contemporary movements in mental health. *Theory & Psychology, 28* (5), 669-683. https://doi.org/10.1177/0959354318796307

CORU. (2022). *Regulating health and social care professionals*. Retrieved: https://coru.ie/

Cosan, D. (2019). *An evaluation of loneliness. The European Proceedings of social and behavioural Sciences* eISSN:2357-1330. https://doi.org/10.15405/epsbs.2014.05.13

Cotterell, N., Buffel, T., & Phillipson, C. (2018). Preventing social isolation in older people. *Maturitas, 113*, 80-84. https://doi.org/10.1016/j.maturitas.2018.04.014

Creswell, J.W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches.* (2nd ed.) Thousand Oaks: Sage.

Crosnoe, R., & Elder, G. H. (2002). Successful adaptation in the later years: A life course approach to aging. *Social Psychology Quarterly*, *65*(4), 309–328. https://doi.org/10.2307/3090105

Crowley, P., & Ni Bhriain, S. (2022). *HSE social prescribing framework. Mainstreaming social prescribing in partnership with community and voluntary organisations*. HSE. Healthy Ireland. Retrieved: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/mental-health-and-wellbeing/hse-social-prescribing-framework.pdf

Cullen, P. (2019). The discursive politics of marketization in home care policy implementation in Ireland. *Policy and Society, 38* (4) 606-625. DOI: 10.1080/14494035.2019.1622274

Cummings, S., Kropf, N. (2008). Chapter 1: Overview of evidence-based practice with older adults and their families. *Journal of Gerontological Social Work, 50* (1), 1-10. DOI: 10.1080/01634370802137736

Cutchin, M. (2003). The process of mediated aging-in-place: A theoretically and empirically based model. *Social Science and Medicine, 57* (6), 1077-1090. https://doi.org/10.1016/S0277-9536(02)00486-0

Dahlberg, K. (2007). The enigmatic phenomenon of loneliness. *International Journal of Qualitative Studies on Health and Well-being, 2,* (4) 195-207. DOI: 10.1080/17482620701626117

Dahlberg, L., & McKee, K., L. (2014). Correlates of social and emotional loneliness in older people: Evidence from an English community study. *Aging & Mental Health, 18* (4), 504-514, 10.1080/13607863.2013.856863

Dail Eireann. (2019). *Home help service provision statements*. Vol 983 (5). Retrieved: https://www.oireachtas.ie/en/debates/debate/dail/2019-06-12/46/

Darawsheh, W. (2014). Reflexivity in research: Promoting rigour, reliability and validity in qualitative research. *International Journal of Therapy and Rehabilitation, 21* (12), 560-568. doi.org/10.12968/ijtr.2014.21.12.560

Darling, N. (2007) Ecological systems theory: The person in the centre of the circles. *Research in Human Development, 4* (3-4), 203-217, DOI: 10.1080/15427600701663023

Datallo, P. (2008). *Sample-size determination in quantitative social work research*. NY: Oxford University Press.

Dean, B., A. (2018). The interpretivist and the learner. *International Journal of Doctoral Studies, 13,* 1-8. https://doi.org/10.28945/3936

Deevy, L. (1983). *Guide for home helps*. Dublin: National Social Services Board.

de Jong-Gierveld, J., van Tilburg, T. G., & Dykstra, P. A. (2006). Loneliness and social isolation. In D. Perlman,& A. Vangelisti (Eds.), *The Cambridge handbook of personal relationships* (pp. 485-500). Cambridge University Press.

Delaney, S., Cullen, K., & Dolphin, C. (2008). *Housing-with-care: A new paradigm?* ENHR Dublin: Work Research Centre.

Dempsey, C., Normand, C., & Timonen, V. (2016). Towards a more person-centred homecare service: A study of the preferences of older adults and homecare workers. *Administration*, *64* (2), 109-136. *doi: 10.1515/admin-2016-0018*

Denzin, N., & Lincoln, Y. (1998). *The landscape of qualitative research. Theories and issues*. Thousand Oaks CA: Sage Publications inc.

Department of Children, Equality, Disability, Integration and Youth. (2021). *Chapter 10: County homes*. Retrieved: https://www.gov.ie/en/publication/28871-chapter-10-county-homes/#

Dept. of Health and Children, (1998). *Adding years to life and life to years. A health promotion strategy for older people.* National Council for Ageing and Older People.

Dept. of Health. (2015). *Care certificate launching on April 1st 2015*. Retrieved: https://www.gov.uk/government/news/care-certificate-launching-on-1-april-2015

Dept. of Health and Children. (2001). *Quality and fairness a health system for you.* Retrieved: http://www.dohc.ie/publications/pdf/strategy.pdf?direct=1

Dept. of Health. (2013). *E-health strategy for Ireland*. HSE. Retrieved: http://health.gov.ie/wp-content/uploads/2014/03/Ireland_eHealth_Strategy.pdf

Dept. of Health. (2013). *National positive ageing strategy*. Retrieved: http://health.gov.ie/wp-content/uploads/2014/03/National_Positive_Ageing_Strategy_English.pdf

Dept. of Health. (2020). *Personal and public involvement*. Retrieved: https://www.health-ni.gov.uk/topics/safety-and-quality-standards/personal-and-public-involvement-ppi

Dept. of Health. (1994). *Shaping a healthier future: A strategy for effective healthcare in the 1990's.* Dublin: Stationary Office.

Dept. of Health. (2002). *The Domiciliary Care Agencies Regulation*. Retrieved: http://www.age-platform.eu/images/stories/uk_minimumcarestandarts_athome.pdf

Dept. of Health, Social Services and Public Safety. (2007). *Safety, quality & standards directorate office of the chief medical office.* Retrieved: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2029-07_2.pdf

Department of Finance. (2021). *Population ageing and public finances in Ireland*. Retrieved: file:///C:/Users/0114174s/Downloads/198456_1c05826e-5682-4537-952d-fce5abb6db33%20(1).pdf

Dieronitou, I. (2014). The ontological and epistemological foundations on qualitative research and quantitative approaches to research. *International Journal of Economics, Commerce and Management, 2* (10), 1-17.

Donabedian, A. (2005). Evaluating the quality of medical care. *Millbank Quarterly, 83* (3), 691-729. https://doi.org/10.1111/j.1468-0009.2005.00397.x

Donnelly, S., O'Brien, M., Begley, E., and Brennan, J. (2016). "*I'd prefer to stay at home but I don't have a choice". Meeting Older People's Preference for Care: Policy, but what about practice?* Dublin: University College Dublin.

Donizzetti A. R. (2019). Ageism in an aging society: The role of knowledge, anxiety about aging, and stereotypes in young people and adults. *International Journal of*

Environmental Research and Public Health, 16 (8), 1-11. https://doi.org/10.3390/ijerph16081329

Donoghue, F., Anheiser, H., K. & Salamon, L., M. (1999). *Uncovering the non-profit sector in Ireland, its economic value and significance*. John Hopkins University/National College of Ireland. Retrieved: http://ccss.jhu.edu/wp-content/uploads/downloads/2011/09/Ireland_NationalReport_1999.pdf

Dostálová, V., Bártová, A., Bláhová, H., & Holmerová, I. (2022). The experiences and needs of frail older people receiving home health care: A qualitative study. *International Journal of Older People Nursing., 17*(1). DOI: 10.1111/opn.12418

El Haj, H., Lamrini, M., & Rais, N. (2013). Quality of care between Donabedian model and ISO90001V2008. *International Journal of Quality Research, 7* (1) 17-30. ISO9001V2008

Elder, G., H. (1998). The life course as developmental theory. *Child Development, 69* (1), 1-12. https://doi.org/10.2307/1132065

Elder, G.H., Jr. and Shanahan, M.J. (2007). The life course and duman Development. In: *Handbook of Child Psychology* (eds W. Damon, R.M. Lerner and R.M. Lerner). doi:10.1002/9780470147658.chpsy0112

Elder, G., H. (1994). Time, human agency, and social change: Perspectives on the life course. *Social Psychology Quarterly., 57*, 4-15. https://doi.org/10.2307/2786971

Elliott, V. (2018). Thinking about the coding process in qualitative data analysis. *The Qualitative Report, 23* (11), 2850-2861. Retrieved from http://libgate.library.nuigalway.ie/login?url=https://www.proquest.com/scholarly-journals/thinking-about-coding-process-qualitative-data/docview/2155621346/se-2?accountid=12899

England, K., Eakin, J, Gastaldo, D., & McKeever, P. (2007). *Neoliberalizing homecare. Managed competition and restructuring of home care in Ontario*. Retrieved: http://faculty.washington.edu/england/Neolibhome.pdf

Epslen, E. (2009). *Gender and care*. Overview report. BRIDGE Development Gender. Retrieved:

https://www.inmujer.gob.es/publicacioneselectronicas/documentacion/Documentos/DE0930.pdf

European Commission. (2018). *Challenges in long-term care in Europe*. Retrieved: file:///C:/Users/0114174s/Downloads/KE-01-18-637-EN-N%20(1).pdf

European Commission. (2011). *Europe 2020 flagship initiative innovation union*. Retrieved: https://ec.europa.eu/info/research-and-innovation/strategy/goals-research-and-innovation-policy/innovation-union_en

European Federation for Older People. (2015). *How "ageing" has found its place on European policy agendas*. Retrieved: http://www.eurag-europe.net/how-ageing-has-found-its-place-on-european-policy-agendas/

European Union. (2012). *Charter of fundamental rights of the European Union*. Retrieved: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:12012P/TXT

EUSTaCEA. (2010). *The European charter of rights and responsibilities of older people in need of long term care and assistance*. Retrieved: https://www.age-platform.eu/sites/default/files/22495_guide_accompagnement_EN_low.pdf

Evans, K. (2002). Taking control of their lives? Agency in young adult transitions in England and the New Germany. *Journal of Youth Studies, 5*:3, 245-269. DOI: 10.1080/1367626022000005965

Facchinetti, G., D'Angelo, D., Piredda, M., Petitti, T., Matarese, M., Oliveti, A., & De Marinis, M. (2020). Continuity of care interventions for preventing hospital readmission of older people with chronic diseases: A meta-analysis. *International Journal of Nursing Studies, 101*, 103396. https://doi.org/10.1016/j.ijnurstu.2019.103396

Faulkner, M. (2001). A measure of patient empowerment in hospital environments catering for older people. *Journal of Advanced Nursing, 34*(5), 676-686. DOI: 10.1046/j.1365-2648.2001.01797.x

Fenge, L. (2001) Empowerment and community care – projecting the 'voice' of older people. *Journal of Social Welfare and Family Law, 23* (4), 427-439. DOI: 10.1080/09649060110079332

Ferguson, I. (2007). 'Increasing user choice or privatizing risk? The antinomies of personalization'. *The British Journal of Social Work, 37* (3), 387-403. https://doi.org/10.1093/bjsw/bcm016

Fersch, B., & Jensen, P. (2011). Experiences with the privatization of home care: Evidence from Denmark. *Nordic journal of social research*, 2, 23-36. https://doi.org/10.7577/njsr.2051

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research, 12* (4), 531-545. https://doi.org/10.1177/104973202129120052

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. Sussex: Wiley Blackwell.

Flanagan, S., & Hancock, B. (2010). 'Reaching the hard to reach' - Lessons learned from the VCS (voluntary and community Sector). A qualitative study. *BMC Health Services Research, 10* (1), 92. doi.org/10.1186/1472-6963-10-92

Fleming G., & Taylor, B., J. (2007). Battle on the home care front: Perceptions of home care workers of factors influencing staff retention**.** *Health & Social Care in the Community, 15* (1)*,* 67-76. DOI: 10.1111/j.1365-2524.2006.00666.x

Fischer, C., S. (2009). The 2004 GSS finding of shrunken social networks: An artifact? *Am Sociol Rev. 74* (4):657–669. https://doi.org/10.1177/000312240907400408

Flick. U. (2011). *Introducing research methodology: A beginner's guide to doing a research project*. London: Sage Publishing.

Flick, U. (2006). *An introduction to qualitative research*. 3rd ed. London: Sage Publications Ltd.

Frączkiewicz-Wronka, A., Kowalska-Bobkob, A., Saganc, A., & Wronka-Pośpiech, M. (2019). The growing role of seniors councils in health policy-making for older people in Poland. *Health Policy, 123* (10), 906-911. https://doi.org/10.1016/j.healthpol.2019.05.016.

Francis, J., & Netten, A. (2003). *Home care workers: Careers, commitments and motivations*. Discussion paper 2053 Personal Social Services Research Unit. Retrieved: https://www.pssru.ac.uk/pub/dp2053.pdf

Friends of the Elderly. (2020). *Loneliness. The cruellest companion*. Retrieved: https://friendsoftheelderly.ie/

Gallagher, C.: *The Community Life of Older People in Ireland*. Lang, P. (2008). Dublin: Technical University Dublin.

Gallagher C. (2012). Connectedness in the lives of older people in Ireland: A study of the communal participation of older people in two geographic localities. *Irish Journal of Sociology, 20* (1):84-102. doi:10.7227/IJS.20.1.5

Gallagher S. (2012). *What is phenomenology?* Palgrave Philosophy Today. London: Palgrave Macmillan.

Gantly, D. (2012). *A guide to regulating the homecare market.* Irish Medical Times. April 5th 2012. Retrieved: http://www.imt.ie/features-opinion/2012/04/a-guide-to-regulating-the-homecare-market.html

Garrett, P., M. (2017). Keywords, care and neoliberalism, critical and radical. *Social Work, 5* (3), 269–85, DOI: 10.1332/204986017X15029697164201

Gatlin, T., & Johnson, M. (2011). Two case examples of reaching the hard to reach: Low income minority and LGBT individuals. *Journal of Health Disparities Research and Practice. 10* (3), 153-163. https://digitalscholarship.unlv.edu/jhdrp/vol10/iss3/11

Geller, J., Janson, P., McGovern, E., & Valdini, A. (1999). Loneliness as a predictor of hospital emergency department use. *The Journal of Family Practice, 48* (10), 801-804. PMID: 12224678

Genet, N., Kroneman, M., Saltman, R., Hutchinson, A., & Boerma, W. (2012). *Homecare across Europe: Current structure and future challenges. European Observatory on Health and Social Policy.* Retrieved: http://www.euro.who.int/__data/assets/pdf_file/0008/181799/e96757.pdf

Gerst-Emerson, K., & Jayawardhana, J. (2015). Loneliness as a public health issue: The impact of loneliness on health care utilization among older adults. *American Journal*

of Public Health, 105 (5), 1013-1019. Retrieved from http://libgate.library.nuigalway.ie/login?url=https://www-proquest-com.libgate.library.nuigalway.ie/docview/1674426659?accountid=12899

Gesler, W., M. (1992). Therapeutic landscapes: Medical issues in light of new cultural geography. *Social Science and Medicine, 34* (7),735-746. https://doi.org/10.1016/0277-9536(92)90360-3

Gierszewski, D., & Kluzowicz, J. (2021). The role of the University of the Third Age in meeting the needs of older adult learners in Poland. *Gerontology and Geriatrics Education, 42* (3), 437-451. https://doi.org/10.1080/02701960.2021.1871904

Giddens, A. (1996). *Modernity and self-identity: Self and society in the late modern age.* Cambridge: Polity Press.

Gierveld, J. d. J., Van Tilburg, T. G., & Dykstra, P. A. (2018). New ways of theorizing and conducting research in the field of loneliness and social isolation. In A. L. Vangelisti & D. Perlman (Eds.), *The Cambridge handbook of personal relationships* (pp. 391–404). Cambridge University Press. https://doi.org/10.1017/9781316417867.031

Gilleard, C., Hyde, M., & Higgs, P. (2007). The impact of age, place, aging in place, and attachment to place on the well-being of the over 50s in England. *Research on Aging, 29* (6), 590–605. https://doi.org/10.1177/0164027507305730

Gilligan, M., Karraker, A., & Jasper, A. (2018). Linked lives and cumulative inequality: A multigenerational family life course framework. *J Fam Theory Rev, 10* (1), 111-125. doi:10.1111/jftr.12244

Gil-Monte, P., R. (2012). The influence of guilt on the relationship between burnout and depression. European *Psychologist, 17* (3), 231–236. https://doi.org/10.1027/1016-9040/a00009

Glasser, W. (2004). A new vision for counselling. *The Family Journal, 12* (4), 339-41. https://doi.org/10.1177/1066480704267486

Glasser, W. (2020). *What is choice theory?* Retrieved: https://wglasser.com/what-is-choice-theory/

Gogtay, N. (2010). Principles of sample size calculation. *Indian J Ophthalmol, 58* (6), 517-518. doi: 10.4103/0301-4738.71692.

Government of England. (2018). *A connected society. A strategy for tackling loneliness-laying the foundations for change.* Retrieved: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/936725/6.4882_DCMS_Loneliness_Strategy_web_Update_V2.pdf

Government of England. (2014). *Care Act 2014*. The National Archives.

Government of England. (2000). *Care Standards Act 2000*. Retrieved: http://www.legislation.gov.uk/ukpga/2000/14/notes/division/2

Government of England. (2008). *Health and Social Care Act 2008*. Retrieved: http://www.legislation.gov.uk/ukpga/2008/14/introduction

Government of England. (2012). *Health and Social Care Act.* The National Archives.

Government of England. (2002). *National Health Service Reform and Care Professions Act 2002.* Retrieved: http://www.legislation.gov.uk/ukpga/2002/17/pdfs/ukpga_20020017_en.pdf

Government of Ireland. (1995). *Child Care (Placement of Children in Residential Care) Regulations, 1995*. Retrieved: http://www.irishstatutebook.ie/eli/1995/si/259/made/en/print

Government of Ireland. (1990). *Health (Nursing Home) Act 1990*. Retrieved: http://www.irishstatutebook.ie/eli/1990/act/23/enacted/en/html

Government of Ireland. (2012). *Health (Professional Homecare) Bill 2012*. Retrieved: http://www.oireachtas.ie/documents/bills28/bills/2012/0612/0612d.pdf

Government of Ireland. (2014). *Health (Professional Homecare Bill) 2014.* Houses of the Oireachtas. Dublin: Stationary Office.

Government of Ireland. (2009). *Nursing Home Support Scheme Act 2009*. Retrieved: http://www.irishstatutebook.ie/eli/2009/act/15/enacted/en/html

Government of Ireland. (1970). *The Health Act*. Retrieved: http://www.irishstatutebook.ie/1970/en/act/pub/0001/sec0061.html#sec61

Government of Ireland/. (2007). *The Health Act 2007. (Care and Welfare of Residents in Designated Centres for Older People)*. Retrieved: http://www.nuigalway.ie/medhousinglawrightsandpolicyia//nationalpolicy/olderpeople/en.si.2010.0036.pdf

Government of Ireland. (2020). *Programme for Government.* Retrieved: https://www.gov.ie/en/publication/7e05d-programme-for-government-our-shared-future/

Government of Ireland. (1968). *The Care of the Aged: Report of an Inter-Departmental Committee on the Care of the Aged, 1968*. Dublin: Government Publications

Government of Ireland. (2009). *Fair Deal Scheme*. Retrieved: https://www.gov.ie/en/service/0d6b5-fair-deal-scheme/

Government of Ireland. (2021). *Nursing Homes Support Scheme(Amendment Act 2021).* Retrieved: https://www.oireachtas.ie/en/bills/bill/2021/76/

Government of Ireland. (2006). *Towards 2016: Ten-year framework social partnership agreement 2006-2015.* Dublin: Stationary Office.

Government of United Kingdom. (2018). *PM launches Government's first loneliness strategy*. Retrieved: https://www.gov.uk/government/news/pm-launches-governments-first-loneliness-strategy

Government of United Kingdom. (2020). *Policy paper: Loneliness annual report January 2020*. Retrieved: https://www.gov.uk/government/publications/loneliness-annual-report-the-first-year/loneliness-annual-report-january-2020--2#progress

Government of Ireland. (2015). Assistant Decision Making and Capacity Act. Retrieved: https://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html

Government of Ireland. (1937). *Constitution of Ireland*. Retrieved: https://www.irishstatutebook.ie/eli/cons/en/html

Government of Ireland. (2013). *The national positive ageing strategy*. Retrieved: https://assets.gov.ie/11714/d859109de8984a50b9f2ae2c1f325456.pdf

Government of Ireland. (2017).*Adult Safeguarding Bill*. Retrieved: https://data.oireachtas.ie/ie/oireachtas/bill/2017/44/eng/initiated/b4417s.pdf

Gray, M., Dean, M., Agllias, K., Howard, A., & Schubert, L. (2015). Perspectives on neoliberalism for human service professionals. *The Social Service Review, 89* (2), 368-392. https://doi.org/10.1086/681644

Green, O., & Ayalon, L. (2016). Whom do migrant home care workers contact in the case of work-related abuse? An exploratory study of help-seeking behaviors. *Journal of Interpersonal Violence, 31* (19), 3236-3256. https://doi-org.libgate.library.nuigalway.ie/10.1177/0886260515584347

Green, O., & Ayalon, L. (2017). The contribution of working conditions and care recipient characteristics to work-related abuse and exploitation of migrant home care workers. *Employee Relations, 39* (7), 1001-1014. doi/10.1108/ER-07-2016-0136/full/html

Greig, G., Entwistle, V., & Beech, N. (2012). Addressing complex healthcare problems in diverse settings: Insights from activity theory. *Social Science & Medicine, 74* (3), 305-312. DOI: 10.1016/j.socscimed.2011.02.006

Gu, D., Dupre, M., & Qiu, L. (2016). Self-perception of uselessness and mortality among older adults in China. *Archives of Gerontology and Geriatrics, 68*, 186-194. https://doi.org/10.1016/j.archger.2016.10.015

Guarnizo, L., & Rodriguez, G. (2017). Paid domestic work, globalization, and informality. *Population Space and Place, 23* (7). DOI: 10.1002/psp.2084

Gulliford, M., Nathani, S., & Morgan, M. (2006). What is "continuity of care"? Journal of Health Services Research & Policy, 11(4), 248–250. https://doi.org/10.1258/135581906778476490https://doi.org/10.1258/135581906778476490

Guthrie, B., Saultz, J., W., Freeman, G., K., & Haggerty, J., L. (2008). Continuity of care matters. *BMJ, 337*, 867 doi:10.1136/bmj.a867

Hadi, M., A. & José Closs, S. (2016). Ensuring rigour and trustworthiness of qualitative research in clinical pharmacy. *Int J Clin Pharm, 38*: 641-646. https://doi.org/10.1007/s11096-015-0237-6

Hansen, A., M. (2016). Rehabilitative bodywork: Cleaning up the dirty work of homecare. *Sociology of Health & Illness, 38* (7), 1092-1105. https://doi.org/10.1111/1467-9566.12435

Hanson, G., Perrin, N., A. Moss, H., Laharnar, N., & Glass, N. (2015). Workplace violence against homecare workers and its relationship with workers health outcomes: A cross-sectional study. *BMC Public Health, 15* (11), 1-13. https://doi.org/10.1186/s12889-014-1340-7

Haslett, D., Ruddle, H., & Hennessy, G. (1998). *The future organisation of the home-help service.* Dublin: National Council on Ageing and Older People.

Haeusermann, T. (2018). Professionalised intimacy: How dementia care workers navigate between domestic intimacy and institutional detachment. *Sociology of Health & Illness, 40* (5), 907-923. DOI: 10.1111/1467-9566.12730

Hayes, L., & Moore, S. (2017). Care in a time of austerity: The electronic monitoring of homecare workers time. *Gender, Work and Organisation, 24* (4), 329-244. DOI: 10.1111/gwao.12164

Hawkley, L. C., & Cacioppo, J. T. (2010). Loneliness matters: A theoretical and empirical review of consequences and mechanisms. *Behavioral Medicine, 40* (2), 218–227. https://doi.org/10.1007/s12160-010-9210-8

Hawthorn University of Third Age. (2022). *About us*. Retrieved: https://u3ahawthorn.org.au/about-us/

Hawthorne, G. (2006). Measuring social isolation in older adults: Development and initial validation of the friendship scale. *Social Indicators Research, 77*(3), 521-548. https://doi.org/10.1007/s11205-005-7746-y

HCCI. (2019). *Providing more citizens the freedom to live at home. A roadmap to the statutory scheme for homecare in Ireland*. Retrieved: https://hcci.ie/news/

Health Information and Quality Authority. (2018). *National standards for children's residential centres*. Retrieved: https://www.hiqa.ie/areas-we-work/childrens-services

Health Information and Quality Authority. (2016). *National standards for residential care settings for older people in Ireland*. Retrieved: https://www.hiqa.ie/reports-and-publications/standard/national-standards-residential-care-settings-older-people-ireland

Hedman, M. G., Pöder, U. L., Mamhidir, A., Nilsson, A., Kristofferzon, M., & Häggström, E. (2015). Life memories and the ability to act: The meaning of autonomy and participation for older people when living with chronic illness. *Scandinavian Journal of Caring Sciences*, *29* (4), 824-833. doi: 10.1111/scs.12215

Hendricks, J. (2012). Considering life course concepts. *The Journals of Gerontology, 67B*, (2), 226–231, https://doi.org/10.1093/geronb/gbr147

Herber, O., & Johnston, B. (2012). The role of healthcare support workers in providing palliative and end-of-life care in the community: A systematic literature review. *Health & Social Care in the Community, 21* (3), 225-35. doi: 10.1111/j.1365-2524.2012.01092.x

Hernandez, M., & Iyengar, S. (2001). What drives whom? A cultural perspective on human agency. *Social Cognition, 19*(3), 269-294.

Herzog, C., Handke, C., Hitters, E. (2019). Analyzing Talk and Text II: Thematic Analysis. In: Van den Bulck, H., Puppis, M., Donders, K., Van Audenhove, L. (eds) The Palgrave Handbook of Methods for Media Policy Research. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-030-16065-4_22

Higginson, S., Warren, M., & Wood, A. (2011). An integrative mechanistic account of psychological distress, therapeutic change and recovery: The perceptual control theory approach. *Clinical Psychology Review, 31* (2), 249-59. DOI: 10.1016/j.cpr.2010.01.005

Hillcoat-Nallétamby, S. (2014). The meaning of "independence" for older people in different residential settings. *The Journals of Gerontology*, *69* (3), 419–430. https://doi.org/10.1093/geronb/gbu008

Hitlin S., & Elder, G., H. (2007). Time, self, and the curiously abstract concept of agency. *Sociological Theory, 25* (2), 170–191. https://doi.org/10.1111%2Fj.1467-9558.2007.00303.x

HIQA (2021). *Regulation of homecare. A position paper*. December 2021. Retrieved: https://www.hiqa.ie/sites/default/files/2021-12/Regulation-of-Homecare-A-Position-Paper.pdf

Hochschild, A. R. (1975). Disengagement theory: A critique and proposal. *American Sociological Review, 40* (5), 553–569. https://doi.org/10.2307/2094195

Holt-Lunstad, J., Smith, T. B., & Layton, J., B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Med*, *7* (7). DOI: 10.1371/journal.pmed.1000316

Home Care UK. (2021). *Reviews for home care, live in care and nursing care providers*. Retrieved: https://www.homecare.co.uk/

Home Instead Senior Care. (2015). *Homecare/home-help*. Retrieved: http://www.homeinstead.ie/homecare-home-help

Horsfall, D., Leonard, R., Rosenberg, J., & Noonan, K. (2017). Home as a place of caring and wellbeing? A qualitative study of informal carers and caring networks lived experiences of providing in-home end-of-life care. *Health and Place, 46*, 58-64. DOI: 10.1016/j.healthplace.2017.04.003

Houses of the Oireachtas. (2020). *Dail Eireann debate- Tuesday September 24th 2020*. Vol 998 no. 1. Retrieved: https://www.oireachtas.ie/en/debates/debate/dail/2020-09-24/29/

House of the Oireachtas. (2019). *Report on the provision of homecare services*. Joint Committee on Health. Retrieved: https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_health/reports/2019/2019-11-21_report-on-the-provision-of-homecare-services_en.pdf

Houses of the Oireachtas. (2012). *Report on the rights of older people*. Seanad Public Consultation Committee.

Housman, J., & Dorman, S. (2005). The Almeda County study: A systematic chronological review. *American Journal of Health Education, 35* (5), 302-308. Retrieved: https://files.eric.ed.gov/fulltext/EJ792845.pdf

HSE. (2013-d). *About health promotion*. Retrieved: http://hse.ie/eng/about/Who/healthwellbeing/Contact_Health_Promotion/

HSE. (2021). Health service employment report: March 2021. Retrieved: https://www.hse.ie/eng/staff/resources/our-workforce/workforce-reporting/health-service-employment-report-jan-2021.pdf

HSE, (2022). Home support service for older people. Retrieved: https://www.hse.ie/eng/home-support-services/

HSE. (2011). *Code of governance. Framework for the corporate and financial governance of the health service executive*. Retrieved: https://www.hse.ie/eng/about/who/directoratemembers/codeofgovernance/hsecodeofgovernance2015.pdf

HSE. (2014). *Health's ageing crisis: Time for action. A future strategy for Ireland's long-term residential care sector*. Nursing Homes Ireland. Retrieved: https://www.lenus.ie/bitstream/handle/10147/313000/health%27sageingcrisistimeforaction.pdf?sequence=1&isAllowed=y#:~:text=It%20is%20estimated%20that%20approximately,in%20long%2Dterm%20residential%20care.&text=The%20percentage%20of%20older%20people,%25%20for%20those%20aged%2090%2

HSE. (2014). *Homecare packages*. Retrieved: http://www.hse.ie/go/homecarepackages/

HSE. (2013-a). *Home-help worker pilot training commences in Donegal*. Retrieved: http://www.hse.ie/eng/services/news/media/pressrel/newsarchive/2013archive/nov2013/homehelppilottrainingdonegal.html

HSE. (2019). *Home support services for older people*. Retrieved: https://www.hse.ie/eng/home-support-services/

HSE. (2020). *Home support service for older people*. Retrieved: https://www.hse.ie/eng/home-support-services/

HSE. (2018a). *HSE home support service. Information booklet*. Retrieved: https://www.hse.ie/eng/home-support-services/home-support-services-information-booklet.pdf

HSE. (2008). *HSE HR Circular 10/2008*. Retrieved: http://circulars.gov.ie/pdf/circular/hse/2008/10.pdf

HSE. (2015). Integrated care programmes: Developing an integrated care system for Ireland. *Newsletter (1).*

HSE. (2013-b). *Infection prevention and control. An information booklet for home-helps and personal assistants*. Retrieved: https://www.hpsc.ie/A-Z/MicrobiologyAntimicrobialResistance/InfectionControlandHAI/Factsheet/File,13739,en.pdf

HSE. (2010). *National guidelines and procedures for the standardised implementation of the homecare packages scheme.* Retrieved: http://lenus.ie/hse/bitstream/10147/120850/1/hcpsguidelines.pdf

HSE. (2012). *New approved service providers in homecare services.* Retrieved: http://www.hse.ie/eng/services/news/newsarchive/2012archive/june12/Approvedhomecare.html

HSE. (2016). *Support for carers*. Retrieved: http://www.hse.ie/eng/services/list/4/olderpeople/carersrelatives/Support_for_Carers.html

HSE. (2013-c). *Primary care home-help Service*. Retrieved: http://www.hse.ie/eng/services/list/2/PrimaryCare/pcteams/mw/KIpcc/homehelp.html

HSE. (2014). *Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures*. Retrieved: https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf

HSE. (2018-b). *National guidelines and procedures for standardised implementation of the home support service. (HSS guidelines).* Retrieved: https://www.hse.ie/eng/services/list/4/olderpeople/national-guidelines-and-

procedures-for-the-standardised-implementation-of-the-home-support-service-hss-guidelines.pdf

Hudson, B. (2016). *The failure of privatised adult social care in England. What is to be done?* Centre for Health and Public Interest. Retrieved: https://chpi.org.uk/papers/reports/failure-privatised-adult-social-care-england-done/

Humphreys, J., Waterman, J. (2015). A comprehensive health service evaluation and monitoring framework. *Evaluation and Programme Planning*, *15* (4), 91-98. DOI: 10.1016/j.evalprogplan.2015.08.006

Hye-Young, J. (2020). Factor associated with successful ageing among community dwelling older adults based on ecological system model. *International Journal of Environmental Research and Public Health, 17.* 3220. doi:10.3390/ijerph17093220

Institute of Public Care. (2012). *Where the heart is… a review of the older people's homecare market in England*. Oxford Brookes University. Retrieved: http://ipc.brookes.ac.uk/publications/pdf/Where_the_heart_is_IPC_MAC_Review_of_Home_Care.pdf

Ivanova, K., & Dykstra, P. (2015). *Ageing without children*. Erasmus University Rotterdam. Retrieved: file:///C:/Users/0114174s/Downloads/RePub_79305_AAM.pdf

Ivey, J. (2011). Focus groups. *Pediatric Nursing, 37* (5), 251. DOI:10.4337/9781849809870.00025

Johnson, J., & Jan, E., Mutchler, J. (2014). The emergence of a positive gerontology: From disengagement to social involvement. *The Gerontologist, 54* (1), 93–100. https://doi.org/10.1093/geront/gnt099

Jones, A., Chan, E., A. & Wong, K. (2013). The relationships between communication, care and time are intertwined: A narrative inquiry exploring the impact of time on registered nurses' work. *Journal of Advanced Nursing, 69* (9), 2020– 2029. doi: 10.1111/jan.12064

Jones J., & Smith ,J. (2017). Ethnography: Challenges and opportunities. *Evidence-Based Nursing, 20*, 98-100. doi.org/10.1136/eb-2017-102786

Kahlke, K. (2014). Generic qualitative approaches: Pitfalls and benefits of methodological mixology. *International Journal of Qualitative Methods, 13,* 37-52. https://doi.org/10.1177%2F160940691401300119

Kajonius, P., & Kazemi, A. (2016). Structure and process quality as predictors of satisfaction with elderly care. *Health and Social Care in the Community, 24* (6), 699–707. DOI: 10.1111/hsc.12230

Kay, R. (2013). 'She's like a daughter to me': Insights into care, work and kinship from rural Russia. *Europe-Asia Studies, 65* (6), 1136-1153. https://doi.org/10.1080/09668136.2013.778566

Karner, T. (1998). Professional caring: Homecare workers as fictive kin. *Journal of Ageing Studies, 12* (1), 69-82. https://doi.org/10.1016/S0890-4065(98)90021-4

Kawam, E. (2012). The rise of neoliberal rhetoric and the intersection of modern day medicaid priority: A study of young residents in nursing homes. *Disability Studies Quarterly, 32* (1). DOI: http://dx.doi.org/10.18061/dsq.v32i1.1643

Kenny, R., A. Turner, N., & Donoghue, O. (2018). *Wellbeing and Health in Ireland's over 50s 2009-2016. Chapter 1: Introduction*. The Irish Longitudinal Data on Ageing. Retrieved: https://tilda.tcd.ie/publications/reports/pdf/w4-key-findings-report/Chapter%201.pdf

Khan, S. (2014). Qualitative research method: Grounded theory. *International Journal of Business Management,* (11), 224—233. DOI:10.5539/ijbm.v9n11p224

Kiersey, R., & Coleman, A. (2017). *Approaches to the regulation and financing of home care services in four European countries. An evidence review*. Health Research Board. Retrieved: https://www.lenus.ie/bitstream/handle/10147/621437/HRBAHRFundingEvidenceReview.pdf?sequence=1&isAllowed=y

Kiger, M., E. & Varpio, L. (2020) Thematic analysis of qualitative data: AMEE Guide No. 131, *Medical Teacher, 42* (8), 46-854. DOI: 10.1080/0142159X.2020.1755030

Kihlgren, A., Blomberg, K., & James, I. (2014). A reciprocal relationship - an opportunity and a solution for a meaningful daily life in home care - the older person's perspective. *Clinical Nursing Studies, 3* (1), 71. doi.org/10.5430/cns.v3n1p71

Killeen, C. (1998). Loneliness: An epidemic in modern society. *Journal of Advanced Nursing, 28* (4), 762-70. doi: 10.1046/j.1365-2648.1998.00703

Kim, I., Noh, S., & Muntaner, C. (2013). Emotional demands and the risks of depression among homecare workers in the USA. *International Archives of Occupational and Environmental Health, 86* (6), 635-644. https://doi.org/10.1007/s00420-012-0789-x

Klinenberg, E. (2016). Social isolation, loneliness, and living alone: Identifying the risks for public health. *American Journal of Public Health (1971), 106* (5), 786-787. DOI:10.2105/AJPH.2016.303166

Knapp, M. R. (1977). The activity theory of aging: An examination in the English context. *Gerontologist, 17* (6), 553-559. https://doi.org/10.1093/geront/17.6.553

Koch, T. (2006). Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing, 53* (1), 91-101. https://doi.org/10.1111/j.1365-2648.2006.03681.x

Kook, R., Harel-Shalev, A., & Yuval, F. (2019). Focus groups and the collective construction of meaning: Listening to minority women. *Women's Studies International Forum, 72*, 87-94. https://doi.org/10.1016/j.wsif.2018.12.004

Krause, N. (2007). Age and decline in age specific feelings of control. *The Journals of Gerontology, 61* (1), 28-35. https://doi.org/10.1093/geronb/62.1.S28

Kuzuya, M., Hasegawa, J., Hirakawa, Y., Enoki,H., Izawa, S., Hirose, T., Iguchi, A. (2011). Impact of informal care levels on discontinuation of living at home in community-dwelling dependent elderly using various community-based services. *Archives of Gerontology and Geriatrics, 52* (2), 127-132. https://doi.org/10.1016/j.archger.2010.02.016

Lang, A. (2010). There's no place like home: Research, practice and policy perspectives regarding safety in homecare. *International Journal for Quality in Health Care*, *22* (2) 75–77. https://doi.org/10.1093/intqhc/mzq007

Larsson, K., & Silverstein, M. (2004). The effects of marital and parental status on informal support and service utilization: A study of older Swedes living alone. *Journal of Aging Studies, 18* (2), 231 – 244. https://doi.org/10.1177%2F0192513X07303837

Law Reform Commission. (2011). *Report: The Legal aspects of professional homecare*. Retrieved: http://www.lawreform.ie/_fileupload/reports/r105carers.pdf

Law Reform Commission. (2019). *A regulatory framework for adult safeguarding*. Issues Paper. Retrieved: https://www.lawreform.ie/_fileupload/Issues%20Papers/LRC%20IP%2018-2019%20A%20Regulatory%20Framework%20For%20Adult%20Safegaurding.pdf

Lečei, A., & Lepičnik, J. (2014). Implicit theories of educators and William Glasser's choice theory. *Methodological Horizons, 9* (2), 35-46. /doi.org/10.32728/mo.09.2.2014.04

Lemon, B. W., Bengtson, V. L., Peterson, J. A. (1972). An exploration of the activity theory of aging: Activity types and life satisfaction among in-movers to a retirement community. *Journal of Gerontology, 27* (4), 511-523. doi: 10.1093/geronj/27.4.511

Lengen, C., & Kistemann, T. (2012). Sense of place and place identity: Review of neuroscientific evidence. *Health and Place, 18* (5), 1162-1171. https://doi.org/10.1016/j.healthplace.2012.01.012

Liang, J., & Luo, B. (2017). It was all planned … now what? Claiming agency in later life in reforming China. *Ageing and Society, 37* (10), 2074-2102. doi:10.1017/S0144686X16000830

Liljas, A., Walters, K., Jovicic, A., Manthorpe, J., Iliffe, S., Goodman, C., & Kharicha, K. (2017). Engaging hard-to-reach groups in health promotion: The views of older people and professionals from a qualitative study in England. *The Lancet (British Edition), 390*, S58. DOI:https://doi.org/10.1016/S0140-6736(17)32993-8

Lindeboom, M., & Ewijk, R. (2015). Babies of the war: The effect of war exposure early in life on mortality throughout life. *Biodemography and social biology, 61* (2), 167-86. 10.1080/19485565.2015.1047489.

Lindquist, L., Ramirez-Zohfeld, V., Forcucci, C., Sunkara, P., & Cameron, K. (2018). Overcoming reluctance to accept home-based support from an older adult

perspective. *Journal of the American Geriatrics Society, 66* (9), 1796-1799. doi: 10.1111/jgs.15526.

Litchman, M. (2014). *Qualitative research for the social sciences*. California: Sage.

Liu, S. W., Singer, S. J., Sun, B. C., & Camargo, C. A., Jr. (2011). A conceptual model for assessing quality of care for patients boarding in the emergency department: Structure-process-outcome. *Academic Emergency Medicine: Official Journal of the Society for Academic Emergency Medicine, 18* (4), 430–435. https://doi.org/10.1111/j.1553-2712.2011.01033.x

Lloyd, L. (2010). The individual in social care: The ethics of care and the 'personalisation agenda' in services for older people in England. *Ethics and Social Welfare, 4* (2), 188-200. DOI: 10.1080/17496535.2010.484262.

Loneliness Taskforce. (2018). *A connected Island. An Ireland free from loneliness*. A report from the loneliness taskforce. Retrieved: https://assets.gov.ie/11714/d859109de8984a50b9f2ae2c1f325456.pdf

Lothian, K., Philp, I. (2001). Care of older people: Maintaining the dignity and autonomy of older people in the healthcare setting. *BMJ*, *322* (7287), 668-670. doi: https://doi.org/10.1136/bmj.322.7287.668

Lundstrom, F. & Mc Keown, K. (1994). *Home-help services for elderly people in Ireland.* Dublin: National Council for the Elderly.

Lynott, R., J., & Passuth-Lynott, P. (1996). Tracing the course of theoretical development in the sociology of aging. *The Gerontologist*, *36* (6), 749 - 760. https://doi.org/10.1093/geront/36.6.749

Machielse, A., & Duyndam, J. (2020). Strategies of socially isolated older adults: Mechanisms of emergence and persistence. *Journal of Aging Studies, 53*, 100852. https://doi.org/10.1016/j.jaging.2020.100852

Maddox, J., G. (1964). Disengagement theory: A critical evaluation. *Gerontologist, 57,* 80-82. https://doi.org/10.1093/geront/4.2_Part_1.80

Maguire, M. & Delahunt, B. (2017). *Doing a thematic analysis: A practical, step-by-step guide for learning and teaching Scholars*. Dundalk IT.

Mallers, M., Claver, M., & Lares, L. (2014). Perceived control in the lives of older adults: The influence of Langer and Rodin's work on gerontological theory, policy, and practice. *The Gerontologist, 54* (1), 67-74. doi-org.libgate.library.nuigalway.ie/10.1093/geront/gnt051

Martin, W. C. (1973). Activity and disengagement: Life satisfaction of in-movers into a retirement community. *Gerontologist, 13* (2), 224-227. https://doi.org/10.1093/geront/13.2.224

Marin, A. (2004). Are respondents more likely to list alters with certain characteristics? Implications for name generator data. *Social Networks, 26* (4), 289-307. https://doi.org/10.1016/j.socnet.2004.06.001

Marmot, M., & Wilkinson, R. (2006). *Social determinants of health* (2nd Ed). Oxford: Oxford University Press.

May, P., Normand, C., Matthews, S., Kenny, R., A. Romero-Ortuno, R., & Tysinger, B. (2022). Projecting future health and service use among older people in Ireland: an overview of a dynamic microsimulation model in The Irish Longitudinal Study on Ageing. *HRB Open Res 2022, 5*: 21 (https://doi.org/10.12688/hrbopenres.13525.2)

Mayo-Wilson, E., Grant, S., Burton, J., Parson, A., Underhill, K. & Montgomery, P. (2014). *Preventative home visits for mortality, morbidity and institutionalization in older adults: A systematic review and meta-analysis*. *PLOS One.* Retrieved: http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0089257

McDonald, A., Lolich, L., Timonen, V., & Warters, A. (2019). "Time is more important than anything else": Tensions of time in the home care of older adults in Ireland. *International Journal of Care and Caring, 3*(4), 501-515. https://doi.org/10.1332/239788219X15622468259858

Mc Garrigle, C., & Kenny, R., A. (2020). *The Irish Longitudinal Study on Ageing.* Trinity College Dublin. Retrieved: https://tilda.tcd.ie/publications/reports/pdf/Report_CareandCaring.pdf

McDonald, L., & Thomas, C. (2013). Elder abuse through a life course lens. *International Psychogeriatrics, 25* (8), 1235-1243. doi:10.1017/S104161021300015X

Mc Gill, P. (2009). *Working paper on research needs in Ireland*. CARDI. Retrieved: www.cardi.ie/userfiles/CARDI_Research%20Needs.doc

McPherson, M., Smith-Lovin, L., & Brashears, M., E. (2006). Social isolation in America: Changes in core discussion networks over two Decades. *American Sociological Review, 71* (3):353-375. doi:10.1177/000312240607100301

McPhaul, K., Lipscomb, J., & Johnson, J. (2010). Assessing risk for violence on home health visits. *The Journal for the Home Care and Hospice Professional, 28* (5), 278-289 doi: 10.1097/NHH.0b013e3181dbc07b

Mc Question, M., J. (2006). *Quality of Care*. Baltimore: John Hopkins University.

Menec, V. H., × Nancy, E. N., Mackenzie, C. S., Shooshtari, S., & Nowicki, S. (2019). Examining individual and geographic factors associated with social isolation and loneliness using Canadian longitudinal study on aging (CLSA) data. *PLoS One, 14*(2) doi:https://doi-org.nuigalway.idm.oclc.org/10.1371/journal.pone.0211143

Merceille, J., & O'Neill, N. (2020). The growth of private home care providers in Europe: The case of Ireland. *Social Policy and Administration*. Epub ahead of print 1 September 2020. DOI: 10.1111/spol.12646.

Mercille, J. (2017). Neoliberalism and health care: The case of the Irish nursing home sector. *Critical Public Health, 28* (5), 1-14. 10.1080/09581596.2017.1371277.

Merriam, S., B. (2009). *Qualitative research. A guide to design and implementation*. San Francisco: Jossey-Bass.

Messer M. (2019). Poor, old and in need of care: A qualitative study about the consequences for home care and participation. *GMS e-journal, 17* (8), 1-8. https://doi.org/10.3205/000274

Metcalf, S. (2017, August 17). *Neoliberalism*: *The idea that swallowed the world*. The Guardian. Retrieved from www.theguardian.com/news/2017/aug/18/neoliberalism-the-idea-that-changed-the-world

Migrants Rights Council of Ireland. (2013). *Migrant workers in the homecare sector: Preparing for the elder boom in Ireland*. Retrieved: https://www.mrci.ie/wp-

content/uploads/2015/09/Migrant-Workers-in-the-Home-Care-Sector-Preparing-for-the-Elder-Boom-in-Ireland.pdf

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods, 5* (1), 25-35. https://doi.org/10.1177/160940690600500103

Mitchell O'Connor, M. (2013). *Our Constitution must not pigeon hole women*. Retrieved: http://www.marymitchelloconnor.ie/our-constitution-must-not-pigeon-hole-women/

Mirowsky, J. (1997). Age, subjective life expectancy, and the sense of control: The horizon hypothesis. *Journal of Gerontology: Social Sciences, 5* (2), 125-134. DOI: 10.1093/geronb/52b.3.s125

Mody, L., Miller, D. K., McGloin, J. M., Freeman, M., Marcantonio, E. R., Magaziner, J., & Studenski, S. (2008). Recruitment and retention of older adults in aging research. *Journal of the American Geriatrics Society, 56* (12), 2340–2348. https://doi.org/10.1111/j.1532-5415.2008.02015.x

Molloy, G., McGee, H., O'Neill, D., & Conroy, R. (2010). Loneliness and emergency and planned hospitalizations in a community sample of older adults. *Journal of the American Geriatrics Society, 58* (8), 1538-1541. https://doi-org.libgate.library.nuigalway.ie/10.1111/j.1532-5415.2010.02960.x

Moore, K., & Ryan, A. (2017). *The lived experiences of nursing home residents in the context of the nursing home as their "home"*. Ulster University. Retrieved: https://nhi.ie/wp-content/uploads/2019/05/UU_NHI_Executive_Summary_Final.pdf

Moore, L., Sian, J., & Hayes, B. (2017). Taking worker productivity to a new level? Electronic monitoring in homecare-the (re)production of unpaid labour. *New Technology, Work, and Employment, 32* (2), 101-114. https://doi.org/10.1111/ntwe.12087

Morse, J., Barrett M., Mayan, M., Olson, K & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1* (2), 13-23. https://doi.org/10.1177/160940690200100202

Morgan, T., Wiles, J., Moeke-Maxwell, T., Black, S., Park, H., Dewes, O., & Gott, M. (2020). 'People haven't got that close connection': Meanings of loneliness and social isolation to culturally diverse older people. *Aging & Mental Health, 24* (10), 1627-1635. DOI: 10.1080/13607863.2019.1633619

Mortimer, J., & Green, M. (2015). *Briefing: The health and care of older people in England 2015*. Age UK. Retrieved: http://www.cpa.org.uk/cpa/docs/AgeUK-Briefing-TheHealthandCareofOlderPeopleinEngland-2015.pdf

Mottaghi, S., Poursheikhali, H., & Shameli, L. (2019). Empathy, compassion fatigue, guilt and secondary traumatic stress in nurses. *Nursing Ethics, 27* (2), 494-505. https://doi-org.libgate.library.nuigalway.ie/10.1177/0969733019851548

Moulton, G., Frankish, J., Rootman, I., Cole, C., & Gray, D. (2006). Building on a foundation: Strategies, processes and outcomes of health promotion in primary health care settings. *Primary Health Care Research & Development, 7* (3), 269-277. doi:10.1191/1463423606pc286oa

Mulvihill. R. (1993). *Voluntary-statutory partnership in community care of the elderly*. Dublin: National Council for the Elderly. Retrieved: https://www.lenus.ie/bitstream/handle/10147/337592/ocr-voluntaryelderlycare.pdf?sequence=1&isAllowed=

Murphy C., & O'Sullivan, M. (2021). Running to stand still? Two decades of trade union activity in the Irish long-term care sector. *Transfer: European Review of Labour and Research, 27*(3):383-397. doi:10.1177/10242589211028461

Murphy, C., Whelan, B., Normand C. (2015). Formal home-care utilisation by older adults in Ireland: Evidence from the Irish Longitudinal Study on Ageing *(TILDA). Health Soc Care Community, 23 (*4): 408-418. http://www.ncbi.nlm.nih.gov/pubmed/25442330

My Homecare. (2015). *Assisted living services.* Retrieved: http://myhomecare.ie/portfolio-view/assisted-living/

Nakaishi, L., Moss, H., Weinstein, M., Perrin, N., Rose, L., Anger, W. K. Hanson, G., Christian, M., & Glass, M. (2013). Exploring workplace violence among home care workers in a

consumer-driven home health care program. *Workplace Health Saf*. 61, 441–50. https://doi.org/10.1177/216507991306101004

Nakrem, S., Vinsnes, A.G., Harkless, G.E., Paulsen, B., & Seim, A. (2013). Ambiguities: Residents' experience of 'nursing home as my home'. *International Journal of Older People Nursing, 8* (3), 216-225. doi:10.1111/j.1748-3743.2012.00320.x

Nasol, K., & Francisco-Menchavez, V. (2021). Filipino home care workers: Invisible frontline workers in the COVID-19 crisis in the United States. *The American Behavioral Scientist*, *65* (10), 1365-1383. doi.org/10.1177/00027642211000410

National Council for the Aged. (1983). *Community services for the elderly*. Dublin: National Council for the Aged. Retrieved: https://www.lenus.ie/bitstream/handle/10147/336284/elderlycommunityservices.pdf?sequence=1&isAllowed=y

National Council for the Elderly. (1994). *Home help services in Ireland: Proceedings of a conference*. Royal Marine Hotel Dun Laoghaire, 1st and 2nd December 1994. Dublin: National Council for the Elderly. Retrieved: https://www.lenus.ie/bitstream/handle/10147/559392/homehelpservforelderlyirldec94.pdf?sequence=1&isAllowed=y

National Economic and Social Council. (2012). *Quality and standards in human services in Ireland: Homecare for older people.* National Economic and Social Development Office. Retrieved: *www.nesc.ie/en/publications/publications/nesc-reports/*

National Health Service England. (2009). *Care Quality Commission (Registration) Regulations 2009*. Retrieved: http://www.cqc.org.uk/sites/default/files/2009_3112s-care-quality-commission-regulations-2009.pdf

National Health Service. (2015). *The care certificate*. Skills for Care. Retrieved: http://nwl.hee.nhs.uk/files/2014/07/Care-Certificate-briefing-and-Qs-and-As-PDF.pdf

Nelson, T., D. (2005). Ageism: Prejudice against our feared future self. *Journal of Social Issues, 61* (2), 207-221. DOI: 10.1111/j.1540-4560.2005.00402.x

Netten, A., Beadle-Brown, J., Caiels, J., Forder, J., Malley, J., Smith, N., Towers, A. M., Trukeschitz, B., Welch, E. & Windle, K. (2011). *Adult Social Care Outcome Toolkit. Main Guidance V2.1.* University of Kent.

Neuman, W. (2014). *Social research methods qualitative and quantitative approaches.* Essex: Pearson.

Newquist, D. D., DeLiema, M., & Wilber, K. H. (2015). Beware of data gaps in homecare research: The streetlight effect and its implications for policy making on long-term services and supports. *Medical Care Research and Review, 72* (5), 622–640. doi:10.1177/1077558715588437

Neysmith, S. (2018). *Using ageism as a lens for challenging inequalities in homecare*. Social Work & Policy Studies: Social Justice, Practice and Theory. University of Toronto.

Nicholson, N.R. (2012). A review of social isolation: An important but underassessed condition in older ddults. *J Primary Prevent* **33,** 137–152 (2012). https://doi.org/10.1007/s10935-012-0271-2

North/South Interparlimentary Association. (2013). *Caring for an ageing society*. The Northern Ireland Assembly and the Library & Research Service of the Houses of the Oireachtas.

Nowell, L. S., Norris, J, M., White, D. E., & Moules, N, J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 6, (1).doi:10.1177/1609406917733847

Nursing and Midwifery Board in Ireland. (2022). *NMBI and the registration of nurses and midwives.* Retrieved: https://www.nmbi.ie/Registration

Ochieng, N.T., Wilson, K., Derrick, C.J., & Mukherjee, N. (2018). The use of focus group discussion methodology: Insights from two decades of application in conservation. *Methods Ecol Evol, 9* (1), 20– 32. https://doi.org/10.1111/2041-210X.12860

Office of the Ombudsman. (2010). *A Report to the Dáil and Seanad in accordance with section 6(7) of the Ombudsman Act 1980.* Retrieved: http://www.ombudsman.gov.ie/en/Publications/Investigation-Reports/HSE-Nursing-Homes/Who-Cares/Who-Cares.pdf

Officer, A., Schneiders, M., Wu, D., Nash, P., Thiyagarajan, J., & Beard, J. (2016). Valuing older people: Time for a global campaign to combat ageism. *Bulletin of the World Health Organization, 94* (10), 710-710A. DOI:10.2471/BLT.16.184960

Ohta, R., Ryu, Y., Kitayuguchi, J., Gomi, T., & Katsube, T. (2020) Challenges and solutions in the continuity of home care for rural older people: A thematic analysis. *Home Health Care Services Quarterly, 39*:2, 126-139, DOI: 10.1080/01621424.2020.1739185

Oireachtas (2018). *Opening statement on home care supports to the joint Oireachtas Committee on health*. Age Action. For all Older People. Retrieved: https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_health/submissions/2018/2018-12-12_opening-statement-celine-clarke-head-of-advocacy-and-communications-age-action_en.pdf

Olds, J., & Schwartz, R. (2009). *The lonely American drifting apart in the twenty-first century*. Boston: Beacon Press.

Oliver, P. (2014). *Writing your thesis* (Third ed., Sage study skills). Los Angeles: Sage.

Olson, S. (2010). *The role of human factors in healthcar*e. Workshop Summary. Division of Behavioural and Social Sciences and Education. National Research Council of National Academics.

O'Shea, E. (2003). *Health aging in Ireland: Policy, practice and evaluation.* National Council on Aging and Older People.

O'Neill, N. (2020). *Privatisation, precarity and pandemic*. TASC. Retrieved: https://www.tasc.ie/blog/2020/04/28/privatisation-precarity-and-pandemic/People

O'Sullivan, C. (2012 August 23). *No plans to regulate private homecare sector despite plans.* Irish Examiner. Retrieved: http://www.irishexaminer.com/ireland/no-plans-to-regulate-private-homecare-sector-despite-calls-205005.html

O'Shea, E. (2017). *The economics and financing of care for dependent older people in Ireland.* Houses of the Oireachtas. Retrieved: https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_health/submissions/2017/2017-11-15_opening-statement-eamon-o-shea_en.pdf

O'Shea, E., & Monaghan, C. (2017). An economic analysis of a community-based model for dementia care in Ireland: A balance of care approach. *International Psychogeriatrics, 29*(7), 1175-1184. doi:10.1017/S1041610217000400

O'Sullivan, T. (2019). The contribution of religious to Irish healthcare. *Studies: An Irish Quarterly Review*, *108*(431), 288–297. https://www.jstor.org/stable/10.35939/studiesirishrev.108.431.0288

Östman, M., Bäck-Pettersson, S., Sundler, A., & Sandvik, A. (2021). Nurses' experiences of continuity of care for patients with heart failure: A thematic analysis. *Journal of Clinical Nursing, 30*(1-2), 276-286. DOI: 10.1111/jocn.15547

Pettigrew, S., Donovan, R., Boldy, D., & Newton, R. (2014). Older people's perceived causes of and strategies for dealing with social isolation. *Aging & Mental Health, 18* (7), 914-920. DOI: 10.1080/13607863.2014.899970

Palmer, E., & Eveline, J. (2012). Sustaining low pay in aged care work. Gender, *Work & Organization, 19* (3), 254–275. https://doi-org.libgate.library.nuigalway.ie/10.1111/j.1468-0432.2010.00512.x

Parks, J,. A. (2003). *No place like home? Feminist ethics and home health care*. Bloomington, Ind: Medical Ethics Ser.

Parliamentary and Health Service Ombudsman (2016). *Breaking down the barriers: Older people and complaints about healthcare*. Retrieved: https://www.ombudsman.org.uk/sites/default/files/Breaking_down_the_barriers_report.pdf

Parsons, J., Rouse, P., Robinson, E., Sheridan, N., & Connolly, M. (2012). Goal setting as a feature of homecare services for older people: Does it make a difference? *Age and Ageing, 41* (1), 24–29. https://doi.org/10.1093/ageing/afr118

Patmore, C. (2004). Quality in homecare for older people: Factors to pay heed to. *Quality and Ageing, 5* (1), 1-14. DOI: 10.1108/14717794200400005

Perlman, D., & Joshi, P. (1987). The revelation of loneliness. *Journal of Social Behaviour and Personality, 2* (2), 63-77.

Phelan, A., Duggan, A., Fealy, G., & O'Donnell, D. (2018). *An evaluation of the consumer directed home care pilot project in community healthcare organisation 3*. Retrieved: https://www.hse.ie/eng/services/list/4/olderpeople/consumer-directed-home-support-evaluation-report.pdf

Phelan, A. (2008). Elder abuse, ageism, human rights and citizenship: Implications for nursing discourse. *Nursing Enquiry, 15* (4), 320-329. **https://doi.org/10.1111/j.1440-1800.2008.00423.x**

Piercy, K., W. (2001). We couldn't do without them: The value of close relationships between older adults and their nonfamily caregivers. *Generations, 25* (2), 41-47. Retrieved: http://libgate.library.nuigalway.ie/login?url=https://search-proquest-com.libgate.library.nuigalway.ie/docview/212185787?accountid=12899

Pikhartova, J., Bowling, A., & Victor, C. (2016). Is loneliness in later life a self-fulfilling prophecy? *Aging & Mental Health, 20* (5), 543-549. DOI: 10.1080/13607863.2015.1023767

Powell, J,. L., & Hendricks, J. (2009). The sociological construction of ageing: lessons for theorising", *International Journal of Sociology and Social Policy, 29*, (1/2), 84-94. https://doi.org/10.1108/01443330910934745

Probst, B. (2015). The eye regards itself: Benefits and challenges of reflexivity in qualitative social work research. *Social Work Research, 39* (1), 37-48. https://doi.org/10.1093/swr/svu028

Quine, S., & Morrell, S. (2006). Fear of loss of independence and nursing home admission in older Australians. *Health & Social Care in the Community, 15* (3), 212-220. https://doi.org/10.1111/j.1365-2524.2006.00675.x

Quinlan, M., Bohle, P., & Rawlings-Way, O. (2014). Health and safety of homecare workers engaged by temporary employment agencies. *Journal of Industrial Relations, 57* (1), 94-114. doi-org.libgate.library.nuigalway.ie/10.1177/0022185614541179

Rabiee, P., Baxter, K., Clarke, S., & Glendinning, C. (2012). *Personalisation of homecare for older people using managed personal budgets.* NIHR School for Social Care Research.

Rabiee, P., & Glendinning, C. (2014). Choice and control for older people using homecare services: How far have council-managed personal budgets helped? *Quality in Ageing and Older Adults, 15* (4), 1-20. DOI: 10.1108/QAOA-04-2014-0007

Randall, O. (1962). Elaine Cumming and William E. Henry, "Growing old: The process of disengagement" (Book Review). *Social Service Review, 36*(1), 99.

Randolph, J. (2009). A guide to writing the dissertation literature review. *Practical Assessment, Research, and Evaluation,* 14 (13). DOI: https://doi.org/10.7275/b0az-8t74

Rappange, D., Brouwer, W., Rutten, F., & Van Baal, P. (2010). Lifestyle intervention: From cost savings to value for money. *Journal of Public Health, 32* (3), 440–447. https://doi.org/10.1093/pubmed/fdp079

Reeves, S., Peller, J,. Goldman, J., & Kitto, S. (2013). Ethnography in qualitative educational research: AMEE Guide No. 80. *Medical Teacher, 35* (8), e1365-e1379. DOI: 10.3109/0142159X.2013.804977

Riedi, M., Mantovan, F., & Them, C. (2012). Being a nursing home resident-- A challenge for one's identity. *Pflege Z. 65* (5), 280-285. doi: 10.1155/2013/932381

Roberts, K., Dowell, A,. & Nie, J., B. (2019) Attempting rigour and replicability in thematic analysis of qualitative research data; a case study of codebook development. *BMC Med Res Methodol 19*, 66. https://doi.org/10.1186/s12874-019-0707-y

Robinson, F., & Lachman, M. (2017). Perceived control and ageing: A mini review and directions for future research. *Gerontology, 63*, 435-442. DOI: 10.1159/000468540

Rodin, J. (1990). Control by any other name: Definitions, concepts, and processes. In Rodin J. Schooler C. Schaie K. W. (Eds.), *Self-directedness, cause and effects throughout the life course* (pp. 1–17). Hillsdale, NJ: Lawrence Erlbaum Associates.

Rokach, A. (2016). *The correlates of loneliness*. Bentham Science Publishers.

Rokach, A. (2019). *The psychological journey to and from loneliness development, causes, and effects of social and emotional isolation*. London: Academic Press.

Rolf, D. (2016). Life on the Homecare Front. *Generations (San Francisco, Calif.) 40*, (1), 82-87.

Roos, V., & Klopper, H. (2010). Older persons' experiences of loneliness: A South African perspective. *Journal of Psychology in Africa, 20* (2), 281-289. DOI: 10.1080/14330237.2010.10820377

Rosedale, M. (2007). Loneliness: An exploration of meaning. *Journal of the American Psychiatric Nurses Association, 13* (4), 201-209. doi.org/10.1177/1078390307306617

Ross, C. E., & Mirowsky, J. (2002). Age and the gender gap in the sense of control. *Social Psychology Quarterly, 65*,125-145. https://doi.org/10.2307/3090097

Rubio-Marin, R. (2016). The (dis)establishment of gender: Care and gender roles in the family as a constitutional matter. *International Journal of Constitutional Law, 13*, (4) 787–818. https://doi-org.libgate.library.nuigalway.ie/10.1093/icon/mov059

Ruddle, H., Donoghue F., & Mulvihill, R. (1997). *The years ahead report: A review of the implementations of its recommendations.* Dublin: The National Council of Ageing and Older People.

Ruiz, I., & Nicolas, M. (2017). The family caregiver: The naturalized sense of obligation in women to be caregivers. *Enfermia Global, 49*, 434-447. DOI: https://doi.org/10.6018/eglobal.17.1.292331

Sage Advocacy. (2020). *Choice matters. Towards a continuum of support and care for older people*. Retrieved: https://www.sageadvocacy.ie/media/2026/choicematters2020.pdf

Sakellariou, D., & Rotarou, E., S. (2017). The effects of neoliberal policies on access to healthcare for people with disabilities. *Int J Equity Health, 16* (199), 1-8. https://doi.org/10.1186/s12939-017-0699-3

Saldana, J. (2021). *The coding manual for qualitative researchers*. Los Angeles, London: Sage.

Sánchez-García, S., García -Peña, C., Ramírez-García, E., Moreno-Tamayo, K., & Cantú-Quintanilla, G. R. (2019). Decreased autonomy in community-dwelling older adults. *Clinical interventions in aging*, *14*, 2041–2053. https://doi.org/10.2147/CIA.S225479

Scannell, L., & Gifford, R. (2017). Place attachment enhances psychological need satisfaction. *Environment and Behavior, 49* (4), 359-389. https://doi-org.libgate.library.nuigalway.ie/10.1177/0013916516637648

Schwandt, H. (2019). *Recession graduates: The long-lasting effects of an unlucky draw*. Policy Briefing. Stanford Institute for Economic Policy Research.

Settersten, R., A. (2015). Relationships in time and the life course: The significance of linked lives. *Research in Human Development, 12* (3/4), 217-223. DOI:10.1080/15427609.2015.1071944

Sharma, N., Chakrabarti, S., & Grover, S. (2016). Gender differences in caregiving among family - Caregivers of people with mental illnesses. *World journal of psychiatry, 6* (1), 7–17. doi:10.5498/wjp.v6.i1.7

Sheehan, A. and O'Sullivan, R., (2020). *Ageing and Public Health – an overview of key statistics in Ireland and Northern Ireland*. Dublin: Institute of Public Health.

Sherwin, S., & Winsby, M., A. (2011). Relational perspective on autonomy for older adults residing in nursing homes. *Health Expect, 14* (2), 182-190. doi:10.1111/j.1369-7625.2010.00638.x

Shinan-Altman, S., Soskolne, V., & Ayalon, L. (2020). Becoming a home care worker: Job-seekers' push and pull factors. *Research on Aging, 42* (2), 62-71. DOI: 10.1177/0164027519886176

SIPTU. (2015). *Employment guidelines for the homecare sector: The workers perspective*. Retrieved: https://www.siptu.ie/media/publications/file_19530_en.pdf

Silverman, R., & Patterson, K. (2015). *Qualitative research methods for community development*. New York: Oxfordshire: Routledge.

Sime, C., & Collins, S. (2019). Compassionate communities and collective memory: A conceptual framework to address the epidemic of loneliness. *British Journal of Community Nursing, 24* (12), 580-584. DOI10.12968/bjcn.2019.24.12.580

Simeone, S., Vellone, E., Pucciarelli, G., & Alvaro. R. (2021). Homecare workers in Italy: A narrative review. *Ann Ig. 33* (2), 163-176. doi: 10.7416/ai.2021.2422. PMID: 33570088.

SIPTU. (2009). *Employment guidelines for the homecare sector. The worker's perspective*. Carers Association. Migrants Rights Council Ireland. Retrieved: https://www.siptu.ie/media/publications/file_19530_en.pdf

Smith, S., Murphy, E., Hannigan, C., Dinsmore, J., & Doyle, J. (2019). Supporting older people with multimorbidity: The care burden of home health-care assistants in Ireland. *Home Health Care Services Quarterly, 38* (3), 241-255. DOI: 10.1080/01621424.2019.1614506

Smith, H., & Noble, J. (2015). Issues of validity and reliability in qualitative research. *Evidence based nursing online, 18* (2), 1-2. doi: 10.1136/eb-2015-102054

Social Care Institute for Excellence. (ND). *Understanding common induction*. Retrieved: http://www.scie.org.uk/workforce/induction/introduction.asp

Social Protection Committee and the European Commission. (2014*). Adequate protection for long-term care needs in an ageing society*. Luxembourg: Publication Office of the European Commission. Retrieved: https://opeuropaeu/en/publication-detail/-/publication/71532344-ddf1-4d34-a7aa-f65c701a22a2

Spong, C. Y., Bianchi, D., W. (2017). Improving public health requires inclusion of underrepresented populations in research. *JAMA, 319* (4), 337–338. doi:10.1001/jama.2017.19138

Stacey, C., L. (2005). Finding dignity in dirty work: The constraints and rewards of low-wage home care labour. *Sociology of Health & Illness, 27* (6), 831-854. DOI: 10.1111/j.1467-9566.2005.00476.x

Stanisława, G., Groot, W., Pavlova, M., & Baji, P. (2016). Health promotion targeting older people. *BMC Health Services Research, 16* (5), 345-345. DOI https://doi.org/10.1186/s12913-016-1514-3

Starfield, B. (2011). *Primary Care Assessment-the PCAT*. John Hopkins Bloomberg School of Public Health.

Sterling, M., Tseng, E., Poon, A., Cho, J., Avgar, A., Kern, L., Ankuda, C., & Dell, N. (2020). Experiences of home health care workers in New York city during the coronavirus

disease 2019 pandemic: A qualitative analysis. *JAMA Internal Medicine, 180* (11), 1453-459. doi:10.1001/jamainternmed.2020.3930

Stern, C., Jordan, Z., & McArthur, A. (2014). Developing the review question and inclusion criteria. *American Journal of Nursing, 114* (4), 53-56. doi: 10.1097/01.NAJ.0000445689.67800.86

Stones, D., & Gullifer, J. (2016). At home it's just so much easier to be yourself: Older adults' perceptions of ageing in place. *Ageing and Society, 36* (3), 449-481. doi:10.1017/S0144686X14001214

Stuckey, H.,L. (2015) The second step in data analysis: Coding qualitative research data. *J Soc Health Diabetes, 3,* 7-10. https://d-nb.info/1183546165/34

Sudbery, J. (2009). *Human growth and development: An introduction for social workers*. London; New York: Routeledge.

Sydor, A. (2013). Conducting research into hidden or hard-to-reach populations. *Nurse Researcher, 20* (3), 33-37. doi: 10.7748/nr2013.01.20.3.33.c9495

Sykes, W., & Groom, C. (2011). *Older people's experiences of homecare in England.* Equality and Human Rights Commission.

Tang, K., & Jik-Joen, L. (2006). Global social justice for older people: The case for an international convention on the rights of older people. *The British Journal of Social Work, 36* (7),1135-1150. http://www.jstor.org/stable/23721353

Tanskanen, J., & Anttila, T. (2016). A prospective study of social isolation, loneliness, and mortality in Finland. *American journal of public health, 106* (11), 2042–2048. https://doi.org/10.2105/AJPH.2016.303431

Taylor, H. (2019). Social isolation's influence on loneliness. *Clin Soc Work J, 48 (1),* 140-151. doi: 10.1007/s10615-019-00737-9

Teijlingen, E., R. & Hundley, V. (2001). The importance of pilot studies. *Social Research Update, 35.* University of Surrey. Retrieved: http://sru.soc.surrey.ac.uk/SRU35.PDF

The Citizen's Assembly. (2017*). How we best respond to the challenges and opportunities of an ageing population.* (2nd Report). Retrieved: https://2016-

2018.citizensassembly.ie/en/How-we-best-respond-to-challenges-and-opportunities-of-an-ageing-population/Final-Report-on-how-we-best-respond-to-the-challenges-and-opportunities-of-an-ageing-population/Final-Report-on-Older-People-Incl-Appendix-A-D.pdf

The Institute of Public Health in Ireland (2018). *Improving home care services in Ireland: An overview of the findings of the department of health's public consultation*. Dublin: Institute of Public Health in Ireland.

The Institute of Public Health in Ireland. (2018). *Improving home care services in Ireland: An overview of the findings of the department of health's public consultation.* Dublin: Institute of Public Health in Ireland.

The National Economic Social Forum. (2009). *Implementation of the homecare package scheme.* National Economic and Social Development Office.

The Working Party on Services for the Elderly. (1988). *The years ahead: Policy for the elderly.* Dublin: The Stationary Office.

Third Age. (2016). *Tackling ageism*. Retrieved: http://www.thirdageireland.ie/news/blog/facing-ageism-head-on

Thornton, A. (2005). *Reading history sideways: The fallacy and enduring impact of the developmental paradigm on family life*. Chicago, IL: University of Chicago Press.

Thurman, W. A., & Harrison, T., C. (2020). Reaching the "hard-to-reach": Recruitment of rural-dwelling adults with disabilities. *Journal of Transcultural Nursing, 31* (2), 171-177. https://doi.org/10.1177/1043659619856667

Tillich, P. (1959). The eternal now. In Feifel, H.(1959), *The meaning of death* (pp. 30-38). New York: McGraw-Hill.

Tilvis, R., Laitala V., Routasalo, P., & Pitkal, K. (2011). Suffering from loneliness indicates significant mortality risk of older people. *Journal of Aging Research, 2011,* 1-5. *doi:10.4061/2011/534781*

Timonen, V. & Doyle, M. (2008). *Breaking the mould: New trajectories in the domiciliary care of older people in Ireland*. Retrieved: www.tara.tcd.ie/.../Breaking%20the%20mould%20-%20new%20trajector...

Timonen, V., Doyle, M., & O'Dwyer, C. (2012). Expanded, but not regulated: Ambiguity in homecare policy in Ireland. *Health and Social Care in the Community, 20* (3), 310-318. DOI: 10.1111/j.1365-2524.2011.01048.x

Timonen, V., & Lolich, L. (2019). The poor carer: Ambivalent social construction of the home care worker in elder care services. *Journal of Gerontological Social Work, 62* (7), 728-748. DOI: 10.1080/01634372.2019.1640334.

Timonen, V. (2008). From the workhouse to the home: Evolution of care policy for older people in Ireland. International Journal of Sociology and Social Policy, 28(3/4), 76-89. http://hdl.handle.net/2262/34567

Timoney, A. (2018). *Homecare for older people: Seven policy challenges.* Spotlight. Houses of the Oireachtas. Retrieved: https://data.oireachtas.ie/ie/oireachtas/caighdeanOifigiul/2018/2018-01-12_spotlight-home-care-for-older-people-seven-policy-challenges_en.pdf

Tlaiss, H.,A. (2014) Women's entrepreneurship, barriers and culture: Insights from the United Arab Emirates. *The Journal of Entrepreneurship, 23* (2):289-320. doi:10.1177/0971355714535307

Tobin, G. A., Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48*, 388–396. doi:10.1111/j.1365-2648.2004.03207.x

Tornstam, L. (1989). Gero-transcendcncc: A reformulation of the disengagement theory. *Aging Clinical and Experimental Research, 1* (1), 55–63. DOI: 10.1007/BF03323876

Turner, N., Schneider, J., Pollock, K., Travers, C., Perry-Young, L,. & Wilkinson, S. (2018). 'Going the extra mile' for older people with dementia: Exploring the voluntary labour of homecare workers. *Dementia*, *19* (7), 2220-2233. https://doi-org.libgate.library.nuigalway.ie/10.1177/1471301218817616

Tracy, S. J. (2010). Qualitative quality: Eight 'big-tent' criteria for excellent qualitative research. *Qualitative Inquiry, 16* (10), 837–851. doi: 10.1177/1077800410383121

Unison. (2012). *Time to care. A Unison Report into homecare*. Retrieved: https://www.unison.org.uk/content/uploads/2013/11/On-line-Catalogue220152.pdf

United Nations. (2022). *Open-ended Working Group on Ageing for the purpose of strengthening the protection of the human rights of older persons*. Retrieved: https://social.un.org/ageing-working-group/

United Nations. (2002). *Political Declaration and Madrid International Plan of Action on Ageing*. Second World Assembly on Ageing. Retrieved: https://www.un.org/esa/socdev/documents/ageing/MIPAA/political-declaration-en.pdf

United Nations. (1982). *Report of the world assembly on ageing*. Retrieved: https://www.un.org/esa/socdev/ageing/documents/Resources/VIPEE-English.pdf

United Nations. (1991). *United Nations Principles for Older Persons*. Retrieved: https://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx

University of Third Age Dun Laoghaire, Dalkey, Killiney. (2022). *About us*. Retrieved: https://www.u3adldk.ie/aboutus.php

Vahdat, S., Hamzehgardeshi, L., Hessam, S., & Hamzehgardeshi, Z. (2014). Patient involvement in health care decision making: A review. *Iranian Red Crescent medical journal, 16* (1), 1-7. https://doi.org/10.5812/ircmj.12454

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nurs Health Sci, 15* (3), 398-405. https://doi.org/10.1111/nhs.12048

Victor, C., Scambler, S., & Bond, J. (2009). *The social world of older people*. New York: Open University Press.

Vidman A., & Strömberg A. (2018). "Well it is for their sake we are here": Meaningful work tasks from care workers' view. *Working with Older People, 22* (2), 111-120. doi:http://dx.doi.org.libgate.library.nuigalway.ie/10.1108/WWOP-09-2017-0024

Wadensten, B. (2006), An analysis of psychosocial theories of ageing and their relevance to practical gerontological nursing in Sweden. *Scandinavian Journal of Caring Sciences, 20*, 347-354. https://doi.org/10.1111/j.1471-6712.2006.00414.x

Walsh, B., & Lyons, S. (2021). Demand for the statutory homecare support scheme. ESRI, Research Series 122. Retrieved: https://www.esri.ie/system/files/publications/RS122.pdf

Ward, M., Layte, R., & Kenny, R., A. (2019*). Loneliness, social isolation, and their discordance among older adults. Findings from the Irish Longitudinal Study on Ageing (TILDA)*. https://tilda.tcd.ie/publications/reports/pdf/Report_Loneliness.pdf

Weiss, R. S. (1973). *Loneliness: The experience of emotional and social isolation.* The MIT Press.

Ward, M., McGarrigle, C., Hever, A., O'Mahoney, A., Moynihan, S., Loughran, G., & Kenny, R., A. (2020). *Loneliness and social isolation in the COVID-19 Pandemic among the over 70s: Data from The Irish Longitudinal Study on Ageing (TILDA) and ALONE*. doi.org/10.38018/TildaRe.2020-07

Weiss, D., & Lang, F. (2012). "They" are old but "I" feel younger: Age-group dissociation as a self-protective strategy in old age. *Psychology & Aging, 27* (1), 153-163. https://doi.org/10.1037/a0024887

Westerhof, G., Whitbourne, S., & Freeman, G. (2012). The aging self in a cultural context: The relation of conceptions of aging to identity processes and self-esteem in the United States and the Netherlands. *The Journals of Gerontology, 67B* (1), 52–60, https://doi.org/10.1093/geronb/gbr075

Wiles, J., Leibing, A., Guberman, N., Reeve, J., & Allen, R. (2012). The meaning of "aging in place" to older people. *The Gerontologist, 52* (3), 357–366. https://doi.org/10.1093/geront/gnr098

Williams-McBean, C,. T. (2019). The value of a qualitative pilot study in a multi-phase mixed methods research. *The Qualitative Report, 24* (5), 1055-1064. Retrieved: https://nsuworks.nova.edu/tqr/vol24/iss5/9

Winstead, V., Yost, E. A., Cotten, S. R., Berkowsky, R. W., & Anderson, W. A. (2014). The impact of activity interventions on the well-being of older adults in continuing care communities. *Journal of Applied Gerontology, 33* (7), 888–911. https://doi.org/10.1177/0733464814537701

Witter, S., Wurie, H., Namakula, J., Mashange, W., Chirwa, Y., & Alonso-Garbayo, A. (2018). Why do people become health workers? Analysis from life histories in 4 post-conflict and post-crisis countries. *Int J Health Plann Mgmt. 33* (2), 449– 459. https://doi.org/10.1002/hpm.2485

Woolhead, G., Calnan, M., Dieppe, P., & Tadd, W. (2004). Dignity in older age: What do older people in the United Kingdom think? *Age and Ageing, 33* (2), 165-170. doi: 10.1093/ageing/afh045

Working Group on Long-Term Care. (2008). *Long-Term Care Report*. Retrieved: http://health.gov.ie/wp-content/uploads/2014/03/long_term_care_report.pdf

World Health Organisation. (2002). *Health statistics and information systems*. Retrieved: https://www.who.int/healthinfo/survey/ageingdefnolder/en/

World Health Organisation. (2009). *How can health systems respond to population ageing?* Retrieved: https://www.euro.who.int/en/health-topics/Life-stages/healthy-ageing/publications/2009/how-can-health-systems-respond-to-population-ageing

World Health Organisation. (2020). *Romania. Country case study on the integrated delivery of long-term care*. Retrieved: file:///C:/Users/0114174s/Downloads/LTC_Romania.pdf

World Health Organisation. (2014). *The case for investing in public health. A public health summary report for EPHO 8*. Retrieved: https://www.euro.who.int/__data/assets/pdf_file/0009/278073/Case-Investing-Public-Health.pdf

World Health Organisation. (2018). *The life-course approach: From theory to practice. Case stories from two small countries in Europe*. Retrieved: https://www.euro.who.int/__data/assets/pdf_file/0004/374359/life-course-iceland-malta-eng.pdf?ua=1

World Health Organisation. (1986). *The Ottawa charter for health promotion*. Retrieved: https://www.who.int/healthpromotion/conferences/previous/ottawa/en/

World Health Organisation. (2021). *Advocacy brief: Social isolation and loneliness among older people*. Retrieved: https://www.who.int/publications/i/item/9789240030749

World Health Organisation. (2022). *A toolkit on how to implement social prescribing.* Retrieved: https://www.who.int/publications/i/item/9789290619765

Wright, M. (2020). *Statutory homecare. Briefing document*. Home Instead. Retrieved: https://www.homeinstead.ie/docs/default-source/2020-Pdf/home-instead-statutory-home-care-briefing-document-2021-wv.pdf?status=Temp&sfvrsn=0.895740938149221

Wray, S. (2003). Women growing older: Agency, ethnicity and culture. *Sociology, 37* (3), 511-527. Retrieved: http://www.jstor.org/stable/42856545

Wurm, S., Warner, L., Ziegelmann, J., Wolff, J., & Schüz, B. (2013). How do negative self-perceptions of aging become a self-fulfilling prophecy? *Psychology and Aging, 28* (4), 1088-1097. doi: 10.1037/a0032845

Whyte, R., Wren, M., A., Keegan, C., & Brick, A. (2020). *An analysis of trends in Irish public healthcare expenditure and staffing*. An ESRI Working Paper. Retrieved: https://www.esri.ie/publications/an-analysis-of-trends-in-irish-public-healthcare-expenditure-and-staffing

Yin, R. K. (2011). *Qualitative research from start to finish*. New York: Guilford.

Youmans, E., G. (1969). Some perspectives on disengagement theory. *Gerontologist, 9* (4), 254-258. DOI: 10.1093/geront/9.4_part_1.254

Zaidi, A. (2018). *Implementing the Madrid Plan of Action on Ageing: What have we learned? And, where do we go from here?* United Nations Development Programme. Retrieved: http://hdr.undp.org/en/content/implementing-madrid-plan-action-ageing-what-have-we-learned-and-where-do-we-go-here

Zainab, N., & Naz, H. (2017). Daily living functioning, social engagement and wellness of older adults. *Psychology, Community and Health, 6* (1), 93-102. doi:10.5964/pch.v6i1.213

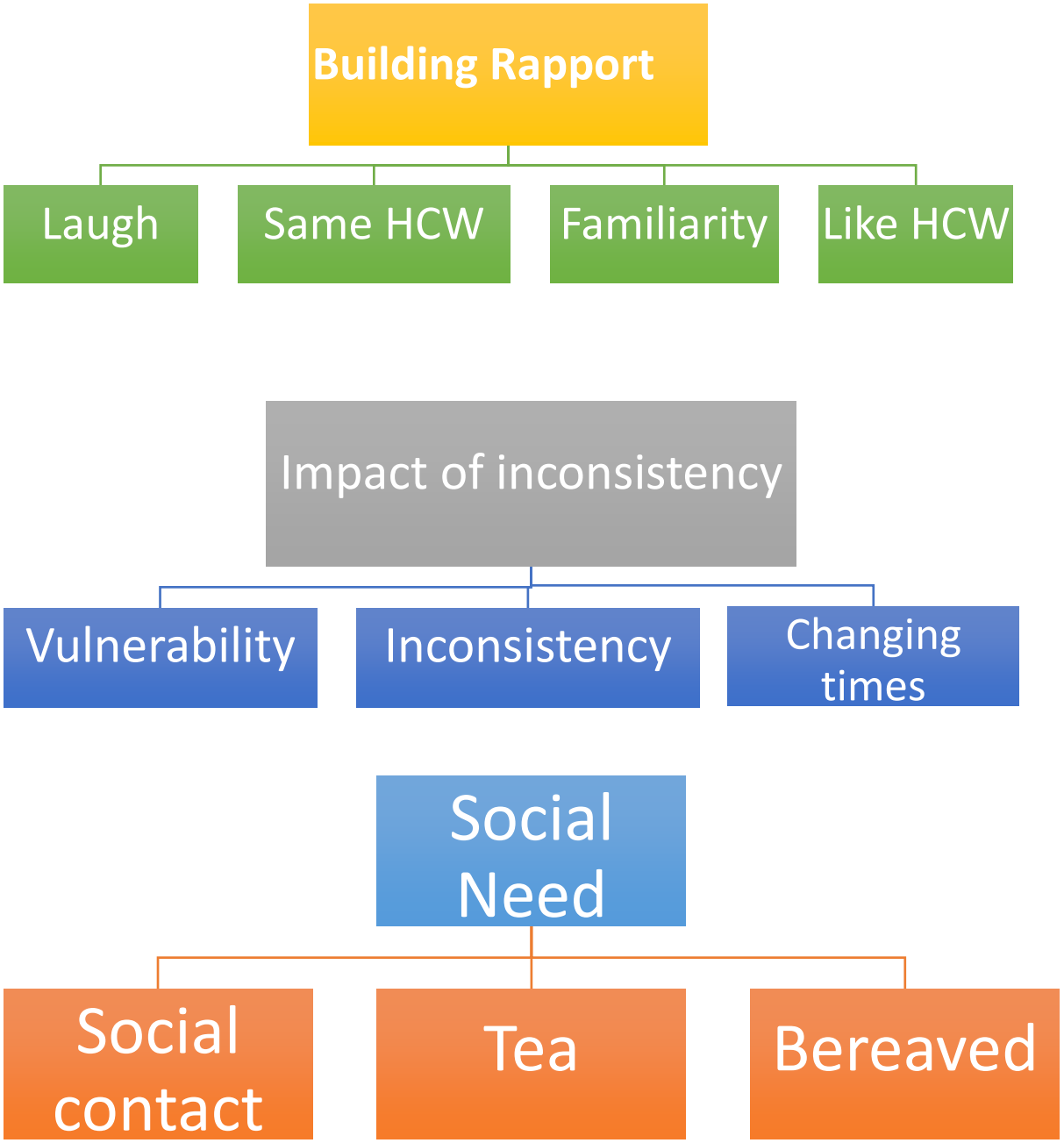
Zavaleta, D., Samuel, K. & Mills, C.,T. (2017). Measures of social isolation. *Soc Indic Res* **131,** 367–391 (2017). https://doi.org/10.1007/s11205-016-1252-2

Zhang, W., Liu, L., Tang, F., & Dong, X. (2018). Social engagement and sense of loneliness and hopelessness: Findings from the PINE study. *Gerontology & geriatric medicine*, *4*, 2333721418778189. https://doi.org/10.1177/2333721418778189

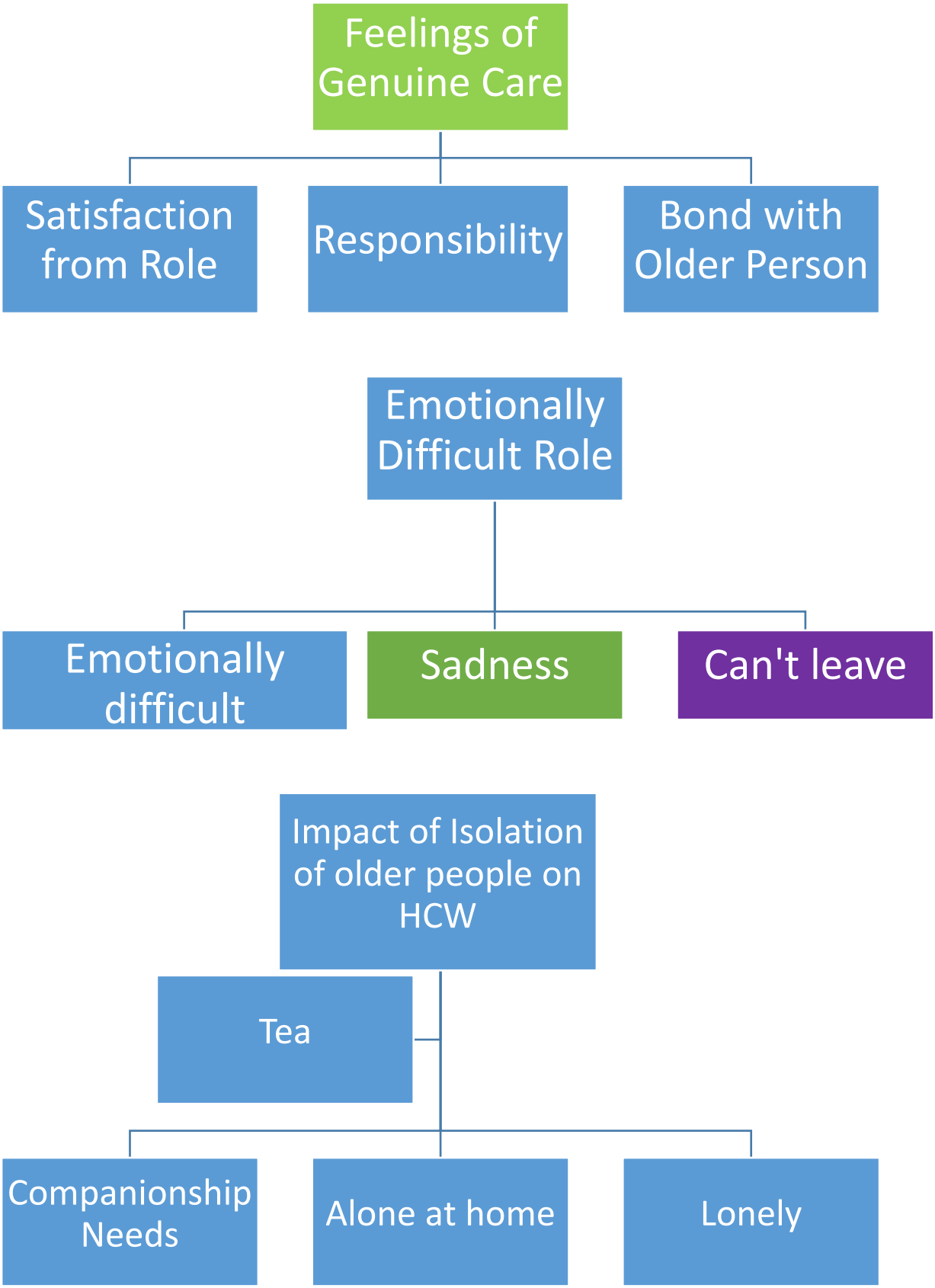
Appendices

Appendix A: Examples of code development/patterns within the data which contributed to the establishment of themes

Phase 1 Theme Development:



Phase 2 Theme Development:



Appendix B: Invitation to Participate in Interview Phase 1

Name of Study: *Older People and Homecare in Ireland: How Much Do We Care?*

Researcher: Lhara Mullins (PhD Student) Dr. Margaret Hodgins (PhD Supervisor)

Dear Sir/Madam,

I am getting in contact to ask if you would be willing to participate in my research study relating to older people and homecare. I worked as a HSE Home-Help from 2006 to 2013, during which time I found that service provision varied significantly between agencies and homecare staff.

The aim of this study is to: examine the current delivery of homecare to older people in Ireland based upon older people's experiences. I plan to interview twenty older people in receipt of homecare services, to gauge their experiences and explore the level of choice and control they feel they possess relating to their care. Interviews will last 30-45 minutes. This information gathered when analysed it is hoped will be used to create a picture of the factors which influence homecare for older people in Ireland, and perhaps influence future service provision or policy.

Participants will be fully informed of the purpose of the study and asked for written consent to partake in this study. Participants will have the right to withdraw their participation at any time. I myself have been Garda Vetted, and this study has been approved by the Research Ethics Committee in NUI Galway. Anonymity will be guaranteed to all participants and all data collected will be password protected, and stored confidentially in NUI Galway.

Please find my contact details below and do get in contact for any additional information or to express an interest in participating in this study.

Kind Regards
Lhara Mullins
Email: lhara.mullins@nuigalway.ie
Phone: 091 494433
Address: Room 230, Aras Moyola, National University of Ireland, Galway.

Appendix C: Invitation to Participate in Focus Group

Dear Active Retirement Group,

My name is Lhara Mullins and I am hoping to meet with groups for older people as part of my research on older people and homecare. I am a lecturer in NUI Galway and am undertaking my PhD. I used to work in the homecare sector and it's a massive aspect of life for some older people. I want to ask older people about their views of homecare, what works best, and what may not work so well. The focus group would be quite informal, all members who wish to take part in the discussion are welcome. It would take about a half hour in total.

I would be delighted if your group would be willing to meet with me. Please find my contact details below:

Kind Regards

Lhara Mullins

National University of Ireland
Galway

Ph: 091 494433

Appendix D: Invitation to Participate Phase 2

Room 230 Aras Moyola
National University of Ireland
Galway

Dear Homecare Manager,

My name is Lhara Mullins and I am currently undertaking a PhD entitled: Older people and Homecare in Ireland: How Much to we Care? This research aims to examine the views of both older people and homecare workers in relation to the homecare they receive/provide. I have undertaken interviews and focus groups with older people in phase one of this study. Now I am hoping to interview homecare workers. Interviews will last approximately 15-20 minutes and can be completed in NUI Galway or at the homecare provider's office if this is more convenient.

I am contacting you to ask if you would be interested in having your company participate in this research? Homecare in Ireland is profoundly under researched, yet is expanding significantly at present, hence the necessity to build the knowledge base and promote best practice.

This research has been given ethical approval from the Research Ethics Committee here in NUI Galway, and I have obtained Garda clearance. Participants may withdraw at any time throughout the research process and will be provided detailed information about this study prior to commencing the interview. Participants will also be provided a consent form prior to participation (attached).

Please get in contact if you have any queries or think that your company could be part of this research.

Kind Regards

Lhara Mullins

Ph: 091 494433

Email: lhara.mullins@nuigalway.ie

Appendix E: Interview Guide Phase 1

1. How long have you been in receipt of homecare?

2. How often do you receive homecare and for how long?

3. Do you feel these hours are sufficient to meet your care needs?

4. Do you have a regular homecare worker for an extended period of time?
   -If not, how many homecare workers provide care to you?

5. How satisfied are you with the care you receive at present?
   –What factors contribute to your level of satisfaction with the care you receive?

6. How much choice do you have in relation to decisions about your homecare? (E.g. days, times, care worker, tasks etc.)

7. Can you tell me about what makes receiving homecare a positive experience for you?

8. Can you tell me about what makes receiving homecare a negative experience for you?

9. To what extent do you feel that the homecare workers who provide you with care are properly trained to do so?

10. Have you ever had a complaint or query relating to your homecare for which you had to contact a homecare manager or supervisor?
    -If so, how was this complaint or query addressed and were you satisfied with this?

11. How frequently are your homecare needs reassessed or your homecare worker's performance monitored?

12. Is there any additional information about your homecare experience you feel may be relevant to this study?

Appendix F: Focus Group Guide Phase 1

1. What factors do you think are most important for older people in relation to the homecare they receive?
2. What factors or issues do you think may make homecare a more positive experience?
3. What factors or issues do you think may make homecare a more negative experience?
4. Would you have any concerns or worries if you were about to begin receiving homecare? If so what concerns or worries might you have?
5. Have any of you had experience with wither yourself or a friend/family member receiving homecare? If so, can you tell me a bit about your experience?

All information from this focus group will be held in the strictest confidence. No names or identifying labels will be used in the transcription. Only my supervisor Dr. Margaret Hodgins and I will have access to the transcripts. However, the overall conclusions from multiple focus groups and interviews will be used to publish a paper on older people and homecare. You can withdraw your participation at any time without consequence.

Appendix G: Interview Guide Homecare Workers (Pilot)

Context

How long have you been working in homecare?

Do you work for the HSE, a private provider or both?

What motivated you to work with older people in homecare initially?

What motivates you to continue working in homecare?

Structure

What level of education or training was necessary for you to work with your current employer?

What types of training have you received since joining this company?

Do you receive ongoing training?
-If so, how frequently?

How are your homecare visits monitored?
-How frequently does this happen?

Process

Can you tell me a bit about supports available to you from your employer which enable you to provide the best care to the older people you look after?

What are the key challenges in providing homecare for older people?

To what extent is managing time challenging in your role?

What do you think the key needs of the older people you provide care to are?

Do you have regular older people you visit every day/week?
-If so, can you tell me a bit more about these service users?

When you are providing care to an older person you haven't met before or are meeting new clients regularly, how does impact the homecare visit?

Have you had an experience of becoming close with an older person you provided care to?
-If so, can you tell me a bit more about this relationship?

Can you tell me a bit about your experience of providing homecare in relation to loneliness experienced by older people?

Outcome

How do you know when older people are satisfied with their homecare?

What are the key issues older people would make a complaint about in relation to their homecare?

Quality of Care

What are your thoughts on quality of care in homecare?

How do you think this is achieved and/or measured?

Appendix H: Interview Guide Homecare Workers

1. How long have you been working in homecare?

2. Do you work for the HSE or a private homecare provider?

3. What initially motivated you to work with older people?-what motivates you now to stay working with older people?

4. Can you tell me a bit about supports available to you from your employer which enable you to provide the best care to the older people you look after?

5. Did you receive training or have an educational qualification prior to starting work in homecare?-if so can you tell me a bit more about this?

6. What types of ongoing training does your employer provide?-How frequent is this?

7. What are the key challenges in providing homecare for older people?

8. To what extent is managing time challenging in your role?

9. What do you think the key needs of older people you provide care to are?

10. Do you have regular older people you visit every day/week? -if so, can you tell me a bit more about these clients? -If not, do you know why?

11. When you are providing care to an older person you haven't met before or are meeting new clients regularly, how does impact the homecare visit?

12. Have you had an experience of becoming close with an older person you provided care to? -If so, can you tell me a bit more about this relationship?
13. How are your homecare visits monitored? -how frequently does this happen?

14. Do you feel you have sufficient time within each homecare visits to meet the needs of the older person? -If not, can you tell me a little more about this?

15. Can you tell me about an experience when an older person was not satisfied with their care and complained? -If not, do you think older people receiving homecare are reluctant to complain?

16. In your experience, is loneliness an issue for the older people you provide care to? -If so can you give me some examples of your experience relating to loneliness?

17. Is there any other information you think might be relevant to this study you would like to add?

Appendix I: Consent form older people

Participant Consent form: Older People in Receipt of Homecare

Title of Study: *Older People and Homecare in Ireland: How Much do we Care?*

Purpose of study: To explore the factors which influence provision of homecare to older people in Ireland.

Researcher: Lhara Mullins

University: National University of Ireland, Galway.

I _____ have been provided with information relating to this study and understand my right to withdraw my participation at any time and without any repercussions.

I further understand that my confidentiality will be protected and my personal details not made public or shared with any party other than the PhD supervisor. I am aware that no identifying information will be used in the write up or any publications.

I am aware that interviews will be recorded with an audio device, and notes will be taken. I am aware that data will be stored confidentially for five years post interview.

I have given my permission for the researcher (Lhara Mullins) to make contact with my health nurse should I show significant distress post interview (this is unlikely).

Signature _____

Print Name_____

Date_____

Appendix J: Consent Form Homecare Workers

Participant Consent form: Older People in Receipt of Homecare

Title of Study: *Older People and Homecare in Ireland: How Much do we Care?*

Purpose of study: To explore the factors which influence provision of homecare to older people in Ireland.

Researcher: Lhara Mullins

University: National University of Ireland, Galway.

I _____ have been provided with information relating to this study and understand my right to withdraw my participation at any time and without any repercussions.

I further understand that my confidentiality will be protected and my personal details not made public or shared with any party other than the PhD supervisor. I am aware that no identifying information will be used in the write up or any publications.

I am aware that interviews will be recorded with an audio device, and notes will be taken. I am aware that data will be stored confidentially for five years post interview.

Signature _____

Print Name_____

Date_____

Appendix K: Ethical Approval Phase 1

Ref: 16-JULY-12

Lhara Mullins

Room 230
Aras Moyola
NUI Galway.

Dear Ms Mullins,

Re: 16-July-12 - Older People and Homecare: How Much Do We Care?

I write to you regarding the above proposal which was submitted for ethical review. At a meeting of the Research Ethics Committee, held on 1 July 2016, it was a decision of the Committee to grant the project **PROVISIONAL APPROVAL** with the below corrections/additions:

1. On page 12 Q20 – please clarify whether geographical location (within/outside County Galway) is an inclusion/exclusion criterion. In respect of Q20 (ii) please clarify who will determine whether potential participants 'appear to lack capacity' or whether there is a query concerning a diagnosis of dementia. Will this be decided by the researcher or by others?
2. This seems to allow for more exclusion from the research than would be ethically appropriate – a participant may have a diagnosis of early stage dementia, or their capacity may be questioned by others, but the older person themselves may still be interested in participating, and with support and reasonable accommodation (including having more time to make the decision and information delivered in a manner that is easy to understand) may be well able to participate. I advise the applicant to revise the exclusion criteria to ensure that only those who would be unable to provide valid free and informed consent will be excluded. This will also require edits to Q31 on pages 14 and 15 and Q39 on page 18.
3. Further, the applicant should clarify whether there a minimum number of participants with experience of public or private provision is required (e.g. at least X participants with experience of private provision) in order to be able to conduct a comparative analysis of the different homecare models and experiences.
4. On page 18 the applicant has ticked 'yes' to Q37 but has not completed Annex 3 for each of the risks identified. I would suggest that 'no' can be ticked to this question as the applicant acknowledges the potential for discomfort and distress in response to Q38 and has outlined appropriate strategies to respond to these issues.

5. In the annexes, a participant information sheet is only provided for homecare providers – none is provided for older persons, but this needs to be added.

When the decision was taken I was chairing the meeting and the following members were also present:

Dr Manus Biggs	Dr Kevin Davidson	Ms Michele Gill
Ms Geraldine McDarby	Dr. Paul O'Connor	Mr. Patrick Towers

Please reply by email confirming the above within 30 days of the date of this letter.

Yours sincerely

Allyn Fives

Chair, Research Ethics Committee

Appendix L: Ethical Approval Phase 2

Sent on behalf of Dr Jane Walsh, Acting REC Chair

21 December 2017
Ref: **17-Nov-11**

Dear Lhara,

Re: Older People and Homecare in Ireland: How Much Do We Care?

I write to you regarding the above proposal which was submitted for Ethical review. Having reviewed your response to my letter, I am pleased to inform you that your proposal has been granted **APPROVAL.**

All NUI Galway Research Ethic Committee approval is given subject to the Principal Investigator submitting annual and final statements of compliance. The first statement is due on or before 20 December 2018. Please see section 7 of the REC's Standard Operating Procedures for further details which includes other instances where you are required to report to the REC. Statement of compliance forms are attached here.

If you require a formal letter of approval, please email ethics@nuigalway.ie, quoting the **reference number** of your application.

Yours Sincerely
Jane Walsh
Acting Chair, Research Ethics Committee