

To Keep a Person in Their Own Wee Corner: An Exploration of the Roles, Responsibilities and Services Provided by Home Care Workers in a Large Health and Social Care Trust

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*'A cradle to
grave concept'*



- Influence of local, national and worldwide demographic trends
- Government legislation, reports, initiatives, policy drivers
- Dearth of published material on role of domiciliary care staff

Why Grounded Theory? “Grounded Theories, because they are drawn from the data, are likely to offer insight, enhance understanding and provide a meaningful guide to action” (Corbin & Strauss, 2008).

- Constant comparative analysis
- Theoretical sampling
- Theoretical sensitivity

A Two Phased study utilising qualitative and quantitative approaches:

- **Phase 1:** Qualitative arm (Grounded Theory) using focus groups, semi-structured interviews and community forum meeting.
- **Phase 2:** Quantitative arm utilising a questionnaire, derived from Phase 1, which further tested the emergence of theory from phase 1.

- Focus Group interviews (n=11) [n=128].
- Semi structured qualitative interviews with senior managers across HSCT (n=3).
- 1 community forum meeting (n=48), field notes/observations and theoretical memos recorded.
- Total of n=179 participants in Phase 1
- All interviews recorded and transcribed verbatim.

- Open, axial and selective coding.
- Field notes/observations & theoretical memos.
- Multiple Diagrams.
- Emergence of sub-categories to support core category?
- Initially manual analysis of transcripts, then NVivo.
- Checking of theoretical construction against participant's meaning of phenomenon (Chiovitti & Piran, 2003, p427)

Paradigm Model

(A) CAUSAL CONDITIONS → (B) PHENOMENON →

→ (C) CONTEXT → (D) INTERVENING CONDITIONS →

→ (E) ACTION/INTERACTION STRATEGIES →

→ (F) CONSEQUENCES

**There is a
disconnect between
the perceived
centrality of the role
of domiciliary care
staff**

**and recognition of the
importance of the role
within the wider Health
and Social Care
Community**

Location of Care

The Characteristics of domiciliary care staff

Caring and the Caregiving Relationship

Role Identification

Role Challenges

Role Conflict

“You do understand that my next door neighbour might be 4 or 5 fields away”. (Interviewee 21)

“So I do the things I do because I care for my client, who is after all, my neighbour, and indeed whilst they might live miles from me see, I see them and theirs as an extension to my own family.” (Interviewee 49)

*“Come on Bridie, it’s all very well talking about this to yer man here but if we don’t get on with it they’ll be talking about you and me in the post office”
(Interviewee 19)*

“Helping to give choice, respect, listening to what they’ve got to say. I love my job”. (Interviewee 52)

“Knowing that I make a difference to the quality of my client’s daily lives and making them so happy. I feel valued and trusted actually”. (Interviewee 16)

“It’s the interaction with the clients, the relationships you build and the support of the team it’s such a worthwhile service”. (Interviewee 48)

“I feel that this is a very stressful job role and I personally feel that I am not delivering quality care it’s upsetting really!” (Interviewee 43)

“That it takes too long when you report to a supervisor for additional help or equipment until it appears, it’s upsetting all round!” (Interviewee 77)

“I’m not a home help, I’m here to do personal care, not home help and if you need those services, well then see a social worker”. (Interviewee 25)

“The roles are becoming closer now.....home helps are being trained to do personal care”. (Interviewee 24)

“We’re now getting hounded over sick leave and overtime as every week somebody is off on sick leave”.
(Interviewee 80)

“I like working with elderly people and I feel I’ve good life experiences especially in respecting sick and vulnerable people?” (Interviewee 15)

“Caring for clients and knowing that I have made a difference to their overall well-being is very important to me”. (Interviewee 2)

“Giving my work 100% is important to me. I would always go over and above the call of duty and this doesn’t bother me at all, it’s who I am”. (Interviewee 1)

Caring and the Care Giving Relationship

“Because you're doing personal care, washing and dressing that doesn't mean to say that that's all that has to be done, nor indeed is it all that I will do either”. (Interviewee 7)

“Plus, whenever you're dealing with the same patients week after week, you can monitor their progress, and see if they are ok, or are feeling depressed, we basically become part of their family too and care for them like our own”. (Interviewee 20)

“Everybody likes their own wee corner at the end of the day....and if there's enough good positive care provided by us in the community, well then it'll stop them from being shipped into a nursing home”. (Interviewee 152)

- Postal questionnaire to all domiciliary care staff employed within HSCT (n=734) with a 42.8% (n=314) response rate overall.
- All questionnaires analysed using SPSS
- Response rate compares favourably with similar research in NI & UK

- The majority of respondents (99%) are females, the majority of whom (75.5%) are married with only a small minority who were single, divorced or widowed.
- The age profile of the respondents ranged from twenty-one to seventy-seven years, with the mean age at 52.27 years.
- A significant number of respondents were over 60 years of age (23.8%), with a small minority under 30 years of age (1.8%).
- Over 50.8% of the total respondents employed within the HSCT were over 40 years of age.
- Discriminant analysis using SPSS indicated that domiciliary helps tended to be older (mean = 56.42 years) compared to domiciliary care workers (mean = 50.65 years).

Formal Qualifications held by Respondents

NVQ Level 1		NVQ Level 2		NVQ Level 3		Other Qualifications	
Held	7% (n = 22)	Held	52.2% (n =164)	Held	7% (n = 22)	Held	7.3% (n =23)
Not Held	92.7% (n =291)	Not Held	47.1% (n =148)	Not Held	92% (n =289)	Not Held	92.7% (n=291)

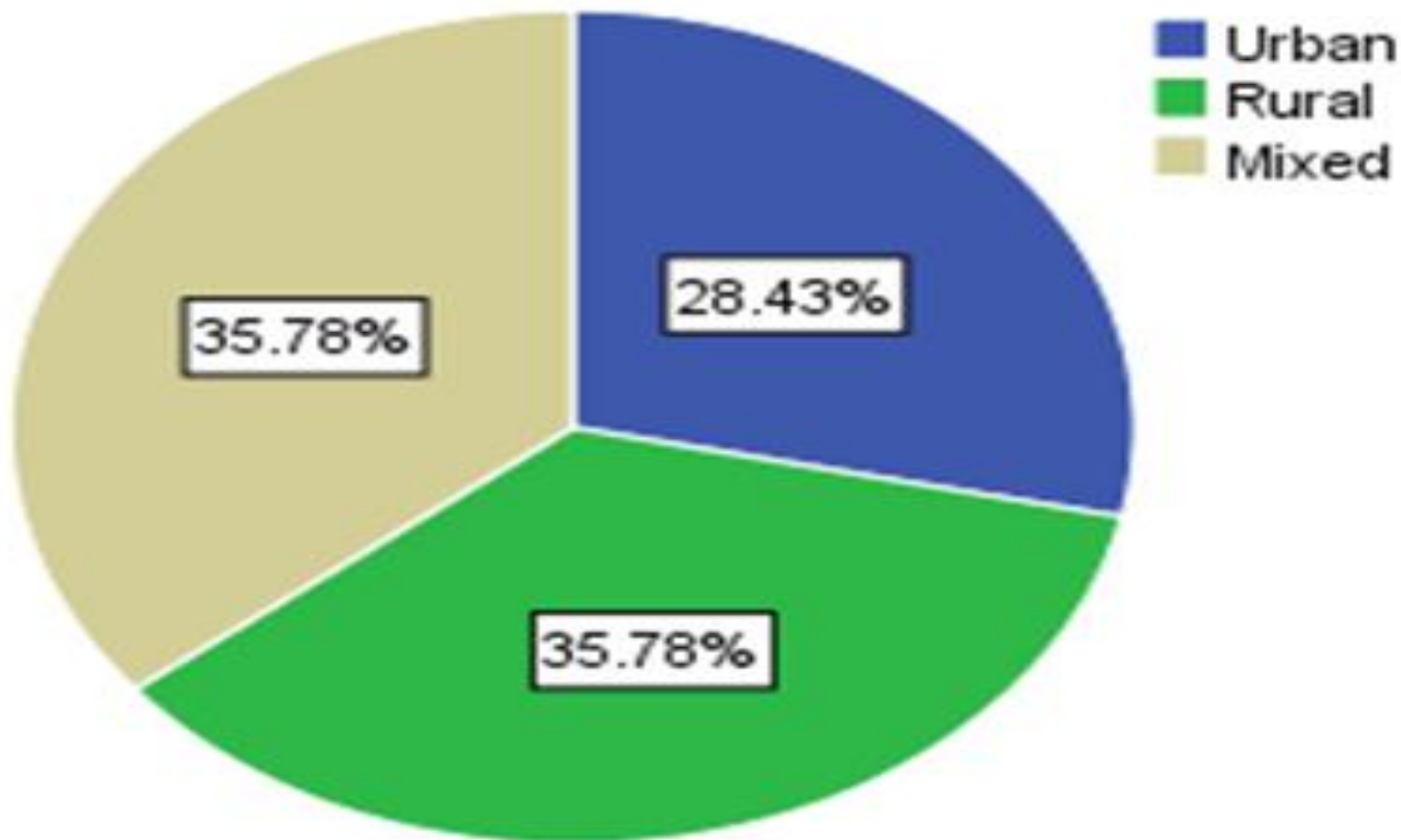
Discriminant Analysis

		Length Employed	Hours Worked Weekly	Clients Visited within WHSCT
Domiciliary Care Workers	Mean	13.16	24.67	22.22
	N	197	197	196
	Std. Deviation	8.861	6.898	16.777
	Median	11.00	24.00	14.00
	Minimum	1	4	1
	Maximum	49	45	84
	domiciliary helps	Mean	18.80	14.21
N		82	81	81
Std. Deviation		8.457	9.682	11.647
Median		18.00	12.00	3.00
Minimum		6	1	1

Prior Experience & Attraction to Post

Details		Results	
		Yes	%
Prior experience in paid care role		n=83	26.4%
Attraction to current post	Extension to caring role	n=143	45.5%
	Terms and conditions of employment	n=92	29.4%
	Promotion	n=20	6.4%
	Prior community experience	n=179	57%
	Free time children at school	n=152	48.4%
	Asked by neighbour to fill gap	n=47	15%
	Other	n=57	18.2%

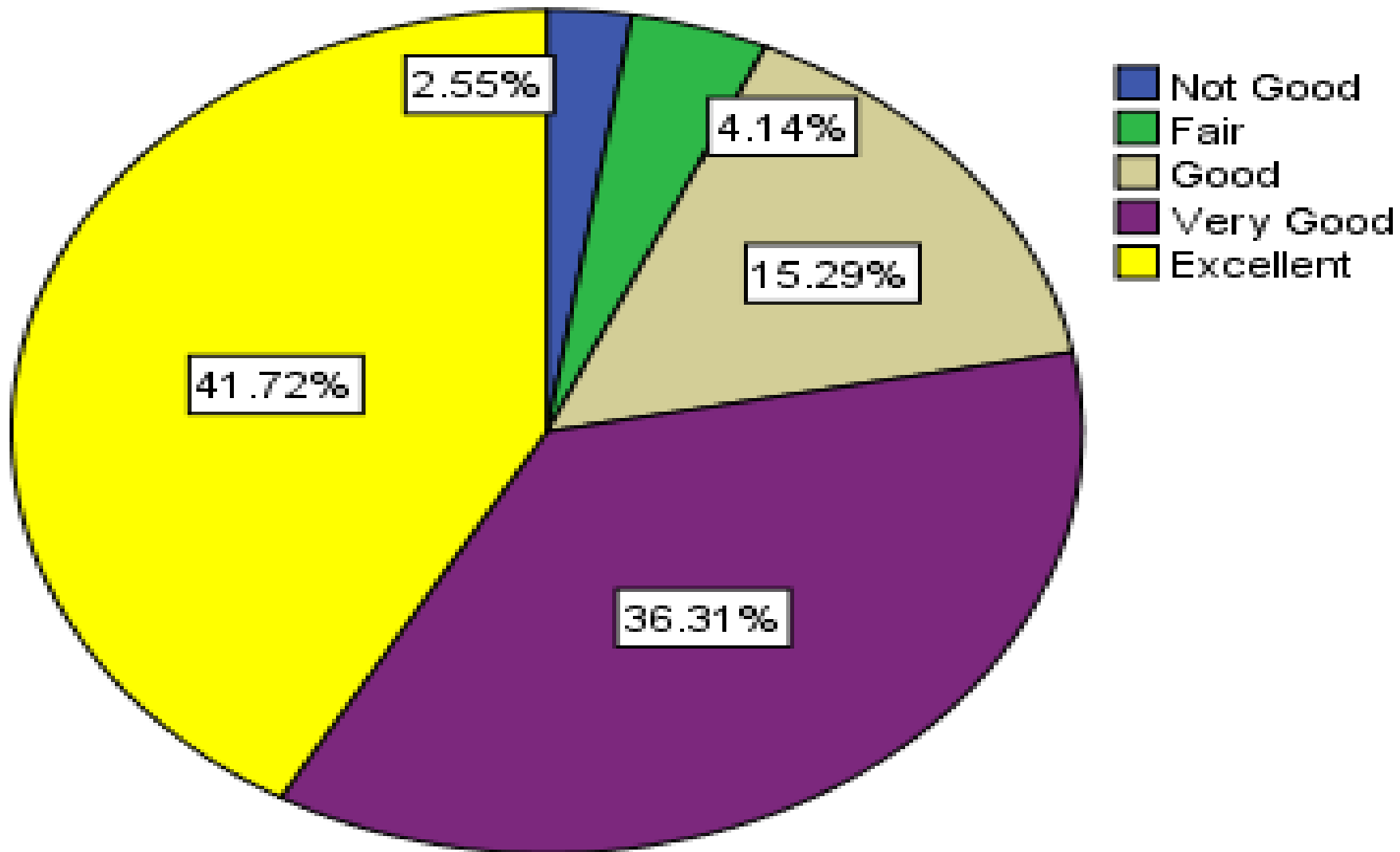
Location of Care



Working Patterns

Details	Results		
		N	%
Capacity employed	domiciliary help	82	26.1
	domiciliary care assistant	117	37.3
	Domiciliary care worker	80	25.5
	Employed in more than one position	34	10.8
Shift patterns	Weekends	269	85.7
	Evenings	134	42.7
	Nights	70	22.3

Quality of Care Provision



Proposed Changes to Role

‘let carers have an input with risk assessments and care plans’;

‘maybe spot checks carried out by my supervisor to ensure that all carers are providing care adequately’;

‘more cover for sickness and especially weekends’;

‘more hours, more time with clients, not to feel rushed in my job’;

‘less recording’;

‘I would like to be more involved when care plans are being allocated or changed for my clients’;

Proposed Changes to Role

‘cutbacks, as the role we provide in the home and to the client is valuable as people are now living longer’;

‘being recognised for the job that I do and paid for same’;

‘working with uncooperative social workers and being taken for granted by clients and family and having to and feeling obligated to travel in bad weather’;

- A training need analysis, linked in a strategic manner to a Nationally Recognised and Accredited Framework, such as NVQ.
- Current training and support mechanisms must be inclusive of client assessment and client evaluation.
- Domiciliary care staff involved in assessments & care reviews.
- Continued monitoring of the impact of domiciliary care on older adult's meaning of home and its potential impact on their recovery.

- Clinical supervision and supervisor support arrangements must place value on the role of its domiciliary care staff.
- Complex client assessments for home care must be underpinned in a collaborative and collegiate manner using the Northern Ireland Single Assessment Tool (2009).
- Quality assurance mechanisms must extrapolate on how domiciliary care workers experience and negotiate their work on a daily basis, thus enabling effective responding to staff needs and compliance with legislative and regulatory frameworks.

- The Integrated Service Delivery Model (DHSS&PS NI, 2011) must be implemented as a priority for effective service delivery.
- Home care for the older person must be based on reablement, Jones et al. (2009).
- The home is clearly the ‘hub’, an operational definition of this is needed.

- Location of care delivery
- Health & Social Care provision at an organisational level with appropriate responsiveness training
- The caring trajectory for the client within the concept of caring
- Continuity of caring ethos within a person centred practice framework
- Responding to the process of change with an effective model for practice

Concluding comment

The effective management of domiciliary care services for the client and their family have the most significant ramifications insofar as the current excellent standards of domiciliary care **must be harnessed, identified and managed within quality performance indicators.** Community nurses and other H&SC staff working collegiately with domiciliary care staff can enable, facilitate and nurture this process within existing professional relationships.

Questions?

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