

**Experiences of Home Care Workers
From Domiciliary Services in Dublin**

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Abstract

The research explores home care workers from their perspective. The design was qualitative and the method was semi-structured interviews. Five employees from agencies for domiciliary services in Dublin were interviewed. The findings indicated that the motivation for caring for HCWs is 80% money. Paid care in home settings involves much more responsibility, skills and personality. Young people found this job overwhelming. Furthermore, the study found that the organisation of the services challenge HCWs. The working conditions and the demands of the job make HCWs feel that equality in society does not apply to them. Mostly of caregivers worked 6 days per week but were paid less than minimum wage. Work intensity affects their health. After starting work as a HCW participants had less private and family time.

Introduction

In the last two decades the Irish home care industry expanded rapidly attracting many private agencies to share the state's care for aged, sick and disabled people (Doyle & Timonen, 2007). The 2015 statistics showed that the HSE budget was €655.1 million for Services for Older People. "Of the 549,300 persons aged 65 and over, 95% live at home, approximately 30% live alone, and 10% have a disability" (MRCI, 2015). The home care industry is providing care in communities, fact that allows the older people or those with disability to stay at home and live independent as long as they can with an additional help (Care Alliance, 2014). Further, the lack of political attention to the Home care sector left this fast growing industry unregulated and uncontrolled leaving the employees of the agencies and clients at risks (Doyle & Timonen, 2008). The aim of this research is to explore agency home care workers from their perspective.

1. 1 The Care Concept

Home Care Workers (HCWs) provide care for older, sick or disabled people at home. In sociology, care is linked with interaction theory. It is defined as a set of activities that promotes the wellbeing of other person and a set of feelings (Phillips, 2007, p.5). As a set of feelings it is divided as *caring about*: recognising and understanding the need for caring, choosing variants of acting in regards to these requirements. *Caring for* includes emotional involvement and taking responsibility for the caring actions (Phillips, 2007, p.15). Mayeroff, (1970, cited in Payne, 2009, p.15) suggested that the set of feelings is part of female psychology, but Lynch (Lynch at all, 2009) stated that care is universal notion and everybody can do it. Caregiving is defined as the concrete work and care receiving as a reaction allowing people to do caring (Phillips, 2007, p.31). It is love labour when a family member does care, and it is a solidarity work when the care is provided by paid or volunteering caregivers (Lynch et al., 2009).

Caring can bring many positive feelings and satisfaction in life, but it is also a work which involves 'effort, time and energy' (Lynch et al., 2009, p.36). Caring includes emotional involvement and commitment. Furthermore, it is a hard physical work which includes lifting, moving, showering and bathing. Care tasks have to be well planned, and they require skills (Lynch et al., 2009). Hence, care is a choice. The person who needs care makes a choice between institutional and home care. On the caregiver side it is an individual choice that emotionally drives someone to the person who needs care and is tied with a set of obligations, duty, love and loyalty (Phillips, 2007, p.16). Caring is an emotional commitment and involves learning how to care (Lynch et al., 2007), but being a loving person is not enough to do care. Caring is associated with an affective caring person, defined as a person, who is understanding, empathetic and has 'skilled behaviour' (Phillips, 2007, p.3).

Furthermore, Phillips (2007) stands against the dependency as an association of care. Instead, she sees promoting active aging as independence associated with care (p.15). She sees the care recipient and the caregiver as powerless and powerful. In conclusion, care is a social construct and is connected with vulnerable people and expectations that they have to be cared for (Phillips, 2007, p.25). Care is divided on formal and informal as differentiation between paid and unpaid care activities.

1. 2 Paid Care

Paid care is a global trend and emerged with the feminist movement. With the development of modern societies, women left their traditional roles of caring for husbands, children and older or sick family members to enter the job market and have a career. In recent years the home care industry replaced informal caring and the existing social order of care in the family (Payne, 2007, p.16) and attracted many migrants and local workers mostly women who fell into the trap of commodified care relationships; they have been paid to do solidarity work in the community for a living (Phillips, 2007, p. 16). When a paid carer is looking after a care recipient, he/she builds a relationship of trust and engages with the person she/he cares for. Those relationships are generating emotional capital through caring (Hochschild, 2004, cited in Payne 2009, p. 15) They can be excellent and can bring self-actualisation (Payne, 2007, p.15) for the care receiver, but they are limited by the contract of work (Hochschild, 1983). It has time limitations as service (one hour, two hours, one day, etc.) and also as

period of provision. State provision has quantity and quality (Payne p.17) and depends on the amount of care that the state can afford. It makes care work an economic exchange and product and is embedded in the social relationships. As a social product both care recipient and caregiver have rights and needs (Underson ,1989, cited in Phillips, 2007, p. 34) and that a clear distinction between the two exists. Paid care, when provided by an agency or state, is associated with standards and is controlled (Payne, 2009, p.17). It has multiple perspectives: health care, social care, home care and is shaped by national and international cultural values in caring (Payne, 2009, p.17).

1.3 Home Care

Home care is subsidised by the budgets of the countries, and what the older population needs is not always what governments can afford. It depends on the economic circumstances of the countries, national traditions in home care and cultural trends (Payne, 2009, p.17).

“Home care is a health and/or care support that is provided at home, either by healthcare professionals or informally by family or friends” (CARDI – Centre for Ageing Research and Development in Ireland, 2011). According to this definition, the paid home care is linked with informal caring as a replacement or additional support. Home care services in Ireland started as domestic help for family carers, but later, research among older and disable people in their homes in 2006, found that client’s needs were not met entirely (Wren et al., 2012, p. 40), a fact that was a turning point for the way those services were settled. The turning point was the transformation from domestic help to personal services, which include washing, dressing, grooming, showering, bathing (Wren et al., 2012 p. 142). It was made in consideration with the “government’s policy to reduce the need for long-term residential care by providing more home care for older adults with low to moderate levels of dependency” (Dr Murphy, TILDA, 2012).

Since the personal care services were included in the Home Care services’ provision, TILDA, CARDI and Care Alliance representatives began a discussion about informal and formal care should go together in the future, or should they be separated with legislation. While Dr Murphy from TILDA (2012) supported the separation of the two sectors- informal and formal, Care Alliance (2014) defended the existing typical Irish model of home care

which is keeping the two areas together. Murphy pointed out that the current system is complicated in a negative way because the domiciliary care has to be standardised, legalised, inspected and fall into social care regulations as it is in most EU countries. Care Alliance argued that it is an achievement that the formal carers support the lives of the informal carers and for that reason they should stay together. Today home care is still between medical care and social care. The Government did not make any decision about which direction home care should go so there is no legal framework for the provision of the services for people in need in the communities.

1.4 Home Care Policy

The documents that home care agencies use are HSE guidance for the provision of services (2010) and Home and Community Care Ireland standards and code of conduct (2014) which are recommendations for the running of the services and the obligations to HSE's clients. Those papers try to unify all vendors; despite that the home care industry itself is a mix of private and state provision. Furthermore, the private sector is a mix of for-profit and not for profit and is organized with home care packages, paid by the state. Irish home care has a quasi-market model: "purchasers funded by general taxation buy services from providers. The purchases may be the service users themselves, but more commonly, they are agents appointed by the state to purchase on behalf of the end-user" (Propper & Le Grand, 1997: 7, cited in Doyle & Timonen, 2007). The agent is in most of the cases the private provider, so that "more patients will get a higher quality home care service at some 70% of the current cost of delivery" (Oireachtas.ie, 2015). This model in other countries works very well because it allows the governments to unify all providers and put them under one legislation and standard of care. In Ireland, this quasi-market model is unique because the unified document is not created yet (Doyle & Timonen, 2007). The lack of a state umbrella to put everything in legal structure brings a lot of concerns about the implementation of the care at home. The only state policy for Home Care Provision is the Health Bill (2014). Care Alliance (2014) commented that this bill did not cover the issues about workers employed in the home care industry and specially the travel time: "in regards to the paying of travel time between clients also raises questions as to whether or not some home care workers are

receiving the minimum wage”. As result of that the quality of care is under question (Care Alliance, 2014). HCWs are important part of the care in communities and they should be included in government policies.

1. 5 International Home Care Workforce’s researches

Researching home care workforce is important for the provision of the care at home. Special attention is paid to the staff management, organisation of the services, staff turnover, job’s satisfaction, training and working conditions as factor related to the quality of provided care. Hewko, et all (2015) investigated the home care workforce for global trends. They found that HCWs have many different names and job description, the workers’ backgrounds in education varies from high-educated to unskilled and are mostly immigrants. The average age of caregivers is 36-45. The demand for HCWs is high, but turnover is also high. Their earning is less than other health care professionals on their level in hospital or nursing homes because of the insecurity of the hours, but the injury rates were more common for HCWs than workers in institutional settings. This research concluded that many complications exist in gathering information about HCW but even so it gave a picture of them in Western societies and the problems they are facing.

A few qualitative studies explored factors relating to the workforce that increase quality of care. While Carr (2014) and Chen (2014) found that employee retention, the opportunity for progression and recognition of their work were the factors affecting the quality of care, King et all (2013) found that improving working condition, organisation and management of the services increased job satisfaction and quality of the provided care. Netten et al.’s experiment study (2007) found that not only management of the services, but also management of the staff are important factors along with “age and experience, provider perceptions of staff turnover, and allowance of travel time, were the most critical influences on service user experiences of service quality”. Their study did an experiment to found what influence the quality of care and provided a qualification training (NVQ) for “those seen as most in need of that training: younger and less experienced care workers” and happens on the job by qualified supervisors.

Another dimension in training was explored in the study of Barken, Denton, Plenderleith, Zeytinoglu & Brookman, (2015). They researched how home care workers accepted and implemented the specific tasks which are shifted from other health professionals to them, for example, physiotherapy, catheter care, hoist lifting, etc. The researchers concluded that those tasks need to be included in the care plans and controlled, they need HCWs to receive in the field training from approved Health Professionals, but they need consistency to achieve the wellbeing of the clients.

A qualitative research of Messing, Caroly, Doniol-Shaw & Lada (2011) in France interviewed long term experienced HCWs and found that fragmentation of the tasks of the services increases not only care quality but also job stress, job dissatisfaction and set back the worker's health, wellbeing and family life. Further, the French study emphasised that only qualified workers were allowed to do personal care, work with hoists and do other specific tasks. The tasks are need oriented and include also taking care of the client's pet. HCWs provided also house cleaning for people over 50 as extra private services to sustain their amount of hours even if their client is in hospital or with family. In this research travel time is not an issue, as in the research of Netten et al. (2007), because the clients are very close to each other and carers spend a maximum of 5 to 10 minutes to transfer. This research also found that carers' long working hours, often with no time for lunch, makes carers feeling exhausted physically and emotionally and unable to meet their own family responsibilities. The research gave a recommendation for organisational reform in home care service sectors to keep the good workers longer in the industry.

In Northern Ireland Fleming and Taylor (2007) also researched the problem of high turnover from home care workers' perspectives. Their study was both quantitative and qualitative. They used a survey questionnaire and a focus group. The findings pointed out that caring is a very demanding job, but the reason for leaving and job dissatisfaction is not the job, it is the irregular and antisocial hours, lack of manager support and recognition, workload pressure and being taken for granted by the clients. Commitment to caring is what keeps the long-time workers in the company.

In summary, International researchers found that organisation of the services, management of the staff; working conditions, employees' satisfaction and quality of provided care are related to each other. Those factors have impact on employees' health and safety.

1.6 Home care workforce research in Ireland

Irish researchers were looking also for a link between caregivers' employment's terms and provision of the care in communities. The research on home care in Ireland in 1994 done by Francesca Lundström and Kieran McKeown (1994) emphasised that the poor working conditions meant high turnover. Further, they stated that the lack of organisational framework led to the unreliability of domiciliary services. As a result of that, people in need of care were left relying mostly on their families, voluntary organisations and community networks. Research by CARDI (2011) found that the services are more reliable, but poor working conditions and high turnover are still a fact.

A qualitative study done by Lynch (Lynch et al., 2009) explored experiences of family carers in Ireland. She found that the family carers were trapped in caring obligations. They are isolated; they lack time for themselves, family and friends, have health problems as result of caring for many years and are in unequal position in society. The study was urgent appeal for affective equality in Irish society. The government reacted and brought many social and financial benefits for family carers.

A literature review of relationships between formal and informal carers was written by the Care Alliance (2014). The document states that the Irish home care workers are low paid, have low status and poor working conditions. Their mileage and travel time is not paid by the providers as a result of the recent budget cuts, the fact that questions the quality of the provided care but stated that the relationships were very good and that it is an achievement.

SIPTU (2014) in collaboration with other organisations did a study of the employment conditions of HCWs. It found a breach of the employment law and human rights of the employee in private care organisations. The document urgently appealed that Irish government should step in with a National Home Care Strategy policy document, and HIQA and SEPA should be empowered to inspect the working conditions and quality of care in domiciliary services. National guidance for the employees in Irish home care industry from their perspective (2014) was issued, but it is not a legal government document.

In summary, the overview of the researches shows that the Irish home care industry is attracting many private providers as result of the rapid expansion, but is not regulated; it lacks political attention and is invisible for the society. HCWs face many problems in caring for older and disabled people in communities. International researches show that issues in regards to working conditions, training, job satisfaction, high turnover and transitional time of the employees in domiciliary services exist and challenge care provision. In the same time Irish home care workforce lack detailed study as in UK and France. What the employees of the care agencies face every day in their work is a concern, because of the lack of transparency and lack of regulations and control. This research is looking for the answer of the question: What are challenges home care workers experience in providing care for people in their homes?

Method

In order to answer the above question a research was conducted. The study was designed and implemented as qualitative. This design is suitable as the researcher is interested in analysing “textual data... that allow people to express their thoughts and beliefs in their own words and on their own terms” (Holloway, 2005, p.5). Qualitative research is designed to explore the meaning of experience by seeing the world through the eyes of the people who are involved in provision of home care services by interacting with them. It is committed to the interactive approach and the researcher is willing to learn from them (Holloway, 2005, p.5). The aim of the research is to explore the home care workforce. The general research question is: What are challenges home care workers experience in providing care for people in their homes?

2.1 Design and method

The method was in-depth interviews. The questions (Appendix 1) were semi-structured and open ended which allowed the interviewed participant to give detailed information. The researcher explored personal opinions, stories and perspectives that were shared in interactive conversations with HCWs. The interview questions were discussed with the research supervisor. There were eight main questions, but during the interviews many more supplemental questions were asked for receiving a detailed answer. Mostly of the interviews were 45 minutes long except the first which was 26 minutes and the second took more than one hour. The research was open to surprises and unexpected discovery. The interviews were recorded with a Dictaphone.

2.2 Participants

For the purpose of the research home care workers from four care companies for domiciliary services which operate in Dublin were interviewed. The chosen number of participants was six, but one of the participants injured her back during the work and was admitted to hospital. The participants were from different age groups and genders with the aim of better understanding the challenges and comparing them. Two of the participants were Irish citizens, but are not of Irish nationality. Other three participants were foreign. The employees were chosen having at least one year experience as a home care worker. All participants were recommended as very good carers. Ina was 25. She worked as home care assistant four years, but a few months ago she moved to another occupation. She was interviewed first and during the interview she stated that: “This is not a job for 22 years old”. She was asked to give a name of another home care assistant of her age to find another opinion about the job. Ann was contacted by Ina’s reference. Ann was almost 25, she was working as a HCW in two care agencies for five years while she was studying and till she found a job after she graduated. Polina, age 35, was referred by Veronica, age 46. Veronica was contacted after being told about the research by third party. Polina had eight years’ experience as a HCW in four companies. The male home care worker, Michael, age 52, was referred by the participant who was admitted to hospital. Access to caregivers was requested from the managers of the area of two companies with special letters, designed for this purpose from DBS, but actually they were contacted through snow ball method, because the managers gave permission for the interviews, but did not assist in contacting the HCWs. Every participant filled in an informed consent form. The researcher met three of the home care workers between client visits in a coffee shop. Two ex-workers – Ann and Ina were interviewed in their homes.

2.3 Method of Analysis

Once all participants were interviewed, the research found many interesting facts about the HCWs that challenge their everyday performance at work. The interviews were transcribed and findings were entered in NVIVO and were interpreted and analysed. The research found many interesting facts about the work and life of HCWs that challenge their

everyday performance at work. This programme is specially designed for a qualitative research and has all useful tools to analyse textual data. Collected data was sorted into four themes: paid care related challenges, organisational constrains, occupational and work-life balance challenges. The themes were analysed, compared to other researches and discussed. The thematic analysis' steps helped to find tendencies in the care provision, workers' related issues and to look for surprising discoveries. It also allows researchers to find out how often one and the same issue exist in the findings of all participants to make conclusion about the bigger picture.

2.4 Ethics

The research obeyed all ethical rules. An informal consent form (Appendix 2) was obtained before the interviews. This form is designed to give evidence that the participants know what they are involved in. It ensured participants that the interviews were confidential, they do not harm anybody and that interviewee voluntarily participates. The participants were respected and valued. The researcher interviewed home care workers on non- sensitive topics. For the purpose of keeping confidentiality the names of the participants were changed and their human rights respected. The participants were free to leave the interview procedure if they wished to do so. Any company information, names of the clients and addresses were not displayed in the findings and report. Although one of the participants mentioned an agency's name, this information was not displayed in the findings and discussion. The study wants to contribute to the knowledge of the home care profession and the researcher was grateful to the interviewees for helping.

Findings

3.1 Paid care challenges

Earlier in this report, care was defined as set of feelings and set of emotions. In family settings love and emotions drive one person to care for another. From all five participants only one-20% entered home care by choice. Polina used to care for her grandmother and when she came to Ireland she chose caring as a profession. Two of other participants became HCWs because was easy to work around their study arrangements (Ann and Ina). The last two- Veronica and Michael got a job as HCWs because they desperately needed work and income. 80 % of caregivers work in this industry not by choice, but because they need income. It was a challenge for them to be trapped in a job that chose them (Ann).

All participants liked the relationship's part of the job. When relationships were good, HCWs enjoy their job (Ina). When "there is no connection" they "still do the job" (Ina). Sometimes the client does not respond to their effort to build a relationship with her/him:

... you may go to someone for a long time and you still feel that distance (Polina).

Sometimes you do not get along with people (Ann).

Ann experienced being rejected by a client, because of her age:

... sometimes they think you are too young to work this job. It has nothing to do with what you can do or cannot do, they are elderly people, they look at you and say:" O, she is too young for me". They do not give you a chance.

Ann was very well trained and she was confident in her care skills, but for that particular client her age was more important than her skills. With another client she built very good relationships which continued even after she moved to another occupation. Building relationships mean also taking personal responsibility for the client. All five participants had to cover shifts with a client if the other caregivers were not available. Covers were in the time when they normally were not working, but they feel engaged with the care and they felt that they "had to do it" (Ann). Veronica and Ann stretched their physical ability to exhaustion to cover the care for clients.

HCWs are responsible not only for the care of the client in general, but also for performing all tasks in the allocated time for the visit. It requires organisational skills and it is a cognitive work:

You have to organise your shift... step by step to do everything, because sometimes the client can be very dirty, you are responsible for medication, for breakfast, for washing. You should not panic; you have to work straight... and to manage calmly, that is the main thing, how many minutes you need for this, for this, for this, you have to finish all your responsibility for this visit in the time located (Veronica).

As seen from the example working with a client involves skilled behaviour that is practised for years to master it to act without panic and frustration. It is also physical work that includes personal care, washing, cleaning, doing laundry and cooking breakfast. It is also emotional work because when caregiver “opens the door and enter client’s house have to be full of positive energy, bringing happiness or brightness to them”(Polina) even when the HCW “is not in that humour”(Polina). When care is paid, expectations of clients are higher. The caregiver is in their home to meet their needs and those needs are not only physical:

You have to listen about their problems, about what they are happy about, what they aren’t happy with, you HAVE to listen... Sometimes you listen about everything a several times (Ann).

Ann found the work emotionally overwhelming:

The whole thing about working with old people or sick people I think is too much, it is not physically, it is mentally exhausting.

In home care the worker is alone with the client and has to be able to cope in every situation, requiring problem solving skills:

... It doesn’t matter how bad it is, or how difficult it is, you try to remember what you are told or what you are trained to do and just cope...find way to cope... and do not put in danger yourself and the client (Polina).

A care recipient could have some medical condition. Dementia clients are “mostly of the time... out of reality” (Polina) and communication and general support for them can be very difficult, but the caregiver has to manage any situation that comes. Day to day work is not the same and that is the difficult and the attractive part of the job (Veronica).

Three of the participants like the job because it gives them feeling that they had done something good (Ann), “make comfort and their life easy, enjoyable and make them happy”(Veronica). Four of the participants found satisfaction in caring for someone, only Ina

did not like it, despite the fact she worked in it for four years. She thought that “it is not a job for 22 years old”, the responsibility were too big for her age.

All five participants describe their job as hard work, because

... you are dealing with people’s emotions, as well as people’s sickness, then you have to deal with people’s family, you need to be very strong.... mentally... as well as physically, because you have to turn people in bed, so you have to be strong (Ann).

Two of the participants shared that HCW has to be strong mentally and physically and the working day can be exhausting (Ann and Polina).

In summary, paid care in home settings involves much more responsibility, skills and personality than the care in institutional or family settings, because the HCW works alone with the client. Young people in the research found this job overwhelming.

3.2 Home care organisational challenges

Home care services are part of home care packages. From the previous studies mentioned earlier, the organisation of the services is very important for the quality of care. The experiences of the interviewed caregivers showed a lack of organisational strategy for efficiency of the services in term of time constrains in transitions, complains and inside house care provision. All five participants complained about how their time is wasted in transitions from client to client. The distances are long, fact that makes them travel three to six hours a day:

Question: Approximately how much time you spend driving per a day?

Around three hours between the clients + one more hour to go to the first client, and go home after the last call (Veronica).

Michael is driving also and he experienced the same:

My rosters are like that -huge distances for 30 minutes or one hour calls. I am leaving my home at 7.30 on the morning and I am out traveling and working till 22.00, 5 days per week to make 25-35 hours per week (Michael).

Ann started usually at 8 am and finished at 21.30, but sometimes before and after the usual time, because she did covers:

Question: How many hours did you make for this 6-7 working days?

Between 30-40 hours per week (Ann)

For the caregivers who use busses the situation is even worse. Polina and Ina take one hour traveling from client to client. For 10 working hours, they are paid only for 5-6 because the transition time is not paid, but they travel or wait for the time of their next client:

but the things with this job is you have to wait for the client when she needs you, it is not exactly up to you, it is up to the client when they need you (Ina).

Michael and Veronica, in contrast, do not have enough time, which makes the client to wait. Veronica tried her best to be on time for the client ignoring the traffic lights:

...the shifts are very close, I have to speed, sometimes I risked my life I crossed during the red light on the traffic lights, just I had to be on time. I know it is not right, but I have to be on time for my client.

Clients have a right to choose their time of visit. It is part of the job demands for the HCW, but in the same time better organisation will benefit everybody.

In term of qualification, only two of interviewees finished Fetac 5 qualification (Veronica and Polina). The other three participants have only a few modules. Even so the home care industry does not separate employees into qualified and non-qualified. The work was for everybody, but not all caregivers were well prepared for the job. Ann shared that sometimes she had to work with caregivers who were not trained well and as a result they scratched the door and the wall of her client, a woman with MS and caused her stress. The caregivers were required to drive the wheelchair instead of the client, but they did not know how to manipulate it. This means that: firstly, HCWs were sent to work with equipment without training, health and safety regulations were skipped; secondly, nobody controlled the action of the caregivers and the agency that sent them. Ann also shared that those working with her MS client needed training from supervisor as she was trained, but because other caregivers were not trained, they had back problems and were not confident in using the hoist. It frustrated her client.

Another job challenge is working as part of HSE team. HSE expects the agency to look after the client on their behalf and to report any changes or difficulties. But when the participants struggle with client's conditions and reported it to the agency, only in two out of several cases the agency and HSE helped the client and the caregiver: one was a case of

incontinence and the second was mobility deteriorating issue (Veronica and Polina). In other cases: hygiene of the clients, self-neglect, lack of facilities, issues about the hygiene of the houses, health and safety issues of the HCWs in one of the client's homes, the agency did not respond and the caregivers are still reporting and expecting help and support from the agency (Veronica, Michael):

“sometimes we hurt our backs because is not easy to move and to bring the hoist (...) she will live at least 10 years more and that mean 10 years at least we have to do that every day and work in a dirty house and in a dirty room and mouldy floor and everything (Veronica).

By not doing anything, agencies left the HCWs struggling in performing their everyday caring job. In two of the reported cases, the clients were wheelchair users and had dogs in their houses. Because of their disability those clients were not able to look after the dogs properly and as a result the houses had hygiene' issues. Care of the client's pet was not taken as part of the client's need; instead, the dog was treated as obstacle to the care of the client:

...in the care plan is written: “Do not wash him if the dog is there” (Michael)

As a result of the agency's lack of respond to the caregiver's reports, the hygiene of some houses and clients challenges the provision of quality care.

Better organisation of the services can increase client's satisfaction and can make HCWs job much easier and safer. Instead it is challenging caregivers' everyday performance, alongside with occupational constrains.

3.3 Workforce challenges

The evidence from this research showed that home caregivers need training in the field from health care professionals. It can benefit not only the client, but also the caregivers. Veronica complained about back pain when she worked with the hoist and heavy clients. She

said that the lack of training in the care field not only cause her back problems, but also lead to high turnover among young people:

Young people don't stay...Maybe because they do not have experience and they are confused.

At the same time Ina, who worked from age of 20 said that the supervisor helped her to get use to the tasks:

The company organised the supervisor to shadow us

The two opinions just showed that not every company prepared the workers for the client and that the training in the office is not enough. It put the caregivers and clients at risks:

the other training is to watch video, how somebody else is doing it, so you try and pick up information from that and then it looks very easy, but when comes to practice, you can see that a lot of things could get wrong (Ann).

Health and safety is important in this job and is connected with working conditions. HCWs not only work in unsafe environments, but also long working days, sometimes without breaks for lunch or dinner, because the time that they are not with a client is used to travel. Michael described that HCW's life as "on the go, and... some sandwich at lunch or dinner time... and cold coffee in a jar in the car...it is a hard life". Polina shared that because agencies do not provide time for lunch or dinner, caregivers, who are in closer relationship with the client, eat in client's house; others skip their meal time or eat on the go:

I make sandwich from home, but I never eat in the client's home, I do not feel comfortable, some carers do, ...sometimes I do not have breaks at all, grab cup of coffee, eat when walk or eat in the evening when I go home.

Furthermore, caregivers pay travel expenses for transits from client to client. From all agencies only Veronica's agency pays petrol. Those expenses shrink the wage. Ann got "just enough to pay (my) petrol, taxes on the car, insurance, bills". Polina explained:

... you receive 10-11 Euros per hour, before tax, but if you consider that I need to spend a minimum of 1.50 Euro on leap card to get to my client and then 1.50 Euro to get back from my client, it is 3 Euros only for one hour work (Polina).

Travel expenses, undeclared anywhere in employment terms and conditions make HCWs' payment less than the minimum hourly wage.

The demands of the job and the working conditions are among the factors for high turnover. Veronica was carer number 11 in her company, but six years later the new HCWs had numbers above 350. Her experience is that the turnover is mainly among young people, but job insecurity is discouraging many employees from staying in this job. HCWs shared that the hours of work vary from 10 to 50. From all participants of the interviews two already left the job, two are thinking of leaving and moving to another caring job (Veronica and Michael) and only one wants to stay in the home care industry (Polina), because she likes caring for people. But she works in two companies to secure her earnings.

3.4 Work- life challenges

All of the participants declared that their personal life changed after they started working as a HCW. It is a result of the intensity and demands of the job. Polina was 35, has been working for eight years as HCW and during those years she had “no time for children, a husband or anything like that”. She said: “If you want to earn money you have to manage work first, then the family (...) if you want the minimum (...) 38 hours”. Michael wasted so much time during the day traveling between the clients. He doesn’t have as much time for his family as he used to. Veronica was going to work when everybody was still in bed and was coming back when everybody was already in bed at night. She needed her precious family time, so she had to reduce her working hours to 30-33 from 40. Ann had time only to see her boyfriend for one hour and her friends for a coffee between two visits. The work takes a lot of caregivers’ time. Even national holidays do not apply to HCWs:

National Holidays doesn’t affect ... work’s roster. I still had my two days off and that was all. I asked in the office and the answer was: “You have roster and unless you have days off, you have to work”. Why is like that? Am I second class citizen or what? Why carers don’t have National Holidays as everybody else? (Michael)

The working conditions and the demands of the job make HCWs feel that equality in society does not apply to them. Mostly of caregivers who were interviewed worked 6 days per week.

The intensity of the work caused not only feelings of inequality but also health problems to the caregivers. Veronica felt exhausted and her health deteriorated after working full time for 6 years. The symptoms were back pain, headache and a sleeping disorder:

... but then I discover I have back pain, headache, and short sleep, and so I said: “ Money aren’t as important as my health” and I reduced my clients and my hours...and now I have Sunday off.

In conclusion, HCWs have a demanding occupation. The lack of the agencies’ organisational strategy leads to overloading of the workers with responsibilities, traveling and difficulties during the visits. The impact of the caring in communities for HCWs is less family and personal time, and health problems as a result of work intensities. Quality of care is affected along with the health and wellbeing of the workers and clients.

Discussion

This research was about exploring the experiences of home care workers. It was designed as qualitative. The review of the literature showed, that this industry expanded rapidly, that the government tried to reduce the cost of care services and left their provision to cheaper private providers without regulating and inspecting them. The main research question was to find what the challenges of home care workers are in providing care for older, sick or disabled people in their homes. The aim of the research was to explore the home care workforce. For this purpose five HCWs from four companies operating in Dublin were interviewed using semi-structured interviews.

The study found similar results to other care studies. Caring as a paid job is as demanding as caring for a family member. Caregivers sacrifice their free and family time to do caring for a living. For paid carers motivation was not love and solidarity, it was money. They were looking for a job and the home care industry offers many positions for HCWs. The government expects that this industry covers family care and puts the workers in the same circumstances as family carers. As a result they experience the same feelings of being trapped in caring obligations, working long days, the same health problems and having less time for their private life and family members as family carers. The results were concluded by comparing this research to the study of Lynch (Lynch et al., 2009) on family carers.

When HCWs started the job they liked the feeling of being good and the interactions with the clients (Ann, Michael, Polina, Veronica). The findings extended the knowledge about relationship between care recipient and caregiver. In the home care industry it is not necessary to have emotional bonds between both sides of the care: the home service can be just “an economic exchange” and lose its’ nurturing character. When the emotions are missing, the care is provided without joy (Ina). But in the same time the care relationships could continue after the contract (Ann). It is a personal choice for the caregiver and the care receiver to continue their relationships or not and in Ann’s case the care went to the field of voluntary solidarity work. Furthermore, this research confirmed the findings that care work involves physical strength. Further, it is an emotional labour, because it requires positive energy and a smile like every service work (Ann and Veronica). It is a very responsible job, expectations and responsibilities are higher than in informal caring because the caregivers

rely mostly on their skills and personal ability to manage any unexpected difficult situations while they are with the client.

In connection with previous discussion about the future of the home care, the research agrees with the Care Alliance that relationship between home care workers, agencies, care recipients and family carers in general are very good. Even so, the industry needs structural reform as demanded by the TILDA and CARDI. This reform has to be in the organisation and the inspection of the services. The research found that without regulations agencies overuse the HCWs leading to excessive working hours but in the same time not always gave them time for breaks which leave caregivers with options to have no lunch at all, eat while driving or walking from client to client or eat in client's homes in the time when they supposed to provide care. Essential human's needs were ignored by the agencies. The research repeated the finding from 1994 in Ireland and other researches internationally about unregulated hours and poor working conditions. Caring in community is very demanding job and part of this issue is related to the nature of the work, but in the same time caregivers have needs too and their employer has to meet their needs as in every other job. The research in France found the same trend- home care workers were left without time for lunch break.

All previous researchers found that caregivers are overloaded. This research found that they are not overloaded with work; they are overloaded with traveling between clients, unlimited obligation to the agencies to covers as part of their contract and responsibility to the clients. HCWs spend unpaid time to transfer from client to client which was estimated on extra 15 to 30 hours per week traveling. This is a result of the quasi- market model of services. This model offers cheaper services, but the research found that very rarely do agencies pay workers travel expenses (Veronica). The Care Alliance commented that it is a concern whether or not caregivers receive the minimum wage (2014). The answer from this research is that HCWs do not receive the minimum wage. The carers declared that their hours vary from 10 to 50. With these irregular hours the researcher is concerned about whether or not HCW are at risk of poverty or in absolute poverty. The outcome of the Irish model is high turnover because the caregivers were left at the level of survival, working to pay bills and supplement their work (Ann).

HCWs are excluded from society as result of the job demands. They minimise their social contacts and family times to make living in this job. The participants acknowledged that they give priority to the work first and then to the family or to their private life in aim to make

living. Those findings are similar to the research of French caregivers (2011). In both cases paid carers are isolated, lack contacts with their colleagues, time for family and are overloaded with their caring responsibilities.

Furthermore, the research found significant issues with client's living conditions and hygiene which affects the quality of care and they raise serious concerns about health and safety of the workers and clients in this industry. In those cases the state has to put in place standards and authorised government bodies which have to check and give further recommendation. It will benefit both clients and carers. A study of Barken et al. (2015) found that specific tasks need training and control because they are linked with the client's health and wellbeing. In a French study (Messing, Caroly, Doniol-Shaw & Lada, 2011) caregivers who do not have qualification were not allowed to do any specific personal care or exercise's tasks. In Irish home care, limits do not exist, but it was mentioned that caregivers suffer from back pain (Veronica) a fact that is result of lack of sufficient health and safety training. Ann said that just watching videos as part of the training was not efficient. One thing that came as outcome is that the carers need in the field training for the safety of the clients and carers. This research conclusion was influenced by the research of (Netten et al., 2007). UK research showed that age, experience and training are related and that training on the field increases the confidence, job satisfaction and job retention.

Another finding was that the care provision does not meet the needs of the client who has pet. It raised caregivers' concerns about hygiene. The care plans for clients with pet should include care for their pet as it is organised in French social services (Messing, Caroly, Doniol-Shaw & Lada, 2011).

The research was open to surprises and found something new in the field of Irish home care that wasn't explored in research yet. It is about young people in the home care industry and training. Two of the participants were ex-students. They do not have much experience in life, but were trained on the field and they were confident as carers (Ann and Ina), but Veronica share that not all young people were confident and were leaving the job. Some young caregivers found difficult to manage the tasks in the allocated time. The research came to conclusion that young caregivers need to be trained in the field to feel confident in their work. The Netten et al. experimental research gave a good example that training caregivers works and keeps workers in the job. Another finding that came in conversation with Ann and Ina raise questions about is the work suitable for young people or not. Ina states

that responsibilities were too large for her age, Ann said that the job makes her feel physically and mentally exhausted and Veronica stated that the turnover is high among young caregivers. Further research about young people in home care work is recommended.

The research had some limitations. The first limitation is the number of participants. A large number of participants including some office staff and service users as per other International the study will be more beneficial. The research was limit to only to Dublin area. Another limitation is the word count. Because it is a student project the researcher had to follow the requirements for the study and limit the report to the word count.

Despite the limitations, the research made some useful discoveries that will benefit the knowledge about home caregivers. Home care industry needs urgent political attention and reforms in organisation of the services and staff management and training. The lack of regulations has impact on care quality and leads to job challenges. Care job is demanding and when is not organise well extends HCWs' working hours and leave them with less private and family time. Job payments are dependent on the hours worked in service and those hours are not guaranteed, a fact that opposes equality in society, job satisfaction and retention. Most of the caregivers have to separate travel money from their wage. This fact reduces their wages below the national minimum. The job challenges have a negative impact over the personal health. Further research about HCWs and the risk of poverty line is recommended alongside with research on young people in the home care Industry and the impact of in the field training for job retention and job satisfaction.

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Appendix A

Questions for the interview:

What did motivate you to choose home care work as an occupation? What did you like?

What are the challenges in this job?

How does one of your working days look like? And week?

What do you not like in this job?

What is your engagement with the clients?

How does this work affect your private life?

How does your company support you?

What will motivate you to stay or to leave this job?

Appendix B:

Interview Consent Form



Experiences of Home Care Workers from agencies for Domiciliary Services in Dublin

My name is Petya Demireva and I am conducting research that explores experiences of home care workers.

You are invited to take part in this study and participation involves an interview that will take roughly 40 minutes.

Participation is completely voluntary and so you are not obliged to take part. If you do take part and any of the questions do raise difficult feelings, you do not have to answer that question, and/or continue with the interview.

Participation is confidential. If, after the interview has been completed, you wish to have your interview removed from the study this can be accommodated up until the research study is published.

The interview, and all associated documentation, will be securely stored and stored on a password protected computer.

It is important that you understand that by completing and submitting the interview that you are consenting to participate in the study.

Should you require any further information about the research, please contact

STUDENT Petya Demireva (1635334@mydbs.ie) or Annette Jorgensen (annette.jorgensen@dbs.ie)

Thank you for participating in this study.

Participant Signature: _____ Date: _____

