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## **'That just doesn't feel right at times' - lone working practices, support and educational needs of newly employed Healthcare Assistants providing 24/7 palliative care in the community: A qualitative interview study**

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# 'That just doesn't feel right at times' – lone working practices, support and educational needs of newly employed Healthcare Assistants providing 24/7 palliative care in the community: A qualitative interview study

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## Abstract

**Background:** Healthcare assistants working in hospice at home settings have a pivotal role in supporting people dying at home and their family caregivers. Some healthcare assistants are working alone in patients' homes, which magnifies some of the issues reported for those working closely with other team members. There is a dearth of evidence in terms of education, training and support needs for healthcare assistants when working alone.

**Aim:** To explore the role of newly employed lone working healthcare assistants delivering palliative care in the community, and their support and educational needs.

**Design:** Qualitative exploratory study using semi-structured interviews.

**Setting/participants:** Healthcare assistants ( $n = 16$ ) employed less than 12 months by a national non-profit hospice and palliative care provider located across the UK.

**Results:** Analysis of interviews identified three main themes: (1) Healthcare assistants have a unique and complex role catering for holistic needs of patients and their family caregivers in the home environment; (2) preparation for the complex role requires focus on experiential learning and specific training to support holistic care provision; (3) lone workers experience loneliness and isolation and identify peer support as a key intervention to support their wellbeing.

**Conclusions:** Given the complexities of their role within community palliative care teams, there are key learning points in relation to healthcare assistant preparation. Education and support networks should be prioritised to reduce isolation and support ongoing learning and development of newly employed healthcare assistants; all of which is vital to ensure safety and quality of care for the growing number of people they support in the community.

## Keywords

Palliative care, qualitative research, healthcare assistant, home care services, after-hours care

### What is already known about the topic?

- Healthcare assistants have a pivotal role across all healthcare systems, including palliative care
- The role of the healthcare assistant in the delivery of community palliative care is a neglected area of research

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**What this paper adds**

- Lone working healthcare assistants have a complex role in meeting the holistic needs of the patient and family caregiver in the community
- Preparation for this role needs to be consistent with a focus on experiential learning.
- Lone working healthcare assistants may experience loneliness and isolation, if their holistic support needs are not met.

**Implications for practice, theory or policy**

- Development and implementation of competency standards to support role preparation of healthcare assistants may have positive impact on safety and quality of care for people they support.
- Face-to-face formal and informal experiential learning appears to be the preferred learning mode by patient-facing healthcare assistants. Further research is needed to understand how this learning mode can be better incorporated in the current environment.
- Health and social care organisations need to support development of effective, safe and responsive peer support for lone workers to alleviate their isolation and loneliness. However, further research is needed to co-design a peer support model meeting the needs of all stakeholders, while minimising potential risks.

**Article****Background**

Globally it is estimated that 53 million people work alone or remotely across the United States, Canada, and Europe combined, representing 15% of the workforce.<sup>1</sup> Whilst lone working is a broad term, it refers to people who operate without any direct supervision or monitoring of their activities.<sup>2-4</sup> Lone working is a common practice across many professions including transportation, manufacturing, and healthcare. Within healthcare, the provision of health and social care in the patient home is advocated,<sup>5</sup> however COVID-19 pandemic has placed an increasing pressure to deliver such care.<sup>6</sup> Internationally unregulated health care workers are essential in home care,<sup>7</sup> whose roles commonly fall under the category of lone worker.

Unregulated health care workers are defined as paid workers who are neither registered nor licenced by a regulatory body. They have no legally-defined scope of practice.<sup>8</sup> Internationally there is no standard title used to refer to this role. Titles include, but are not limited to, personal support workers, nursing aides, health care assistants and nursing care assistants.<sup>9</sup> In the United Kingdom, the term healthcare assistant is advocated and like other countries, they do not have a professional designation nor are subject to accredited training and education.<sup>10</sup> Variation exists in the requirements for registration across United Kingdom. Where there is no current requirement, the training, monitoring and oversight responsibilities are covered within the care-provider's regulation standards. and healthcare assistants are regulated by their employer. Global staff shortages, escalating demands and financial constraints have seen a rise in the number of unregulated healthcare workers across health-care settings<sup>11,12</sup> including community palliative care.<sup>13,14</sup> Evidence suggests that they are at the forefront of lone working in community home-based palliative care,

providing most of the direct care<sup>11,15-18</sup> to patients who have a higher likelihood of multi-morbidity and polypharmacy at the end of life. Within the home, they also deal with unsafe working conditions,<sup>19</sup> changing home environments,<sup>20</sup> challenging conversations,<sup>21</sup> potential presence of drugs or alcohol,<sup>22</sup> as well as a geographical dispersion and professional isolation.<sup>23</sup>

Whilst limited,<sup>24</sup> most research on healthcare lone working has focused on the safety for registered professionals, indicating risks of verbal and physical abuse.<sup>25-27</sup> To resolve issues, nurses often reported applying their own solutions, with a tendency to rely on their own intuition to guide individual safe decision-making.<sup>28,29</sup> Whilst dated, evidence suggests that lone worker incidents and concerns were often under reported as nurses wished to avoid blame, ridicule, and reprisal from management.<sup>30,31</sup> Yet similar findings have also been reported in a survey of over 1300 lone workers which highlighted chronic under-reporting of safety concerns, whilst most employers believed concerns were being reported.<sup>32</sup> Huang et al.,<sup>33</sup> believes that many lone workers view risks as part of their job therefore are more accepting.

Given that workplace safety can lead to increased stress, anxiety and turnover of staff,<sup>34</sup> impacting on productivity, and reduced clinical decision making,<sup>35</sup> it has the potential to negatively impact on the quality of patient care. However, research relating to homecare<sup>36</sup> and the healthcare assistants experience of lone working in palliative care is lacking. Such an understanding is essential to prepare and support staff, but also to ensure the provision of high-quality patient care. The rationale for targetting those employed for less than 12 months is based on internal organisational audits showing high attrition rates within this timeframe, the reasons for which were unknown. The support and educational needs were the focus of this study, based on previous evidence<sup>37</sup> showing that effective support and

development of the competency within the remote health workforce, may be an effective retention strategy. This is critical to understand as the service providers are faced with widespread workforce challenges<sup>38</sup> while demand for community palliative care over the next 20 years is predicted to rise.<sup>39,40</sup>

## Methods

### Design

A qualitative exploratory design was adopted<sup>41</sup> as most appropriate to answer the research question. The study was reported following the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.<sup>42</sup>

### Setting

Participants were recruited from a national non-profit palliative care provider located across the UK, that serves on average over 60,000 terminally ill patients per year. At the time of the study (April to August 2021) approximately 1250 healthcare assistants were employed in the community providing hospice at home services, with the majority working in a lone capacity and during the out-of-hours period. This data was number was based on employment figures at two separate data points received from the human resources department. The UK definitions of hospice at home and out-of-hours care are provided in Box 1.

#### Box 1. UK hospice at home and out-of-hours definitions.

**Hospice at home** is an integral component of community end of life care aiming to enable patients with advanced illness to be cared for at home, and to die at home if that is their preference. Care may be provided to prevent admission to, or facilitate discharge from, inpatient care for crisis management or for longer periods of care. Care may also support times of rapid change. Hospice at home often works in partnership with many other health and social care professionals to achieve this.<sup>43</sup>

**Out-of-hours** – from 6.30 pm to 8.00 am on weekdays and all day at weekends and on bank holidays<sup>44</sup>

### Population

Individuals were considered eligible if they were a community-based healthcare assistant aged over 18 years and employed for less than 12 months by in Northern Ireland, Scotland and England. Wales could not be included as there was no research gatekeeper in that region to support recruitment. Only those who work alone in patient's homes for at least part of their role were included. The total eligible population was  $n = 280$  across the UK.

### Sampling

Purposive sampling was employed to identify healthcare assistants who met the eligibility criteria from the recruitment sites (see Population section above), aiming to recruit 4–5 participants from each site, and 15–20 participants in total.

### Recruitment

The community services managers (made up of healthcare professionals, the majority of which were registered nurses, who line managed healthcare assistants) screened for eligibility and sent an invitation email with a participant information sheet attached to the eligible participants ( $n = 280$ ). The community services managers were invited to project meetings and briefed on the purpose of the sampling approach, and inclusion criteria. If interested, healthcare assistants were instructed to contact the researcher to gain further information, if required, and to consent to proceed to interview.

### Data collection

Interviews were completed online and video recorded on Microsoft Teams by the lead female author (KP). KP is a clinical academic with a dual role as Research Nurse (Marie Curie) and Community Nurse (nursing agency) who has undergone qualitative research training. At the start of each interview, participants were asked to complete an anonymised demographic questionnaire to collect descriptive sociodemographic information and details of previous palliative care education and training, and to verbally consent to proceed with interview. KP was known to some participants due to involvement in their training (one online session facilitated by KP). The interview schedule was developed through an iterative process between the research team (KP, TM and FH) and advisory group (made up of members of the public and healthcare assistants ( $n = 2$ )). The first interview acted as a pilot for learning and confirmed that no changes were required to the interview schedule. Semi-structured interview items covered participants' perspectives on lone working practices, support and educational needs (See appendix 1). Recruitment continued until the predetermined sample target based on pragmatic considerations was met. Sample size was also influenced by the richness of the data collected to ensure sufficient information power of the sample.<sup>45,46</sup>

### Data analysis

Interviews were transcribed *verbatim* by KP and an external transcription service provider. Transcripts were compared with video recordings to ensure accuracy. Transcripts were coded in NVivo v.12 using an inductive

reflexive thematic approach.<sup>47,48</sup> Analysis was led by KP with data analysed independently by FH. Transcripts were read several times for familiarisation with data. Reflexive notes were kept minimising any bias in interpretation and increasing validity of findings.<sup>48</sup> The initial codes were subsequently categorised into potential sub-themes and themes. Interpretation of findings was collaborative and iterative throughout the analysis within the research team. Findings were shared with participants via email for their validation in terms of accuracy, in order to enhance the trustworthiness of the findings.<sup>49</sup> However, 6 out of 16 participants had left the organisation by the time findings were shared, and the remaining 10 did not respond.

### Ethical considerations

Ethical approval was received from Ulster University Nursing and Health Sciences Ethics Filter Committee (FCNUR-20-038) and Research Governance Committee at each participating site.

## Results

### Sample characteristics

Sixteen healthcare assistants were interviewed between April and August 2021. The demographic and employment characteristics of study participants are shown in Table 1. It is important to note that participants' experience in caring role varied substantially. Pseudonyms are used below when identifying quotes and all identifying details have been removed, protecting participant confidentiality. Interviews lasted between 35 and 77 min, with mean length 55 min.

Three key themes were identified through the analysis which are presented in turn as follows: (1) Unique and complex role (2) Preparation for the role (3) Loneliness and isolation of the lone worker.

### Unique and complex role

Participants reported they often encounter complex emotional and social situations, including challenging family dynamics. Although, they receive a referral before the visit, the quality of information varies, and the patient status and family situation can change rapidly. They reported provision of holistic care, responding to the patients emotional, spiritual, social and physical needs. Continuous observation, assessment, judgement, and escalation of concerns were crucial to the healthcare assistant role. Whilst healthcare assistants acknowledged they were allocated to care for a specific patient, often they also support family caregivers, which they perceive as equally important. Participants recognised the importance of reducing

**Table 1.** Demographic participant characteristics ( $n = 16$ ).

Participant characteristics	$n$ (%)
Country	
Northern Ireland	5 (31.25%)
Scotland	4 (25%)
England	7 (43.75%)
Sex	
Female	15 (93.75%)
Male	1 (6.25%)
Age range	45–54
18–24	0 (0%)
25–34	1 (6.25%)
35–44	5 (31.25%)
45–54	5 (31.25%)
55–64	4 (25%)
65+	1 (6.25%)
Ethnicity (Self-reported)	
Asian	1 (6.25%)
White	5 (31.25%)
White British	7 (43.75%)
White Irish	1 (6.25%)
White European	1 (6.25%)
White Scottish	1 (6.25%)
Employment type	
Contract	9 (56.25%)
Bank (as and when required)	7 (43.75%)
Hours worked	
Full time	5 (31.25%)
Part time	11 (68.75%)
Length of current employment (mean)	7.3 months
Range	3–11 months
Length of experience (in years) as a healthcare assistant (mean)	10.16 years
None	3 (18.75%)
0–2 years	0 (0%)
3–10 years	7 (43.75%)
10–20 years	2 (12.5%)
20+ years	4 (25%)
Palliative care education and training	
Induction from employer and mandatory courses only	7 (43.75%)
Short courses, attending conferences	4 (25%)
National Vocational Qualification Level 2	3 (18.75%)
National Vocational Qualification Level 3	2 (12.5%)
Other healthcare qualifications (self-reported)	
Registered Nurse (not registered currently)	2 (12.5%)
Student Nurse	1 (6.25%)
Bachelor of Science degree	1 (6.25%)
Complementary therapy	1 (6.25%)

family caregiver burden by offering respite, recognising the challenges of their caring role, along with referring to registered professionals or services when appropriate.



*'But especially when they are very end of life care you are seeing to every patient's needs. . . but it's more the family. It's the family members you are there speaking to. It's the family members that you are there supporting. It's them that get a lot of the benefit of what we are doing'.*

Cara

Providing emotional care and talking with patient and family about dying was a recurrent theme amongst participants. They informally assess patient and family distress, along with emotional and social needs and respond accordingly. This holistic approach to caring helps to create a safe space for conversations about death and dying. Participants reported the conversations being initiated by the patient or family at a time when they are ready to engage. Most often during the night when trust and rapport have been built and the intimacy and quietness facilitates those important conversations to take place. When explaining, participants underestimated their role in emotional support and describe it as simply listening and providing reassurance.

*'Just having an ear. Just being there to listen to them. And I think that can be important. In some families, as well, it can be a shock to them if they've received bad news. Or it can be quite emotional watching the journey of someone, of their loved one, dying. And they cope in different ways. . . And I think it's important to let them know that you are there to support them as well, where you can, and be able to listen and support them in any concerns that they may have'.*

Ella

Healthcare assistants faced multiple decision-making responsibilities caring for patients and family caregivers, often undertaken with limited information and training, especially during the COVID-19 pandemic. Those decisions ranged from determining if and how to reposition a dying patient while causing minimal distress, how to approach the family who are in denial over their loved one's condition, to deciding if it is the right moment to wake up the family, when the healthcare assistant feels that the patient's death is imminent. Consequently, participants reported that the decisions are often based on their previous care experience, prior knowledge of the patient condition and gut instinct. This led to some participants experiencing decision burden. Many of these complex decisions are an attempt to manage the patient's situation and avoid escalation to out-of-hours services. Participants reported issues around availability of, and variability in out-of-hours service delivery across the country.

*'So you are watching the patient and thinking, right, I may not see somebody for an hour. So I might need to ring before it becomes critical. . . it can feel a wee bit kind of. . . depending on the situation, you can be a wee bit apprehensive'.*

Margaret

## Preparation for the role

Participants described that prior to the pandemic, they would have received face to face 5-day induction training before commencing lone working in the community. This incorporated a variety of topics including introduction to services, care of the dying and practical skills, for example, patient handling and syringe pump monitoring. They would have the opportunity to meet other staff and start building networks. However, in 2020, restrictions imposed due to the COVID-19 pandemic resulted in the 5-day induction training being delivered virtually. Participants felt disadvantaged due to lack of face-to-face contact with their employer and colleagues throughout the recruitment and induction process with one of the participants saying, *'You begin to think, is there anybody actually out there?'.* Furthermore, training received was variable across locations. Sometimes, the first and only contact with another colleague was during two short 2-h induction shadow shifts, which was the only face-to-face role preparation. This contributed to uncertainty about their skills and knowledge, and general apprehension about the role. Participants acknowledged that many of their skills and knowledge were gained on the job, informed by previous care experience and/or liaising with peers and other healthcare professionals visiting the home.

*'I don't know that felt. . . sort of like. . . like at first a bit like a deer in the headlights like right – here's. . . you go and do it and you're on your own and you are literally on your own'.*

Irene

The virtual communication and online training, imposed by the pandemic, did not meet the needs of some participants with limited experience in a caring role. Small number had only cared for their own family members and lacked formal training. Participants expressed strong preferences for face-to-face experiential learning, in particular shadow shifts, supervision in practice and discussing case scenarios with more experienced colleagues. They reported that although the online learning available to them had been of high quality, it should be supplemented by the above learning methods to better prepare them for the role. Consequently, participants reported experiencing moral uncertainty, querying if they are *'doing'* or *'saying the right thing'*, which created additional emotional burden.

*' . . . and also sometimes I doubt myself. . . I hope I'm doing everything OK. There's nobody to tell you that you're not. And that would worry me. I would be concerned that, oh my goodness, what if I'm using the wrong technique here? Or I'm doing something that somebody would say, oh hold on. . . Whereas you are basically on your own'.*

Tanja

Furthermore, while the participants reported that they understood the boundaries of their role and safety implications, frustration and anxiety were voiced at their inability to provide help needed by the patient. Some participants reported having had responsibility for and experience of administering medications in previous roles in other settings, such as care homes. They expressed the importance of being given training in and responsibility for administering a wider range of medicines, which would both ease the suffering of the people they support, provide rest to families and lower the burden on overstretched out-of-hours services.

*'There's times I've had to waken up somebody out of their sleep to come and give somebody medication that I could confidently give them, but I'm not allowed to, because I'm not trained. . . to me that fact that I am wakening that person up, totally contradicts why I am there. I am there to help them get a rest. But yet, I am going to go and waken them up to come and administer medication. So that frustrates me.'*

Margaret

Moreover, as their role involves supporting both patients and families during emotionally difficult times, participants expressed the need for further training in communication skills, emotional and spiritual support, along with grief and bereavement support. Often, they don't feel adequately prepared for the difficult situations they frequently face.

### *Loneliness and isolation of the lone worker*

Participants had access to formal support from registered staff with clinical expertise such as their service managers, community nurses, clinical supervisors, mentors, etc. Those practitioners provide clinical advice, supervision in practice and emotional support. However, some participants described not feeling cared for by the employing organisation as formal support always had to be initiated by themselves, rather than feeling that support was offered.

*'And I think this support is there, there is plenty of stuff they do offer. And I think it's on you if you. . . you don't really get someone to ring you, email you directly saying 'how are you doing?'.*

Irene

Uncertainty regarding their skills and knowledge base, fears of being recognised as inferior or not being taken seriously and not wanting to 'bother' others also created barriers to accessing formal support systems. The absence of proactive support combined with perceived barriers accessing formal support led to healthcare assistants experiencing loneliness and isolation. Interestingly, when talking about support, participants had broad

understanding of support encompassing all contacts with other practitioners, from supervision in practice to debrief after difficult shift. All these meant human contact with colleagues as oppose of being alone.

*'That's very hard. You are quite alone as a healthcare assistant, and especially through Covid it's been quite difficult, because you can't meet up with anybody. Which I think previously they had been. But it's mostly you, the family and the patients. And then you can provide your feedback to the senior nurses and your other managers if you need support. But it really is just you, the family and the patients.'*

Sara

This led to the development of informal and organic peer support systems (i.e. support offered healthcare assistant to healthcare assistant), based on the desire to help one another. This created a community of practice from which people could approach each other for support without fear of judgement. Participants gave examples of informal chat groups organised within their local teams and healthcare assistants checking the rota online and texting their colleagues who were working the same night. Interestingly, access to and usage of this informal workplace support was dependent on having had previous face-to-face contact with colleagues and in the context of trusting relationships, so they felt safe approaching peers for help and guidance.

*' . . . it would have been good. . . knowing if there was somebody else to say. . . and not feel stupid about it. . . so that on a night, if you are having issues and you need to speak to another healthcare assistant, not somebody like a senior person, that there's maybe somebody that you could bounce something off, by sending them a text or whatever, rather than feeling, oh should I ring them or should I not. So, if you knew somebody, then that might be. . . just a quick yes, you could do this, or no, you could do that. Or what do you think?'*

Alex

Peer support was repeatedly highlighted as the most valued by participants. Some had a sense of belonging to their team, influenced by their regular contact, or where they had joined well established pre-pandemic teams. But some felt on their own and longed for the feeling of connectivity with others as part of the team. Peer support offered reassurance, the chance to debrief and guidance in a confidential and informal manner, at any point of the day or night. It helped to alleviate the decision burden, as well as isolation and loneliness. Participants valued the responsiveness and understanding of their peers who had the same responsibilities, role boundaries and similar challenges. Peer support was particularly significant during the first solo shifts when participants felt apprehensive. They said it was very important to know of someone they can contact while with the patient and family.

*'Initially I found it quite anxiety provoking because I have always been with somebody. Even if I've been working on my own . . . always been somebody else around. But what I find quite reassuring is that there are other. . . workers on the evening or an overnight and they are a phone call away or a text message away if I need some backup or some guidance so I would refer to them if I've got an issue.'*

Tracy

## Discussion

### Main findings

The findings show that healthcare assistants are operating in an unpredictable home environment caring for vulnerable patients with complex needs, and their family caregivers. Working alone without direct supervision adds additional level of complexity. Previous research on the healthcare assistant role refers to the provision of mostly task orientated care activities, with only a few studies recognising psychosocial assessment and support,<sup>50</sup> with dearth of evidence existing about those working without direct supervision in hospice at home settings. Provision of emotional support for families, recognised in previous studies,<sup>15,17,51</sup> has yet to be recognised in practice and underpinned by relevant training. Inconsistent preparation for the lone worker role combined with the added complexity of the environment and patient cohort has widespread implications. This results in participants working to varying levels of ability and skill with reports of feeling unprepared and underestimating their role with regards to emotional support offered. COVID-19 further impacted on role preparation; restricting delivering of face-to-face training, also observed in other settings,<sup>52</sup> which had detrimental consequences on learning. Unsurprisingly participants recommended the need for further development delivered face-to-face, combining both formal and informal experiential learning,<sup>53,54</sup> reflecting preference from other clinical settings.<sup>55,56</sup> Exposure to other professionals' practices can support benchmarking of individual's practice against their colleagues and help identify knowledge gaps.<sup>56</sup> It is yet unclear how best to incorporate this within lone worker capacity.

The complexity of this role, combined with limited experience, variable preparation, while working alone was reported to have an impact on the healthcare assistants' wellbeing. Similar to previous research, findings from this study highlight the emotional labour,<sup>51,57–61</sup> challenging conversations,<sup>21</sup> isolation and loneliness of lone workers,<sup>62,63</sup> exacerbated by pandemic related restrictions. Additionally, participants in this study experienced work-related stress, decision burden and frustration, when unable to ease suffering by undertaking tasks located within their scope of practice, for example administration of medicines, but relevant training had not been provided. Such factors combined may have long term

implications on the lone worker's wellbeing and compassion, affecting retention of healthcare assistants. Reflecting previous research,<sup>64</sup> the impact on wellbeing of healthcare assistants may be more acute the longer spent in the role. Despite this potential negative impact, participants in this study reported a commitment to their role, believing their ability to *'make a difference'* to people's lives, developing trusting relationships and having time for people, were protective factors. Whilst such findings have been reported within various healthcare workers' groups,<sup>15,65,66</sup> this study highlights the need for further research on the impact of lone working on wellbeing of healthcare assistants.

Another key finding highlighted by participants and reiterated in the literature<sup>65</sup> is the limited value placed on formal support mechanisms (i.e. supervision provided by registered staff) such as line management support, counselling services or online wellbeing resources. Whilst participants were aware of such services, they did not align to their needs. Similarly to previous research,<sup>63–65,67–72</sup> sourcing peer support (i.e. support provided by healthcare assistants to other healthcare assistants) was reported as helping to cope with the emotional challenges of practice coupled with a positive impact on the care provided, while enhancing competence, confidence and building participants' resilience.<sup>70–72</sup> Further research on peer support among healthcare assistants is especially important in the context of risks associated with not accessing formal support and potential underreporting of risks<sup>30–32</sup> hiding true exposure of risks among this cohort. It is also important to understand, when support or guidance offered by peers may contribute to increased risks for the lone worker, patients, families and the organisations in the absence of relevant training.

### Implications for practice

As highlighted by the Francis report,<sup>73</sup> lack of appropriate role preparation, ongoing training and support raise questions on the quality of care provided. Development and implementation of competency standards to support role preparation of healthcare assistants such as career development and progression framework<sup>74</sup>, may have positive impact on safety and quality of care for people they support. Face-to-face formal and informal experiential learning is the preferred learning mode by patient facing healthcare assistants, and organisations could explore how to overcome challenges with facilitating this learning mode within geographically dispersed workforce. Furthermore, lone working without appropriate support and role preparation may have a potential negative impact on healthcare assistant wellbeing and retention, worsening the staffing issues in the hospice at home settings. Health and social care organisations need to support development of effective, safe and responsive peer support for lone workers to alleviate their isolation and loneliness.



## Strengths and limitations of the study

Despite an increased focus on community palliative care, there has been little research into the lone working experiences, support and educational needs of healthcare assistants. To the researchers' knowledge, this study is the first to explore this topic through interviews with newly employed hospice at home staff. Despite being limited to one organisation in the UK and staff employed for less than 12 months, the study highlights the complexity of the role and challenges with accessing appropriate support and training, which may be relevant elsewhere. It is important to note that the participants were recruited during the COVID-19 pandemic. Demographics of participants in this study show lack of diversity but are reflective of those in the National Health Service, mainly female, white, middle aged.<sup>75</sup> Caution is required in drawing conclusions for the wider healthcare assistant workforce. Future research could explore how these experiences and needs vary across different settings and length of employment, and the impact of unmet holistic support needs on staff wellbeing and retention. It would be also vital to consider what are the elements of effective, safe and responsive peer support and how it can be operationalised in practice.

## Conclusion

There is an overriding need to acknowledge the complexity of the healthcare assistant role in delivering palliative care in the community. There should be a review of training and competencies, and requirements for ongoing support of those newly employed would be beneficial. Isolation experienced by lone workers, limited role preparation, without expedient access to support, may be detrimental to wellbeing and a factor in staff retention and should be a priority for future research. Given that service providers are faced with widespread workforce challenges, this research highlights the need to invest resources to develop and support newly employed lone workers. Multi-layered education and support systems need to be developed using co-production principles to ensure they meet staff needs, benefit those entrusted to their care and are feasible for real-world practice.

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## Authorship

KP drafted the original manuscript, analysed study data and conducted qualitative interviews. FH, TM, CM made substantial contributions to the study design, data analysis, and manuscript revisions for important intellectual content. All authors provided critical feedback to several drafts of the manuscript.

## Data sharing

Data relating to this research project can be obtained by contacting the lead author at [kasia.patynowska@mariecurie.org.uk](mailto:kasia.patynowska@mariecurie.org.uk)

## Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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## Research ethics

Ethical approval was received from Ulster University Nursing and Health Sciences Ethics Filter Committee (FCNUR-20-038) and Research Governance Committee at each participating site.

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## Supplemental material

Supplemental material for this article is available online.

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