Lived Experiences of Support Workers

Navigating Work and Family Life During the COVID-19 Pandemic in the UK.

by

Pavlos Kasdovasilis

A thesis submitted in partial fulfilment for the requirements for the degree of Professional Doctorate in Clinical Studies, at the University of Central Lancashire

03/2024

RESEARCH STUDENT DECLARATION FORM

Type of Award Professional Doctorate in Clinical Studies

School of Medicine

*Sections marked * delete as appropriate*

1. Concurrent registration for two or more academic awards

*I declare that while registered as a candidate for the research degree, I have not been a registered candidate or enrolled student for another award of the University or other academic or professional institution

2. Material submitted for another award

*I declare that no material contained in the thesis has been used in any other submission for an academic award and is solely my own work

3. Collaboration

Where a candidate's research programme is part of a collaborative project, the thesis must indicate in addition clearly the candidate's individual contribution and the extent of the collaboration. Please state below:

N/A

4. Use of a Proof-reader

**The following third-party proof-reading service was used for this thesis -Rubrica Services- in accordance with the Policy on Proof-reading for Research Degree Programmes and the Research Element of Professional Doctorate Programmes.

A copy of the confirmatory statement of acceptance from that service has been lodged with the Academic Registry.

Signature of Candidate

Print name: Pavlos Kasdovasilis

ABSTRACT

Support workers are an 'invisible' part of the health sector whose work requires them to continue to work through different events such as pandemics. This thesis focuses on exploring the lived experiences of support workers during the COVID-19 pandemic in England and the strategies they used in order to cope and manage both work and family life while all social restrictions were still in place. The thesis is comprised of a meta-ethnography, a qualitative exploration of the lived experiences of support workers and a proposed supervisory protocol (PSP) for guiding supervisors to assist support workers during the COVID-19 pandemic. The meta-ethnography screened 167 articles out of 211 results, identifying four qualitative studies that explored the support workers' experiences during the COVID-19 pandemic. Eight key themes were identified from studies in the UK and US, which informed a qualitative study, conducted based on the principles of reflexive thematic analysis (RTA). For the qualitative study, fifteen (15) support workers were interviewed sharing their lived experiences of working during COVID-19 and while all COVID-19 restrictions from the government were still in place. Five themes were identified.

The thesis contributes to our understanding of the lived experiences of support workers under extreme health (e.g., pandemic) and societal (e.g., lockdown, social distancing) conditions. This is the first time that research conducted in the UK focuses on support workers undergoing these emotionally challenging experiences during the COVID-19 pandemic and while all governmental restrictions were in place.

TABLE OF CONTENTS

TABLES OF FIGURES

Figure 1 PRISMA 54

GLOSSARY OF TERMS

Term	Definition
AMED	Allied and Complementary Database
APA PsyArticles	American Psychological Association full text
APA PsyInfo	American Psychological Association abstract text
CINHAHL	Cumulative Index to Nursing and Allied Health Literature
Covidence	Software to manage and streamline systematic reviews
CQC	Care Quality Commission. Public health body that regulates Health and Social Care in England, inspecting all social care services (CQC, 2022a).
EBSCOhost	Online platform that hosts academic databases
epidemic	Occurrence of an illness within a region that surpasses the normal expectancy (Madhav et al., 2017)
healthcare workers	Any or all staff members working within a healthcare setting without particularly including or excluding any group. Various healthcare workers fall under the healthcare umbrella: nurses, doctors, medical workers, technicians, pharmacists, administrators, support staff and healthcare workers with undefined specialty (Li et al., 2021).
information power	Used as an alternative to data saturation, the information power basis of participant size is built around: (a) study aim, (b) sample specificity, (c) use of established theory, (d) quality of dialogue, and (e) analysis strategy (Malterud et al., 2016).
JBI	Joanna Briggs Institute. Global organisation promoting and supporting evidence-based research. Specialty in systematic reviews.
lived experience	Representation and understanding of an experience, choices and option and how these influence one’s perception of knowledge (Boylorn, 2008, p.489)
Lockdown	England was in national lockdown between late March and June 2020. Initially, all ‘non-essential’ high street businesses were closed and people were ordered to stay at home, permitted to leave for essential purposes only, such as buying food or for medical reasons (UK Parliament, 2021).
MEDLINE	National Library of Medicine’s premier bibliographic database

meta ethnography	A qualitative review that synthesizes qualitative data from various ethnographic studies with the aim of understanding a phenomenon (Noblit & Hare, 1988; Britten et al., 2002).
pandemic	Large scale epidemics that cause high morbidity and mortality rates across large geographical areas impacting various human sectors such as health, economy and politics (Madhav et al., 2017).
PICO	Population, Interventions, Comparison, Outcomes Tool used extensively for evidence-based practice within the health sector in order to answer clinical questions (Scells et al., 2017
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
reflexivity	Act of examining one's assumptions and offering insight into the unique perspective of the researcher (Walsh & Downe, 2006)
registered manager	Legally responsible individual for the day-to-day operation of a health service. All services registered with CQC have a Registered Manager (NHS, Hospitals, GPs, Care Homes etc.).
social care services	Services providing a health or social aspect such as NHS, GPs, care homes etc.
SPIDER	Sample, Phenomenon of Interest, study Design, Evaluation, Research type. Tool to narrow down the search language by offering specificity (Methley et al., 2014)
support bubble	A support bubble is a support network that links two households (GOV, 2021).
support workers	The individuals providing one, a mixture or all of the following: personal care, assistance with daily living, housekeeping, meal prepping, toileting, dressing, emotional support, companionship, care, personal care, bathing, cleaning, medical tasks, vital signs, and wound care (Sterling et al., 2020; Bandini et al., 2021).

CHAPTER 1. INTRODUCTION

1.1. Current project

The current thesis aimed to explore the lived experiences of healthcare support workers during the COVID-19 pandemic, as well as provide a guide map for the future. Lived experience is defined as below:

> *Lived experience, as it is explored and understood in qualitative research, is a representation and understanding of a researcher or research subject's human experiences, choices, and options and how those factors influence one's perception of knowledge. Lived experience speaks to the personal and unique perspective of researchers and how their experiences are shaped by subjective factors of their identity including race, class, gender, sexuality, religion, political associations, and other roles and characteristics that determine how people live their daily lives.* (Boylorn, 2008, p.489)

However, defining lived experience in research depends on the overall approach adopted by the researcher. For the present study, lived experience is viewed within a phenomenological framework, whereby only those experiencing specific phenomena have the capacity to communicate them to others and, therefore, questions of lived experiences are inevitably connected with those actually experiencing phenomena and attributing (or not) a specific meaning to them (Mapp, 2008).

As far as the project's structure is concerned, Chapter 1 (the current chapter) introduces the researcher and provides a brief overview of his background as well as the reason he decided to pursue this particular topic. Additionally, it starts by explaining the current regulations in England and providing information for some of the core professions within the care sector.

Chapter 2 provides a comprehensive background divided into smaller sections outlining the differences between pandemics and epidemics and the lack of focus deriving from a problematic terminology within healthcare research. It also further expands on stress, coping, the interrelationship between work and life and psychological recovery. Finally, it builds a narrative for the journey of healthcare staff while narrowing the focus onto support workers during the COVID-19 pandemic.

Chapter 3 presents a systematic meta-ethnographic study that examines existing research around the lived experiences of support workers. During this meta-ethnography all available evidence of the job aspects that entail a support worker's role was collected, and with this meta-ethnography a clear distinction between support workers and all other healthcare professionals was formulated. This work establishes there is a significant gap in existing knowledge.

Chapter 4 presents the qualitative approach used for exploring the experiences of support workers, explaining the identification and selection of the most appropriate qualitative methods for this project. Their experiences provided insight into the issues experienced by support workers during the COVID-19 pandemic and highlighted their support requirements.

Chapter 5 includes the findings of the qualitative study, and Chapter 6 features the discussion, wherein I propose a theoretically informed intervention based on the findings of the meta-ethnography, the qualitative study and my professional expertise in order to support organisations and managers to effectively supervise and guide support workers.

As part of the professional doctorate, I need to evidence how it supported me to enhance my career prospects, how I grew as a researcher and how I intend to use it for my future career. In order to address this, at the end of Chapters 2, 3, 4 and 5 I will include a small reflective piece outlining lessons learned and how these lessons had an impact on my work outcomes and ethics. These chapters signify the three main pieces of the thesis: the meta-ethnography, the qualitative study and the proposed supervisory protocol (PSP). At the end of Chapter 6 I have included a reflective piece on the professional doctorate as a whole and its impact on my career.

1.2. Author's note

I graduated with a BSc (Hons) in Psychology in 2010, and after working in the armed forces as a practitioner, I decided to pursue my MSc in Health Psychology, researching the interrelation between cravings and smoking behaviour (Kasdovasilis et al., 2019). My early-stage career focused on delivering interventions that aimed at improving the quality of life of staff members in various organisations.

In 2015 I was part of a research team from Anglia Ruskin University investigating the lived experiences of individuals who were diagnosed with HIV (Stroumpouki et al., 2020).

In 2017 I started working at a homelessness charity (Penrose) as a Deputy Service Manager overseeing the mental health services and support in Luton, closely collaborating with the NHS teams and the Luton & Dunstable Hospital mental health wards. Through my visits to the wards, I conducted evaluations with patients whilst supervising the Mental Health Floating Support team.

In 2018 I started working for a private care organisation as the Head of Service overseeing a scheme with service users diagnosed with paranoid schizophrenia. My role was to run the daily operations supervising health teams, ensuring the service compliance with the regulations and performing audits, supervision and hospital visits. Furthermore, I created strong links with the local council attending different forums (e.g., housing and mental health) and advocating for the quality of mental wellness.

In 2020 I was promoted as the Head of Psychology for a subsidiary company within the care organisation, focusing on creating online mental health solutions for people, training frontline staff members, covering session development between clients-practitioners, developing policies (e.g., confidentiality, safeguarding) and providing empirical tools for psychological evaluation.

That same year I decided that I wanted to pursue my Professional Doctorate in Clinical Studies in order to try and fill some gaps within the sector and provide care companies with a better insight into the frontline staff members' experiences. I followed the Professional Doctorate route as opposed to a PhD because I was already working within the healthcare sector and I wanted to advance my career prospects, improve my knowledge of the current practices and potentially directly contribute to the organisations I was working for as well as develop via a route that heavily includes the practical element.

In 2022 I was able to successfully publish the meta-ethnography and the main qualitative study of the current thesis in a peer-reviewed journal as well as, in 2023, the PSP that I proposed (see Appendices 18, 19 and 20, respectively).

I have left my previous post, and I am currently working as a healthcare consultant for private care companies supervising staff, evaluating policies (e.g., safeguarding) and providing recommendations for improving overall care. Additionally, as of October 2022 I am working as a Lecturer in Psychology at the University of Bedfordshire, and I am a unit coordinator for counselling and health units.

Being a healthcare consultant, I witnessed first-hand the immense pressure that the pandemic brought to bear on healthcare support workers in the UK. To me, this not only highlights the need for effective coping mechanisms but also underscores the importance of developing intervention protocols that can support these mechanisms. Given the evident issue at hand, I felt inspired to explore the challenges faced by healthcare support workers in the UK during the COVID-19 pandemic, and to develop a PSP that could support their coping mechanisms. My hope is that this project will not only contribute to the existing body of knowledge on this subject but also provide practical solutions that can improve the psychological wellbeing of healthcare support workers in the UK.

1.3. Healthcare in England

Healthcare in England is regulated by the Care Quality Commission (CQC), a non-executive departmental public body of the Department of Health and Social Care. The conception and establishment of the CQC goes back to 2009, and its primary role is to inspect and regulate all social care services (CQC, 2022a). Social care services normally have a large organisational management chart (e.g., from director to deputy director and regional operations manager), but the care duties are performed by support workers. For purposes relevant to the introduction of this research, we are going to focus briefly on the day-to-day operations manager, called a registered manager (RM), who perform a crucial role within the structure of the care sector as they have to, for example, supervise the staff, make sure all documentation is in place, ensure medication is administered appropriately and that staff files are audited, and oversee the completion of health and safety (H&S) checks. Overall, a RM is responsible for upholding the standards set out by the CQC, and upon failure, the CQC can take legal action against the RM and the provider (Workforce Intelligence, 2024). The worst-case scenario is the service being taken over by the CQC or the RM being removed from the premises (CQC, 2022b). However, the CQC provides the service with an inspection report[1], which is made publicly available on their website with one of four (4) outcomes: outstanding, good, requires improvement or inadequate.

As part of providing evidence-based care and effective decision-making, care organisations rely on keeping and maintaining accurate records (General Medical Council, 2023) as these allow better communication between professional teams and provide accurate information regarding their care to the service users upon request (Douglas-Moore, Lewis & Patrick, 2014). The CQC actively looks at documentation during their inspections, something that the RM is responsible for. However, it is not the RM who writes said documentation but rather the support worker team. The RM is responsible for making sure everything is in place. A traditional phrase circulated by everyone within the health sector is *"if it is not written down, it never happened"* (Andrews & St. Aubyn, 2015).

Practically, documentation is important in order to evidence that systems or procedures are put in place by the providers in order to show CQC evidence of completion or progress (Andrews & St Aubyn, 2015) but also to make sure that the organisation is providing good quality care since proper documentation provides a storyline of what happened, when and why. It is worth mentioning that all documents within the healthcare sector are considered legal documents if they are requested as evidence by a court no matter how insignificant (e.g., a note that someone passed on a night shift to their colleague) (Dimond, 2005).

Not all support workers follow the guidelines set up by the CQC when documenting (e.g., crossing out mistakes with a single line and then putting a date and signature) resulting in the RM having to check all documents one by one (Adult Social Care Practitioner Guidelines, 2011). However, support worker issues are not uncommon within the health sector. From the pay to what the job entails, the long hours and the constant requests from management for extra shifts, this has been a long-lasting challenge in care. Adding the COVID-19 pandemic to the abovementioned problems, stretching the services to their maximum capacity, resulted in staff members going off sick (Mohanty, Kabi & Mohanty, 2019).

One of the ways to support effectively support workers is by providing supervision. Supervision by the RM or team leader needs to take place regularly (normally every two to

---

[1] The interested reader can find more information about CQC reports here: https://www.cqc.org.uk/.

three months, depending on policy) and offers an excellent chance for the staff to make themselves heard and discuss issues with their supervisor. It is a dynamic process, and both parties need to sign a document outlining the structure of supervision (e.g., confidentiality) including what to do with the notes after the supervision (e.g., supervisor sends the notes to the supervisee to amend, if necessary). However, during the COVID-19 pandemic when services were challenged on a daily basis, supervisions were left behind because the needs of the service users were prioritised over the needs of staff (Martin et al., 2022). Services are a dynamic space in which individuals live their lives, and as such, it is very difficult to concentrate on supervisions when having to deal with multiple problems at once on a daily basis, and with COVID-19 in particular (Martin et al., 2022).

The focus of the current thesis is on these supervised staff and specifically support workers. As the role is quite diverse and the terminology regarding the role differs from organisation to organisation, the reader will notice the references to support workers throughout the thesis. Therefore, the next subsection will try to define the role as accurately as possible for better clarity.

1.4. Support workers

One significant challenge is the lack of a standardised definition of support worker. The range of definitions of support worker is quite wide, and it differs from organisation to organisation. Different studies have used different terminologies in order to define the profession of support worker, with two of them describing it as just providing ‘care’ (Nyashanu et al., 2020a, 2020b) whilst another two used terms such as support for the elderly, home stay, personal care, assistance with daily living, housekeeping, meal prepping, toileting, dressing, providing emotional support, companionship, home healthcare workers, bathing, cleaning, medical tasks, taking vital signs and wound care (Sterling et al., 2020; Bandini et al., 2021).

All the different tasks and various definitions effectively describe the support worker role – a low paying, highly responsible profession with a lot of responsibilities but limited control and power over the tasks they perform within the private sector.

Support workers can also be found in the NHS; however, the job title is slightly different as the job role is advertised as ‘healthcare support worker’. The role can be also known as healthcare assistant, nursing assistant or midwifery assistant (NHS, 2024).

Two of the biggest differences between a private support worker and an NHS support worker are the resource accessibility and the structure. Within the NHS, one can find that there are specific specialties within which one can work, such as mental health, community, primary care, acute, midwifery, children's services, and learning disabilities (NHS, 2024). By contrast, the roles within private care are primarily focused on care homes and supported living, which often include elderly care, children's services, and drug and alcohol addiction (Skills for Care, 2024).

According to Skills for Care (2024), the role progression within the private sector ranges from working in different settings or different client groups, perhaps moving to a job with more responsibility. In contrast, within the NHS the job progression clearly states healthcare workers either specialise or train to qualify to become a healthcare professional such as a nurse or midwife (NHS, 2024).

Quite often the term healthcare worker is used, although it is fundamentally different from healthcare support worker. Healthcare workers are all the workers within a healthcare setting (e.g., nurses, doctors, biomedical lab technicians) (Li et al., 2021) as opposed to healthcare support workers, who provide the care as described above.

Within the private care sector, total posts account for 115,580 for care workers and senior care workers (Workforce Intelligence, 2024). By comparison there are 166,351 support workers (or healthcare support workers or healthcare assistants) across all the areas of the NHS (e.g., Learning Disability (1,825), Mental Health (1,866), Mental Health Adult (2,791)) (NHS Workforce Statistics, 2024). However, the data includes staff within pharmacies, A&E, domestic etc., which implies that the actual figure is less than the one presented above, and a clear comparison in terms of workforce is very difficult to establish. For example, some healthcare assistants perform care work whilst others work within a completely different environment (biomedical lab technician).

Support workers in the private sector clearly lack any professional progression and struggle with unclear and unstructured terminology. This can lead to different emotions as job titles have far-reaching implications for employees' senses of identity (Grant, Berg and Cable, 2013). For the purposes of the current thesis, a support worker is considered the staff dealing with the day-to-day care of service users including but not limited to personal care, assistance with daily living, housekeeping, meal prepping, toileting, dressing, emotional support, companionship, care, personal care, bathing, cleaning, medical tasks, vital signs and wound care (Sterling et al., 2020; Bandini et al., 2021).

The current project focused on the private care sector for two main reasons. Firstly, the private care sector has fewer resources than the NHS, which results in various difficulties such as low pay, no immediate access to other NHS professionals (e.g., doctors, pharmacists etc) and being unable to use the same NHS systems for communication. Furthermore, social care has been significantly underfunded. The 2022/2023 figures show that the Department of Health and Social Care spent £181.7 billion on the day-to-day running of NHS (The King's Fund 2024a). Social care is funded by local authorities; however, the Department of Health and Social Care provides fundings via grants to each local authority. For 2022/2023, the spending on social care was only £20.9 billion (The King's Fund, 2024b).

Secondly, the nature of the Professional Doctorate programme is *'to empower healthcare practitioners to drive change and innovation in their workplace by applying cutting-edge research to real-life practice'* (University of Central Lancashire, 2024). At the point of conducting of this research, I was working within the private care sector and therefore using the Professional Doctorate as intended by creating a bridge of theory to practice. At the same time, I was conscious that the research could be expanded into other private care organisations or the NHS. However, given the nature and timing of the research it would have been very difficult for (1) other organisations to provide resources (2) to expand into NHS as this would create a (a) private vs public comparison that was not the aim of the current thesis and (b) potentially risk already sensitive timescales, given that NHS Ethics were only fast-tracking research that focused on studying a vaccine, prophylactic or early treatment, or diagnostics for COVID-19 or studies to understand its transmission (NHS, 2022). More details regarding why there is a need for further research will follow in section 2.9.

1.5. The role of support worker

Within the adult social care sector in England there are currently 1.79 million employees with a 28.3% yearly turnover (Workforce Intelligence, 2024). Healthcare support workers are the backbone of many organisations within health and social care, forming a large group of low-paid professionals that are required to support people with their intimate social and personal activities both within their homes and their communities (Rossiter & Godderis, 2020). The turnover rates of support workers are as high as 38 percent for direct care workers (Vadean & Saloniki, 2023), and the job is significantly different from other healthcare professionals since support workers have frequent interactions with service users and their immediate family members. Additionally, they are responsible for the service users' daily living as well as attending doctor appointments, and they normally work shifts from one service user's home to another (Chen et al., 2021). In comparison, doctors and nurses work within a structured environment and their health status regarding COVID-19 is regularly monitored (Rossiter & Godderis, 2020).

Long term care (LTC), especially within care homes, is labour intensive. Factors that have an impact in relation to turnover rate are job satisfaction, work stressors and burnout. Staffing issues can lead to direct negative outcomes for the quality of care and support provided to service users (Costello et al., 2019), and professionals working in long term care facilities such as care homes experience high physical and emotional workloads due to the nature of their jobs. Burnout among care support workers is directly linked with a reduced quality of care provided to service users, and it prompts behaviours that are not supportive and can have dangerous implications for the service users' lives (Costello et al., 2019).

Within the sector, professionals have to cope with responsibilities (e.g., performing welfare checks with service users whilst maintaining their own mental health) that can be stressful, resulting in their mental and emotional resources becoming drained. Regulating their emotions is a helpful strategy to help them cope with the challenges of the profession as well as prevent behaviours that lead to stress-related outcomes and cognitive decline. Regulating emotions refers to the management of emotional reactions that is necessary in order to cope with daily demands (e.g., communicating with work colleagues) and successfully following social rules, such as the implementation of social distancing (Hadjiantonis et al., 2020). However, regulating one's emotions is subject to the availability of cognitive resources (Hadjiantonis et al*.,* 2020).

1.6. Challenges of the profession

Regulating the role of support worker is the most important challenge within the sector, a role which is changing according to organisational and service needs, and this issue has been evident for at least the past 16 years (Royal College of Nursing, 2007; Duffield et al., 2014). For an average £18,952 annual salary (PayScale, 2024), the role includes tasks with great responsibility and regulating the role provides a safety net for staff and organisations alike since they can measure performance against registered criteria (Royal College of Nursing, 2007).

Support workers provide the main workforce supporting service users within their own homes. They also make a significant contribution to the private social care sector in the UK. However, little is known about the role, including the actual job description and title. Herber and Johnston (2013) conducted a literature review to identify the duties of support workers when caring for people at the end of their life, identifying nine studies across five distinct domains: (1) personal care, (2) emotional and social support, (3) domestic support, (4) respite care for family carers, and (5) collaborating with professional and family carers. They then try to summarise the tasks that support workers undertake on a daily basis to support their service users.

1.7. Qualifications and job role

Overall, their role involves experiencing two fundamental difficulties adding to an already challenging environment (e.g., low pay workers, low skilled individuals, unrecognised and/or undervalued professionals), the first of which is inadequate training. Often healthcare organisations employ people with no previous experience (Lewis & Kelly, 2015) since the legal structure around the training requirements is minimal. As long as someone can complete a Level 2 training qualification in health and social care (often provided by the organisation as part of their induction process), pass the background checks (e.g., the Disclosure and Barring Service – DBS) and has satisfactory references covering a five-year period, they can become a support worker in the UK.

The second issue lies within the scope of ambiguity. In my experience, the role is so vast in terms of terminology (e.g., healthcare support worker, support worker, care worker, long term care worker, mental health support worker, domiciliary care worker, nursing support workers) that support workers are often found in a situation where they have to complete any task and generally go above and beyond on every shift or else be prone to accusations of neglect, for example (e.g., if a service user is not cleaning their room, and the service user has capacity, the support team is not allowed to leave the room in a state of starting to smell as this will be seen as neglect).

1.8. COVID-19 and support workers

It is understandable that this puts a lot of pressure on individuals who perform a role with so many legal, social and personal responsibilities. During the COVID-19 pandemic, support workers had to care for vulnerable individuals and in some instances, they had to live with the service users to manage COVID-19 exposure. The job in its entirety is a stressful one without factoring in the pandemic; however, adding the pandemic to the situation, one can understand the burdens and the difficulty of the work.

1.9. COVID-19 impact statement

The current thesis was undertaken during the COVID-19 pandemic and while all restrictions were in place. (More details about the definition and explanation of the restrictions can be found in 2.2). Consecutively, I was also greatly affected by the pandemic and the restrictions.

Regarding ethics, I was able to apply for an enhanced ethics application, which was granted to research students researching anything related to COVID-19. The enhanced ethics application allowed an eligible application to receive their ethics decision within five working days.

Regarding the research component, the meta ethnography was not affected by the COVID-19 pandemic owing to the nature of the review, e.g., literature search, collating evidence via manuscript search and analysis, all of which were conducted by myself within a controlled environment (e.g., no ethics application or interviews needed).

For the qualitative study I was not able to interact face to face with any of the participants, which was a new experience for me. A detailed analysis is presented in Chapter 4. I was also aware that, owing to the circumstances and uncertainty at the time, the participants may have been more vulnerable than initially thought during the ethics application; therefore, I verbally informed the participants that they could talk to their managers if they felt uncomfortable at any point and wished to discuss this with someone from within the organisation. Additionally, participants were given a reminder via the debrief form that they could speak to the CQC or local authority if they felt that something was wrong within the service. Furthermore, they were encouraged to seek further support if they felt they needed this after the interview, e.g., contacting a charity concerned with mental health (MIND), an emotional support charity or 111.

No participants raised any issues or requested additional support from me, the supervision team or the university, even though some experienced strong emotions during the interviews.

Additionally, the fact that the current project was time-limited and regulations kept changing within England (for the first-year timeline, please check Table 1), I was under pressure to make the right choices and keep going regardless of other external factors which placed a considerable amount of stress on me, thereby affecting the speed of my work and available resources. For example, one of the biggest challenges was that there was limited time to recruit participants as the circumstances (e.g., COVID-19 and subsequent restrictions) meant I could not go back and improve or amend any potential issues.

COVID-19 added considerably more to my personal and professional life workload, leaving less time to dedicate to the Professional Doctorate in its entirety.

Furthermore, I had to also cover and manage challenging incidents within the care company I was working for, while also focusing on my research responsibilities.

In addition, I experienced a lot of emotions that, in insight, resonated with the group I was investigating. Essentially, this made reflexivity very important as an ongoing process to examine my own experiences, with the aim of strengthening the credibility of the findings.

In the following chapter, I explore in detail the psychological effects of pandemics, overall exposure to stress, psychological detachment, the dynamics between work and life, recovery and different roles, including their access to services.

CHAPTER 2. BACKGROUND

2.1. Epidemics and pandemics

Outbreaks of infectious diseases can have a powerful psychological impact on individuals, including emotional distress, discomfort and inability to adapt (Kisely et al., 2020; Lateef, 2020), and they can develop and be classified as either epidemics or pandemics. An epidemic is the occurrence of an illness within a region that surpasses the normal expectancy. Pandemics are large-scale epidemics that cause high morbidity and mortality rates across large geographical areas, impacting various human sectors such as health, the economy and politics (Madhav et al., 2017). The Coronavirus disease (COVID-19) is an infectious disease caused by the coronavirus SARS-CoV-2 (World Health Organisation, 2020), and on 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

Pandemics are not an uncommon phenomenon in recent history: from the Spanish influenza pandemic (1918-1919) and the 'First Germ Panic' (1900-1940s), to Severe Acute Respiratory Syndrome (SARS) emergency (2002-2003), Ebola (2014-2016), and, more recently, the coronavirus SARS-Cov-2 or COVID-19 (2019). Infectious diseases, both those epidemic and pandemic in nature, require more psychological resources and mental adaptation compared with normal circumstances (Liu et al., 2020).

2.2. What is COVID-19? And what are the COVID-19 responses?

Coronaviruses are a type of virus that can be potentially dangerous as the cause of a disease. Once such virus, SARS-CoV-2, was identified in 2019 and caused a global pandemic of the respiratory illness named COVID-19 (NHS, 2022).

Symptoms of COVID-19 include cough, fever and chills, shortness of breath, body ache, sore throat, loss of smell, diarrhoea, headache, fatigue, nausea and vomiting, and a runny nose (NHS, 2022). Some people may develop several of the above symptoms whilst others experienced no symptoms at all. In some rare cases, COVID-19 leads to more severe symptoms like respiratory failure, heart and muscle damage, kidney failure or death (NHS, 2022).

Medical research has established that COVID-19 is spread via droplets in the virus load in the air when the individual breathes, via talking, laughing, coughing and sneezing (NHS, 2022).

Even though the bigger droplets of saliva can drop in the air, the smaller ones can accumulate in indoor places, particularly if larger groups of people are gathered. This is why global advice included mask wearing (e.g., to avoid droplet exposure), hand hygiene (e.g., to remove any virus on hands) and physical distancing (e.g., to reduce the likelihood of getting the virus from droplets from another individual) (NHS, 2022).

Because of the way COVID-19 is transmitted, as described above, the government introduced various restrictions to the UK including national lockdowns. England was in a national lockdown between late March and June 2020, a second national lockdown November 2020 and a third national lockdown January 2021 (Government Digital Service, 2022). Initially, all 'non-essential' high street businesses were closed, and people were ordered to stay at home, only permitted to leave for essential purposes, such as buying food, or for medical reasons (UK Parliament, 2021). Local lockdowns meant restricted gathering, and people were allowed only to interact within a 'bubble' (a support network that linked two households; GOV, 2021). Under this strategy, a household was allowed to interact with another household to form a 'social bubble'. There was no set size for the 'bubble' but rather the term household was used, as numbers of family members can differ. Each household was allowed to have only one bubble, which meant they could interact only with one other household (GOV, 2021), and this allowed for some social interaction whilst at the same time protecting the social bubble (Leng et al., 2020). The first year of living within the COVID-19 pandemic in England is presented in the table below (see Table 1). There were some exceptions to these rules; keyworkers were exempt from travel restrictions if it was for work. Keyworkers included health and social care staff and people working in education and childcare, utilities and communication, food and necessary goods, transport, key public services, public safety and national security, and national and local governments (Census, 2021). Within care services the government guidance said:

> *family and friends should be advised not to visit care homes, except next of kin in exceptional situations such as end of life[…] alternatives to in-person visiting should be explored, including the use of telephones or video, or the use of plastic or glass barriers between residents and visitors.*
>
> *(Parliament (2021). Restrictions on visiting care homes during the pandemic, section 18.*

Table 1 Timeline of UK coronavirus lockdowns, March 2020 – March 2021 (Institute for Government, 2021)[2]

March	2020	16th PRIME MINISTER (PM) says ‘now is the time for everyone to stop non-essential contact and travel’ 19th PM says ‘UK can turn tide of coronavirus’ in 12 weeks 23rd PM announces the first lockdown in the UK ordering people to ‘stay at home’ 25th Coronavirus Act 2020 get royal assent 26th Lockdown measures come into force
April	2020	16th Lockdown extended for at least three weeks. Government sets out five tests that must be met before restrictions are eased. 30th PM says ‘we are past the peak’
May	2020	PM announces a conditional plan for lifting lockdown and says that people who cannot work from home should return to the workplace but avoid public transport.
June	2020	1st Phased re-opening of schools in England 15th Non-essential shops reopen in England 23rd PM says UK’s ‘national hibernation’ coming to an end, announces relaxing of restrictions and 2m social distancing rule 29th First local lockdown to be applied to Leicester and part of Leicestershire
July	2020	4th Local lockdown comes into force, but restrictions are eased in England. Pubs, restaurants and hairdressers reopen. 18th Local authorities in England gain additional powers to enforce social distancing.
August	2020	3rd Eat Out to Help Out scheme, offering 50% discount on meals in the UK 14th Lockdown restrictions are eased further, including reopening of theatres, bowling alleys and soft play.
September	2020	14th ‘Rule of six’: indoor and outdoor gatherings of more than six people are banned in England.

---

[2] The interested reader can see a visual timeline on the Institute for Government website: https://www.instituteforgovernment.org.uk/sites/default/files/timeline-lockdown-web.pdf

		22nd PM announces new restrictions, including return to working from home and a 10 pm curfew for the hospitality sector. 30th PM says ‘critical moment’ in the crisis and would ‘not hesitate’ to impose further restrictions if needed.
October	2020	14th A new three-tier system of Covid-19 restrictions starts in England. 31st PM announces a second lockdown in England to prevent a ‘medical and moral disaster’ for the NHS.
November	2020	5th Second national lockdown comes into force in England. 24th PM announces up to three households will be able to meet up during a five-day Christmas period of 23 to 27 December.
December	2020	2nd Second lockdown ends after four weeks and England returns to a stricter three-tier system of restrictions. 15th PM says Christmas rules will still be relaxed but urges the public to keep celebrations ‘short’ and ‘small’. 19th PM announces tougher restrictions for London and South East England with a new Tier 4: ‘Stay at Home’ alert level. Christmas mixing rule tightened. 21st Tier 4 restrictions come into force in London and South East England. 26th More areas of England enter Tier 4 restrictions.
January	2021	4th PM says children should return to school after the Christmas break, but warns restrictions in England will get tougher. 6th England enters third national lockdown.
February	2021	15th Hotel quarantine for travellers arriving in England from 33 high-risk countries begins. 22nd PM expected to publish roadmap for lifting the lockdown.
March	2021	8th Planned return to school for primary and secondary school students in England

2.3. Impact of outbreaks to healthcare professionals

Previous research indicates that frontline health-care professionals are at an increased risk of developing work-related mental health problems during outbreaks of infectious diseases (Lee et al., 2018). There is also evidence of elevated anxiety and high depression levels amongst frontline staff during different epidemic outbreaks (e.g., SARS) (Maunder et al., 2003). Within the broader literature concerning healthcare staff in general (e.g., doctors, nurses, ambulance medical workers), adaptation strategies for COVID-19 included spiritual practices (e.g., praying), getting informed by trusted sources, professional commitments and seeking help (Sharov, 2020; Moghaddam-Tabrizi & Sodeify, 2021; Atashi et al., 2022). Other strategies that helped staff cope with an outbreak included the need for clear communication amongst staff and management, ongoing training and knowledge surrounding infectious diseases, adhering to infection control protocols, adequate PPE and the ability to access psychological interventions (Maunder et al., 2003; Kisely et al., 2020). Public health recommendations from the WHO and government bodies during the COVID-19 pandemic were numerous and imposed restrictions on daily living such as isolation and social distancing (Ammar et al., 2020; Liu et al., 2020). Within the health sector, providers were faced with the challenge of implementing and managing restrictions and guidelines whilst also having to look after vulnerable populations (Liu et al., 2020). Blake et al. (2020) suggest that the coronavirus pandemic (COVID-19) would have a significant psychological impact on healthcare workers, in particular frontline workers. In addition, staff shortages within the sector had been a recognised issue prior to the pandemic, and there was a need to recruit skilled professionals and to retain existing staff workers (Czuba, Kayes & McPherson, 2019).

Typically, when organisations face an acute shortage of staff due to sick leave, for example, there are measurable ripple effects on workload and stress levels, leading to staff feeling more exhausted and overwhelmed if experienced over a prolonged period of time (Czuba et al., 2019). Adding to the abovementioned challenges, a pandemic (e.g., public restrictions, understaffed organisations, high anxiety levels) creates unprecedented situations for healthcare providers that require additional resources in relation to responding and managing the situation. Healthcare professionals often had to stretch their emotional resources to the maximum in order to be able to cope with their workload, and without being able to put up boundaries that would allow them some form of psychological recovery (Trogolo, 2022).

2.4. Psychological effects of pandemic(s) and/or epidemic(s)

Health professionals have to cope with a physically (e.g., long hours), emotionally (e.g., exposure to COVID-19 death) and mentally (e.g., daily fear of getting the virus) demanding job (Katana et al., 2019). According to NHS Digital (2020) in the United Kingdom there are currently more than 1.1 million full time employees with 53.1% being clinical staff. Across the NHS there is a shortage of 100,000 staff (including medical and paramedical) predicted to rise up to 250,000 by 2030 (King's Fund, 2018). Within the health industry, private organisations (e.g., care homes, charities working with vulnerable adults) and local authorities (e.g., NHS trusts, local councils) require more skilled professionals than what the supply can provide (Czuba, Kayes & McPherson, 2019).

Understanding how healthcare staff cope within the context of a pandemic allows us to prepare for the future and explore the emotional and behavioural outcomes experienced. At the same time, it allows us to further define the importance of work-life balance and how it could be achieved in such a context. During a pandemic we can identify common feelings as well as behavioural patterns that allow us to prepare in advance protocols, preventative systems and coping mechanisms (World Health Organisation, 2017). Furthermore, during pandemics such as COVID-19 and SARS healthcare workers face the same ethical dilemmas: (1) whether to respond to the 'call' and (2) how to manage lifesaving resources for both patients and themselves (Iserson, 2020).

Since COVID-19 had such a great impact on the European Union and the UK, identifying previous pandemics/epidemics is imperative in order to find similar traits to help us explore the psychological outcomes for support workers. As such, while prior pandemics can give us a wealth of knowledge and information (e.g., SARS, Ebola), their applicability to the COVID-19 pandemic, particularly in the context of England's healthcare support workers, is limited because of several factors. These factors include the distinct characteristics of the viruses causing these diseases, the unprecedented scale and duration of the COVID-19 pandemic, the societal and technological changes since previous outbreaks, and the differences among healthcare systems (Chersich et al., 2020; Greenberg et al., 2020). New research is important, given COVID-19's scale of impact and prolonged stress, in order to support new coping mechanisms (Shanafelt, Ripp & Trockel, 2020).

With COVID-19 the global public health recommendation including government measures imposed numerous restrictions on daily living such as isolation, social distancing, and home confinement (Ammar et al., 2020), and adhering to the above measures alongside treating patients with COVID-19 is challenging (Liu et al., 2020). If we take into consideration previous pandemics globally, it is important to take into consideration how governments tried to keep the staff and population safe. For example, during the SARS epidemic in Hong Kong precautions were taken in order to protect patients, healthcare workers and the public since the spread of the disease was unknown, resulting in the above-mentioned groups experiencing feelings of fear and disruption (Chung et al., 2005). During SARS, feelings such as uncertainty and the process of re-evaluating one's ethics were identified amongst healthcare staff members, and worrying about family, getting additional information and micro-supporting patients (e.g., smiling, encouragement) were amongst the most prevalent drivers that kept the staff going (Chung et al., 2005). During the Ebola outbreak in West Africa, communities mis-trusted and stigmatised the health workers due to their job role (Raven, Wurie & Witter, 2018), and as a result, health workers experienced feelings of isolation and loneliness. Additionally, they did not feel confident in relation to their skills or knowledge in order to fight the disease. Shared emotions amongst health workers were those of fear, anxiety and hopelessness, and they were afraid that at some point they would contract the virus or pass it on to their family members (Gee & Skovdal, 2017). Another powerful experience was the loss of a colleague due to the virus and as a result feelings of fear were commonly identified amongst those groups (Gee & Skovdal, 2017; Raven, Wurie & Witter, 2018). The above studies highlight the importance of preparedness, education and social inclusion.

A meta-analysis exploring the psychological effects of emerging virus outbreaks on healthcare workers (Kisely et al., 2020) examined the impact of pandemics and/or epidemics on psychological reactions (e.g., fear of infection, inadequate training, stigma). More than 10,000 studies were screened and 59 studies selected with the results identifying three main categories of effect: factors that put healthcare professionals at risk, protective factors and helpful strategies. Predisposing factors included fear of infecting family, pre-existing psychological issues, increased exposure with patients, lack of training, stigma and inadequate compensation for the work they were doing. Factors that protected professionals from experiencing negative outcomes were taking adequate time off work and short breaks, particularly from clinical duties, effective communication among team members, access to psychological interventions, access to PPE, faith and seeing infected colleagues recover. The last category of effect was adopting helpful strategies including clear communication, providing training on the infectious disease, enforcing infection control protocols, having adequate PPE, access to psychological interventions, careful redeployment of staff and regular breaks for staff caring for infected patients. The above studies reveal a common approach towards outbreaks of infectious disease by identifying the challenges (e.g., stigma) and the ways of safeguarding professionals (e.g., PPE, training).

Research has shown that, prior to the COVID-19 pandemic, healthcare professionals reported high levels of absenteeism, stress and burnout at work in relation to other sectors (Brand et al., 2017). It is therefore important to explore stress as a whole and understand the processes involved.

2.5. Stress and coping

Selye's definition of stress, published in *Nature* in 1973, was one of the first, defining it as 'the nonspecific response of the body to any demand made upon it' (Selye, 1980, p.93). Stress can impact both an individual's physical and mental health, and even though low exposure to stressors can positively affect task performance, it becomes problematic when the demands outweigh the resources of the individual. Prolonged exposure to stressful events can even lead to episodes of depression (Babore et al., 2020).

The outcome of stress

High levels of stress can affect the work environments and compromise performance levels, particularly during an emergency (Babore et al., 2020), and COVID-19 had a significant psychological impact, particularly on frontline healthcare workers (Blake et al., 2020). More specifically, research identified that healthcare staff felt powerless and afraid and had to cope with feelings of guilt (Felice et al., 2020). Additionally, Benfate et al. (2020) identified that due to the levels of anxiety, workload and handling of the pandemic, healthcare staff developed traumatic stress.

Excessive stress as a result of one's job may lead to burnout (Kim & Lee, 2021), a process in which the resources of an individual that are related to a job are drained and therefore the individual starts developing feelings of hopelessness (Franza et al., 2020). Burnout is prevalent in human service professions such as doctors, nurses and teachers. However, different professionals within the healthcare sector may experience stress and cope with it in different ways. Prior to COVID-19, it was well reported within the literature that healthcare professionals experience increasing levels of stress and burnout (Mark & Smith, 2012; Elfering et al., 2016; Çetinkaya et al., 2019; Lucas, 2020).

Nurses & Social Workers: an example.

In a survey study conducted by Gellis (2002), 323 healthcare professionals (155 of whom were nurses and 168 social workers) completed a self-reported questionnaire comprising the job stress index, the Ways of Coping Checklist (WCC), and the job satisfaction scale. Results indicated that nurses reported higher job stress because of their emotion-focused coping (coping in stressful situations with mechanisms that allow the avoidance of direct confrontation with the stressor). As a result, in order to manage their mental health, they developed multiple avoidance strategies (avoiding colleagues, trying to 'forget', not talking about how bad things were). In contrast, social workers reported higher job satisfaction and active problem-solving coping strategies. Despite this differential finding, the data also indicated that as stress increased, job satisfaction decreased in both groups. However, the findings reported a difference between the nurses and the social workers. With nurses having a more active and physical role in patients' lives, they coped differently and perceived their job role differently than social workers did theirs. Throughout their career the nurses need to interact with pain, death and emotionally charged environments, while social workers on the other hand interact with service users or patients by means of talking. They do not have to get physical with patients nor do they accompany the patients throughout their health journey (e.g., when in hospital). It is important to note that even though they have fundamentally different roles, they are both classified in both research and in wider society as healthcare professionals.

Stressful events such as the COVID-19 pandemic can have a negative impact on employees' mental and physical health (Babore et al., 2020). The simple act of physically going to work can be a stressor since healthcare professionals must prioritise their patients as well as their own physical and emotional wellbeing (Bielicki et al., 2020). Previous survey studies in

Australia and South Korea reported high levels of stress amongst healthcare workers during the SARS and South Korea MERS epidemics, and the samples for the studies consisted of senior nurses and unidentified hospital workers, respectively. Additionally, healthcare providers (e.g., hospitals and hospital employees) in South Korea and Australia caring for patients during the SARS outbreak of 2003 and the MERS outbreak of 2015 were under extreme stress due to the increased likelihood of infection, stigma and understaffing issues, particularly among those caring for patients diagnosed with SARS or MERS (Maunder et al., 2003; Lee et al., 2018). These studies validate the previous research examples and systematic reviews that irrespective of infectious outbreak (e.g., SARS, MERS) the healthcare professionals always face the same issues (e.g., stigma, lack of PPE, stress), suggesting a pattern across the outbreaks. The difference between COVID-19 and the previous infectious outbreaks lies in the introduction of new social rules such as social distancing (e.g., two meters apart from each other), restrictions in movement (cannot leave the area you live in) and social interaction (you can only interact with individuals from your own household or support bubble). The above restrictions were put in place due to the way COVID spreads, as when someone speaks, breathes, coughs or sneezes, small droplets of saliva containing the virus are released (NHS, 2022). Healthcare professionals had to continue to work uninterrupted despite the high demands within the healthcare sector, and the frontline healthcare services (both NHS and care homes) are considered to be one of the most susceptible to the development of psychological stressors during the COVID-19 pandemic (Babore et al., 2020) because of the management of the pandemic in addition to the already draining nature of the job and understaffing issues.

The disaster effect

COVID-19 is a global pandemic that caused millions of casualties worldwide and therefore can be categorised as a disaster (Hao et al., 2020). Published results from 225 disaster studies, including several disaster types: a) natural, e.g., floods, wildfires, earthquakes; b) technological, e.g., nuclear accidents, chemical spills, industrial; and c) mass violence, e.g., peacetime terrorist attack, shooting sprees (Norris et al., 2006) revealed that 1) researchers have monitored the short and intermediate psychopathological effects of the disasters but little data is available in relation to very long term effects, and 2) disasters have an indirect effect on secondary victims. One example of an indirect effect is the 9/11 terrorist attack on the twin towers in the US, when individuals were not affected directly even though the emotional impact of the disaster was global (Bonanno, 2004), although this effect is normally less severe than the one experienced by those affected directly. Past research has demonstrated that humans are resilient in the face of stressors (e.g., death) as well as equipped with psychological tools (e.g., positive emotions, laughter) that help with recovery (Bonanno, 2004).

Similarly to natural disasters, the COVID-19 pandemic is considered to be a generation-defining public health issue (Anicich et al., 2020). Households that are free from any symptomatology of the virus (e.g., no coughing, no fever, smell is not affected) can experience major stress, particularly if there is emotional pressure leading to burnout (e.g., such as having to try harder to maintain employment), depression or economic difficulties (e.g., at least one of the individuals supporting a household losing their job). Stress is increased with social isolation, which clashes with the human relatedness of connecting with other human beings (Baumeister & Leary, 1995). Social interactions are contributory factors that help people regulate their emotions and cope with stress and anxiety (Hawkley & Cacioppo, 2010), whereas social isolation affects people psychologically (e.g., loneliness, stress) and physically (e.g., increasing risk of cardiovascular and immune health) (Bavel et al., 2020).

Financial stressors

In the UK in 2018 the median salary of an accountant was £35,727, a registered nurse received £25,349 and a residential support worker £18,726 (PayScale, 2021). What these figures suggest is that society pays more to fund financial services rather than to take care of people who need immediate medical or long-term care, and adding low pay to the already stressful working environment is a significant cause of stress (Chiang & Chang, 2012). There is a lack of scientific evidence on the impact of life events (e.g., death) and the effect on wellbeing while experiencing the event (e.g., understanding the impact of COVID-19 while within the pandemic) (Georgellis, Lange & Tabvuma, 2012; Hakanen & Bakker, 2017; Bakker, Du & Derks, 2019; Liu et al., 2020). Life stressors deriving from the above-mentioned disasters, and in particular COVID-19, are characterised by the immediate onset of a stress event such as social distancing, mortality rates and change of the work-life dynamics (Anicich et al., 2020). Therefore, understanding the nature and timing of emotional recovery of healthcare staff is important as well as the processes that would help individuals to cope during a pandemic

(Anicich et al., 2020).

Roles and Stress

Roles in the healthcare sector, particularly those in direct patient care roles, have been consistently identified as ones within a high-stress environment because of a multitude of factors. Healthcare professionals are often exposed to high levels of stress due to the demanding nature of their work, including long working hours, high patient loads and the emotional toll of dealing with severe illnesses and death (Portoghese et al., 2014). This is further exacerbated by the need to make critical decisions under pressure, often with limited resources and support. Similarly, a systematic review by Aiken et al. (2012) found that nurses, in particular, are at high risk of burnout, job dissatisfaction and even intent to leave their profession due to the stressful nature of their work. The review highlighted that these stressors are not only detrimental to the mental health of the professional but also have significant implications for patient safety and quality of care. Moreover, the emotional labour involved in healthcare work, defined as the requirement to manage personal emotions in response to job demands, has been identified as a significant source of stress (Delgado et al., 2017). This is particularly relevant for healthcare support workers who often have close and prolonged contact with patients and their families, requiring them to manage not only their own emotions but also those of others. In addition, organisational factors such as lack of managerial support, inadequate staffing levels and poor workplace culture have been identified as significant contributors to stress among these professionals (Shanafelt et al., 2012).

Overall, the factors point to a very demanding and stressful job, outside of the COVID-19 occurrence. It is therefore important to understand how individuals can support themselves in a healthy way by balancing these stressors and feeling overwhelmed in general. This is something that can be achieved by understanding the role of psychological detachment.

2.6. Psychological detachment

Working within the healthcare sector can be challenging. However, the addition of the COVID-19 pandemic created an environment that was beyond challenging. One way employees recover from their working environment is through ‘detachment’. Etzion, Eden and Lapidot

(1998) described ‘detachment’ as the physical (e.g., going home after the contractual hours) and emotional (e.g., not thinking about work) distance from the working environment (Wendsche & Lohmann-Haislah, 2016). Meanwhile, Etzion et al.’s (1998) work focused on large respite intervals of at least two weeks. As a continuum to Etzion et al.’s work, Sonnentag and Bayer (2005) defined psychological detachment as the emotional state of an individual’s distancing from thoughts that arise due to one’s job. The main difference is the importance of short-term intervals and particularly the effect of detachment during the same day after returning from work, therefore emphasising the importance of time. Another characteristic of detachment is that the individual is involved neither physically nor emotionally in any way with work-related tasks, and the ability to be able to detach from work at regular intervals is linked with a healthier lifestyle such as better eating patterns and low alcohol consumption. Detachment helps individuals relax (e.g., when going out, when at home) as well as recover from work-related stress (Wendsche & Lohmann-Haislah, 2016), and distancing oneself from the working environment, both physically and emotionally, during non-working hours, helps restore depleted resources (Buljac-Samardzic, Doekhie & Wijngaarden, 2020).

A systematic review of 297 studies showed a significant positive relationship between psychological detachment, wellbeing (e.g., life satisfaction) and job performance (e.g., time management, effectiveness at work) (Buljac-Samardzic, Doekhie & Wijngaarden, 2020). Within the field of health and social care, psychological detachment is important because it directly affects service users as it empowers caregivers to be focused, alarmed and engaged, therefore preventing potential issues while working (Buljac-Samardzic, Doekhie & Wijngaarden, 2020), and it supports professionals as it assists in reducing potential stressors. As described previously, prolonged stress can result in depression, which can hinder the quality of care provided to patients or service users, and being able to detach and therefore reduce stress can have a significantly positive impact on the quality of working life. The inner resources are replenished, which are then used to perform adequately within a busy environment.

Psychological detachment is crucial when it comes to switching off from work. When psychological detachment is not achieved the individual is at risk of complications such as burnout or creating/bringing problems into the home/life domain.

2.7. Psychological recovery and work

Psychological recovery is the ability to return all emotions to the state before the stressors started (Sonnentag & Bayer, 2005). Work recovery is a process that affects both the physical and mental domain of an individual, and it aims at restoring the depleted resources. Recovery is linked to detachment since it is largely influenced by the extent of disengagement from work-related tasks and thoughts (Vandevala et al., 2017). Although previous research has focused on examining the recovery process, the process was primarily examined only after the stressor had passed (Shepherd & Haynie, 2011), and the literature suggests that there is a lack of scientific evidence on the lived experiences and how people adapt during a life event. For example, earthquake victims were approached only after their life was becoming normal again and not whilst undergoing the struggles linked to the disaster (Georgellis, Lange & Tabvuma, 2012; Hakanen & Bakker, 2017; Bakker, Du & Derks, 2019). Major life events such as floods, earthquakes and nuclear accidents can affect the work–life balance and the level of stress of individuals (Norris et al., 2006), and experiencing a pandemic is considered a major life event as well as a generation-defining public health issue (Anicich et al., 2020).

2.8. Anxiety, the roles and access to services

Previous research has shown that frontline healthcare professionals are at an increased risk of mental health problems such as increased anxiety levels and depression; however, the research does not identify the exact categories of healthcare professional (Maunder et al., 2003). A cross-sectional study by Vandevala et al. (2017) identified that 96 ICU healthcare professionals (58 doctors and 38 nurses) experienced significant stress due to their profession. High ICU stressors, such as dealing with death or treatment withdrawals, were linked with burnout and depression with findings suggesting that 32 percent of the sample was categorised as being at risk of psychiatric morbidity and 18 percent as being at risk of depression. Furthermore, working for more than 40 hours per week left the professionals with little time to focus on recovery. The authors suggested that because of the job demands and shift patterns within the sector, health professionals may experience high levels of fatigue, irritability and decreased work efficiency.

Depending on the responsibilities (e.g., deciding how to allocate medical resources as a hospital manager vs deciding the best way to approach customers in a IT firm) as well as the level of flexibility of the working sector (e.g., physical hospital presence vs working from home), some individuals are able to detach and recover more easily than others. Moving from the health sector to an equally busy environment, that of technology, Mache, Servaty and Harth (2020) conducted a longitudinal study with 71 employees within the technology department, examining whether different work arrangements correlated to occupational stress, recovery and psychological detachment. Results indicated that professionals who transitioned to open work spaces perceived that they had to do more than what was asked from them – something known as the ‘autonomy paradox’, which describes how, when professionals are given more autonomy, they tend to work more than anticipated. Additionally, when professionals were given the opportunity to select their place and time of work (e.g., work from home), it had a positive effect on occupational stress as well as the need for psychological recovery.

Even though both studies examined busy environments, the concept of detachment as well as psychological recovery were more easily achieved in the technological sector.

Even though healthcare professionals have access to different services that could potentially help them (e.g., helplines, mental health champions, therapists), the nature of the job does not allow them to focus on detaching or recovering. The working hours, in addition to the level of human interaction, have an impact on the above concepts, as a frontline healthcare professional has to deal with trauma, pain and, depending on the occasion, even death. On the other hand, professionals within the technology sector are customer-oriented and can work their contractual hours without having to deal with emotionally challenging cases.

2.9. Need for further research

Following the above narrative, it is important to explore the lived experiences of support workers because they are an underrepresented profession that impacts thousands of lives on a daily basis through supporting people to be independent or to live.

Since the topic of interest concerns support workers within a pandemic, similar studies, systematic reviews and other meta syntheses were traced concerning healthcare support workers and frontline staff in general (Amaratunga et al., 2007; Koh, Hegney and Drury, 2011; Billings et al., 2021; Busch et al., 2021; Li et al., 2021). It seems that support workers are indeed an underrepresented profession within the healthcare sector (Chan et al., 2020), as they were not included in those reviews.

More specifically, Amaratunga et al. (2007) conducted a critical gap analysis examining the support mechanisms of healthcare workers during the 2003 global SARS outbreak without identifying who the healthcare workers were, even though there was a distinct focus around nurses. Koh, Hegney and Drury's (2011) systematic review explored the perceptions, risks and coping strategies of healthcare workers from 1997 to 2009, focusing on nurses and other healthcare personnel such as doctors, pharmacists and management staff as well as hospital cleaners and clerks. Billings et al.'s (2021) systematic review focused on frontline healthcare workers and their views regarding support during COVID-19 and previous pandemics, examining general healthcare workers, management decision-makers, community nurses, consultants, general medical staff, midwives, healthcare providers and volunteers. Meanwhile, Busch et al.'s (2021) systematic review explored the psychological burden of frontline healthcare workers without identifying the roles of the professionals. Li et al. (2021) conducted a systematic review on the prevalence of depression, anxiety and post-traumatic stress disorder among healthcare workers, in which the participants were nurses, doctors, other medical workers (e.g., technicians, pharmacists), administration and support staff and healthcare workers with undefined specialities.

The results of the abovementioned reviews explored the experiences of healthcare staff in general. Therefore, a need for further research in relation to support workers is necessary. A healthcare support worker is someone who looks after the wellbeing of service users, supporting individuals with physical (e.g., wheelchair) and mental disabilities (e.g., paranoid schizophrenia) as well as enabling them to live more independently and be part of a community. Additionally, healthcare support workers try to empower individuals to manage their symptoms, resulting in them improving their overall quality of life.

It is important to study how infectious diseases affect healthcare workers as a whole, especially considering the impact past outbreaks had within the healthcare sector. Understanding better factors like stress, work–life balance, burnout and recovery can be crucial to improving healthcare environments during a pandemic. However, it is important to make clear separations between the healthcare teams and professionals as different jobs have different levels of responsibility and therefore different lived experiences, and one group that is often either not included or not specified is support workers.

In consequence, it seems that a further qualitative literature review in relation to support workers is needed as qualitative research can capture the essence of feelings and experience with information-rich cases (Schultze and Avital, 2011).

The question of the meta ethnography was to identify what the experiences of support workers are as a result of an outbreak and to identify any factors that allowed support workers to cope and/or adapt during that outbreak. In order to select the appropriate method for the qualitative research, firstly, existing types of qualitative reviews were traced in the relevant bibliography.

2.10. Aims and objectives of the current thesis

The aim of this thesis is to explore the lived experiences of healthcare support workers during the COVID-19 pandemic in the UK, as well as provide a guide map for the future.

This will be achieved by (objectives):

1) examining the current evidence of the lived experiences of support workers within healthcare internationally (see Chapter 3 - Meta-ethnography)
2) exploring the lived experiences of support workers in the UK via interviewing them during the COVID-19 pandemic while all the restrictions were in place (see Chapter 4 - Qualitative study).
3) proposing an intervention/guidance for the future (sees section 6.3 - PSP for supervision) based on the results from (1) and (2) and my knowledge.

Reflection for Chapter 2

During my first year and a half at the university, I was building the initial skeleton-rationale for my research topic. When I first enrolled, it was exactly one month prior to the pandemic and the introduction of the national lockdowns in the UK and Europe, and the university offered me the opportunity to defer my entry to the next year, which I refused. The reason for my refusal was because I found it fascinating that I would be able to work on this piece of research while it was happening. However, it took me more than a year to be able to properly navigate my focus and what I wanted to achieve, as I had to show growth as an entry researcher as well as working full time and the field of my work had to align with my Professional Doctorate.

It was so difficult to pinpoint one particular group of health professionals upon which to focus my research, primarily because most available research is conducted for 'healthcare professionals', and it was quite a challenge to gather the evidence presented in Chapter 1 because I had to take a lot of information from other groups and different countries in order to build my rationale. For example, I had to research pandemics in Asia and Africa, but then I had to also identify the roles of support workers in these countries so that I could present the materials appropriately. Additionally, not all healthcare systems are the same, and it was very challenging to present a cohesive structure.

However, it was clear that by working within my company in the role I had at the time, as well as researching the above, I developed a comprehensive understanding of the role and what was happening in different countries. The above influenced my working organisation to offer me a role as Head of Psychology for a subsidiary company because of my health psychology background and my understanding of COVID-19, pandemics in other countries and the overall challenges of healthcare staff. The company created an online mental health solution in Pakistan and Brazil including an online pharmacy and GP service, and I was tasked to build those services. The company is now integrated under one platform.

Following the above, I had to further explore the studies available, specifically for support workers which led me to the conclusion that I have to conduct a literature review and try to identify what precise information is available out there for support workers as there seems to be gap in the research explicitly for support workers or even including them under the more generic healthcare professionals sphere.

Considering that I have spent more than a year working on the skeleton of the thesis, reading and exploring the background information gave me more confidence as a researcher as I was extensively reading articles, reading about common methodological approaches, and contemplating comparing and contrasting my own knowledge to what I was reading. I believe part of me was feeling overconfident in the beginning, primarily because I gave too much emphasis to my career, sometimes forgetting that I was just beginning to develop as a researcher.

When I was writing subsections 2.5 and 2.6, I started becoming more vocal in relation to work–life balance, asking the Managing Director and the Head of Quality more questions about their thoughts and how they thought we might approach this. I think it started as an exploration of my surroundings prior to actively making suggestions on how we could improve the work–life balance within the company.

CHAPTER 3. META-ETHNOGRAPHY

3.1. Types of qualitative reviews

Currently there are nine distinct methods of synthesis for analysing qualitative research: (1) meta-narrative, (2) critical interpretive synthesis, (3) meta-study, (4) meta-ethnography, (5) grounded formal theory, (6) thematic synthesis, (7) textual narrative synthesis, (8) framework synthesis and (9) ecological triangulation (Barnett-Page & Thomas, 2009). A brief explanation of each method is outlined below.

Meta-narrative

Reviewing literature in a way that does not exclude major theoretical and methodological differences between them but rather collecting similar studies and drawing out the conceptual insight from the results (Chinn & Homeyard, 2017).

Critical interpretive synthesis

A methodology combining both qualitative and quantitative studies into one. A technique that is an adaptation of meta-ethnography and grounded theory with a process adopted from systematic reviews. Critical interpretive synthesis uses an inductive approach to create a central theory by combining different theorical outcomes into one (Depraetere et al., 2021).

Meta-study

A meta study comprises three components. A meta data analysis (further analysis of the findings), a metamethod (analysis of methods) and a metatheory (the analysis of the theoretical frameworks). It is the higher level of analysis of articles and concepts that allow then for a meta-analysis (Paterson, 2001), and this method generates or improves/expands on frameworks based on the collected data of the individual studies (Drew et al., 2019).

Meta-ethnography

This methodology comprises of a rigorous seven-phase qualitative evidence synthesis (France et al., 2019), allowing the formulation of a higher level of understanding. The seven steps include 1) getting started, 2) deciding what is relevant to the initial interest, 3) reading the studies, 4) determining how the studies are related, 5) translating the studies into one another, 6) synthesising translations, and 7) expressing the synthesis (Britten et al., 2002).

Grounded formal theory

This methodology uses a higher level of data sources (e.g., substantive theories) and moves towards describing a human response to the identified problem (Kearney, 1998). Grounded formal theory matches similar studies to one another to form a higher level of understanding.

Thematic synthesis

An approach that combines the characteristics of meta-ethnography and grounded theory, the methodology involves systematic coding of the data in order to generate analytical themes from the studies. It follows an inductive approach where themes are created on a step-by-step basis aimed at reaching at higher order themes (Nicholson et al., 2016).

Textual narrative synthesis

This methodology allows for studies to be arranged into more homogenous groups, synthesising different methodologies (e.g., qualitative, quantitative) by identifying the similarities and differences and comparing them across studies (Barnett-Page & Thomas, 2009).

Framework synthesis

Framework synthesis recognises that qualitative research produces a vast amount of raw data, which can pose a problem during the analysis, and therefore a framework synthesis offers an approach by which data is organised more structurally (e.g., numerical codes, translating data into charts etc.) (Barnett-Page & Thomas, 2009).

Ecological triangulation

Ecological triangulation involves studying phenomena from different vantage points. It builds an 'evidence base' of what is effective, what does and does not work and under what circumstances (Barnett-Page & Thomas, 2009).

3.2. Review focus and outcomes

All the above reviews are well established tools focusing on different approaches and outcomes. However, understanding the different focus and outcomes of each can provide clarity as to why meta-ethnography was selected. Since only qualitative studies would be included, the available reviews fitting this criterion were meta-ethnography, grounded formal theory, thematic synthesis and textual narrative synthesis (see Table 2). I was investigating lived experiences and as such was looking for depth rather than an explanation or a narrative approach; therefore, grounded formal theory and textual narrative synthesis were excluded on the grounds of outcomes. Thematic synthesis, even though relevant, was not fit for purpose as I was not looking to analyse different themes based on the studies but rather to translate studies while exploring in-depth lived experiences.

Table 2 Approaches including the focus and the outcomes as described in section 3.1

	Study	Focus	Outcomes
1	Meta Narrative	Developing a coherent narrative across studies	Conceptual understanding of a phenomenon
2	Critical Interpretive Synthesis	Interpreting qualitative & quantitative data through critical lens	Critically informed interpretation of findings
3	Meta Study	Synthesizing in-depth different parts between studies	Evidence to support or refute hypotheses
4	Meta Ethnography	Synthesizing qualitative data from ethnographic studies	Deep understanding of phenomena
5	Grounded Formal Theory	Developing grounded theory from qualitative data	Grounded theory explaining a phenomenon
6	Thematic Synthesis	Identifying themes across qualitative data	Identified themes and patterns across studies
7	Textual Narrative Synthesis	Creating a narrative account from qualitative data	Narrative account of a phenomenon
8	Framework Synthesis	Developing a conceptual framework from qualitative data	Conceptual framework for understanding a phenomenon
9	Ecological Triangulation	Combining quantitative and qualitative data from different sources	Integrated understanding of quantitative and qualitative data

3.3. Meta-ethnography

From the suggested methods for analysing qualitative research, meta-ethnography was selected as it aligns perfectly with the research aims. Meta-ethnography is a well-established method that generates a novel, in-depth and more complete understanding of personal experiences and concepts (Fernández-Basanta, Lagoa-Millarengo & Movilla-Fernández, 2021). In comparison with a common literature review or meta-analysis, meta-ethnography identifies patterns of conceptual relevance among different studies, a process described as 'translation', adding a new understanding of cross-textual findings that may surpass each study's original meanings (Soundy & Heneghan, 2022). Since the topic explored is primarily influenced by personal beliefs, experiences and cultural factors, this methodology allows for a unique understanding of these experiences. Meta-ethnography as a systematic approach, combining data from multiple qualitative studies to enable a new understanding of patients or healthcare professionals' experiences (Sattar et al, 2021) and generating evidence that is used for healthcare practice and policy-making (Sattar et al., 2021).

The present study followed the suggested phases of guidance in meta-ethnographic qualitative synthesis (see Table 2) (Noblit & Hare, 1988; Feeley, Thomson & Downe; 2019).

Table 3 Noblit and Hare's (1988) Seven Phases

1. Getting started (the search)
2. Deciding what is relevant to the initial interest
3. Reading studies and extracting data
4. Determining how studies are related (identifying common themes and concepts)
5. Translating studies (checking first and/ or second order concepts and themes against each other)
6. Synthesising translations (attempting to create new third order constructs)
7. Expressing the synthesis

Even though, the above phases are suggested to guide researchers on their meta-ethnographic qualitative synthesis, recent articles suggest that the phases are not designed to be followed separately or in clear distinction, but some of them may also run in parallel (Sattar et al., 2021).

3.4. Review question, aims and objectives

Research questions play a key role in research, guiding data selection and better defining the scope of the meta-ethnography. The accurate research questions will help the meta-ethnography in phase 2 to identify studies relevant to the topic of interest and determine what is relevant and what is not for a meta-ethnographic synthesis (Sattar et al., 2021).

In order to formulate our research questions, I used and modified the traditional PICO (Population, Interventions, Comparison, Outcomes) tool accordingly, which was developed for quantitative review questions (Butler, Hall & Copnell, 2016). However, a modified version using PCO (Population, Context, Outcome) or PICo (Population, Interest, Context) can be used for the effective synthesis of qualitative data (Riesenberg & Justice, 2014). PICo is used extensively in evidence-based practise within the health sector in order to answer clinical questions (Scells et all., 2017). Since the background research revealed that this area is under-researched, there was a focus on using a well-established tool in order to support the process and contribute to the validity and authenticity of the work.

Within this framework, I used the PICo tool (see Table 4) in order to generate the overall search terms and formulate the research questions that are suited to identify qualitative evidence (Butler, Hall & Copnell, 2016). The PICo tool is divided into population (which for this meta-ethnography was the care and/or support workers), the research interest (which was their lived experiences and how they adapt to and cope with any interventions), and the context (which was different pandemics, COVID-19 and the care sector).

Table 4 PICo for meta-ethnography

Population or Problem	Interest	Context
Care worker	Lived experiences	Pandemics
Support worker	Adaptation	COVID-19
	Coping	Care sector
	Interventions	

The question for this meta-ethnography is separated into two parts. The first is to identify the experiences of support workers as a result of an outbreak, and the second to identify what enabled (e.g., interventions) support workers to cope and/or adapt during the outbreak within the care sector.

The objectives of this meta-ethnography cover three aspects: firstly, to identify previous and current research around outbreaks of infectious diseases and the impact they had on support workers; secondly, to try and give an initial framework to support workers' job roles by combining all relevant roles; and thirdly, to understand the coping mechanisms used by support workers by analysing their lived experiences.

Aim

This meta-ethnography aims to explore the available qualitative literature for support worker's experiences during a pandemic internationally and identify different strategies that may be used to support them.

Objective

To achieve this, there are 3 objectives:

1) To identify qualitative literature from different online libraries

2) To ‘translate’ the identified studies to one another

3) Present the findings.

3.4.1. Search strategy and selection criteria

To complete phase 2 in the present meta-ethnographic synthesis – identifying relevant studies – effective search strategies and selection criteria were needed. Since systematic review searches may have a level of complexity, effective strategies that can be executed across various databases and on different platforms are needed (Bethel & Rogers 2014). For the present study, electronic searches were conducted on 27 April 2021 of five databases: AMED, APA PsyArticles, APA PsyInfo, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and MEDLINE. The interface used for the above databases was EBSCOhost, which provides various options of advanced search settings, save results and document extraction in various formats (e.g., CVS) that could then be imported to other tools (e.g., PROSPERO) for further analysis. EBSCOhost has been used extensively when conducting literature searches including in reviews such as meta-ethnographies (Xiao & Watson, 2019; Bhattacharjee & Nath, 2022).

The search strategy was developed using the Sample, Phenomenon of Interest, study Design, Evaluation, Research type (SPIDER) tool (see Table 5), which was selected as an effective tool that yields a higher rate of results and therefore reduces reviewing time by identifying relevant articles more accurately (Cooke at al., 2012). Furthermore, Methley et al. (2014) suggested that SPIDER is often an optimal tool for specificity given its ability to narrow down the search language used, which means it is a tool that is best used by research teams with limited resources. By incorporating the SPIDER tool, I arrived at the search terms that were then refined through a scoping exercise. The reader may note that the search strategy is quite broad, and this happened deliberately so that more articles could be identified, screened and potentially included in the study as it would be less likely to miss articles that are overly prescriptive.

The final search terms used were *(care worker or support worker or senior support worker or senior care worker) AND (care home or nursing home or assisted-living or residential home) AND (pandemic or epidemic or outbreak or covid-19 or coronavirus) AND (descriptive or* *qualitative).*

Apart from the articles identified through the search strategy, I hand-searched the reference lists of all included papers to identify any potentially relevant articles that could be included in the study.

Table 5 SPIDER tool

Sample	**Phenomenon of Interest**	**Study Design**	**Evaluation**	**Research Type**
Care worker	Pandemic	Descriptive	Care home	Qualitative
Support worker	Epidemic	Qualitative	Nursing home	
Senior support worker	Outbreak		Assisted living	
Senior care worker	COVID-19		Residential home	
	Coronavirus			

3.4.2. Inclusion and exclusion criteria

The review was limited to qualitative studies that examined support workers within the care sector. The studies that were included in the review had to meet four criteria: focus on lived experiences of the support workers; be within the care sector including but not limited to supported living, nursing homes, domiciliary care; provide clear information on the ‘how to’ or the emotional journey of the support workers; and be published in English.

Studies were automatically disregarded if they featured any of the following: any quantitative, survey or statistical report; focus on the professional’s opinion in relation to the treatment or patient care; or studies that examined healthcare workers in general without a clear distinction between support workers-carers and other health professionals (e.g., doctors, nurses).

3.4.3. Reference management

Abstracts from all papers identified by the database and hand searches were exported into Covidence[3] online software. Duplicates were removed automatically by the Covidence

---

[3] The interested reader can find more information about the software here: https://www.covidence.org/

software. Screening was undertaken independently by two reviewers (PK and NC), firstly by screening by title and abstract and then through the full text of all potentially included papers in line with the phases of the meta-ethnographic criteria. Disagreements were resolved through discussion.

It is an increasing belief amongst qualitative experts that a good meta-ethnographic study requires articles with strong conceptual depth that can support a meaningful interpretation and, ultimately, synthesis (France et al., 2019). However, there is an ongoing debate as to whether one can appraise qualitative work with concepts such as 'validity' and or 'quality' based on the per se epistemological stance (Garside, 2014). For the current meta-ethnography, I used Downe et al.'s (2009) template for meta-synthesis as it focuses only on technical aspects of research (e.g., appropriate participants, design, reflexivity etc.) leaving the ultimate decision to me using the said tool. The Critical Appraisal Skills Programme Tool (CASP[4]) also represents an alternative option (Critical Appraisal Skills Programme, 2023), but it was not selected because even though it has very similar questions to the 'template for meta-synthesis' it also asks the researcher 'How valuable is the research?', which I found a slightly leading question regarding quality purposes, given that I believe that the value of a paper has to be measured by metrics and outcomes rather that subjective opinion.

The quality of the included articles was assessed using the 'Template for meta-synthesis of qualitative research studies' (Downe et al., 2009) (see Table 6 or Appendix 1 for the detailed analysis) by two independent reviewers, PK and NC. No quality bias was identified during the quality process, and discrepancies were resolved through discussion. The quality appraisal tool used considered the aims, participants, design, methodology, analysis, results, reflexivity, context, rigour and ethics of the studies.

3.5. Translating the studies to one another

To synthesise the review, I immersed myself in the studies by repeated readings, which allowed me to identify core categories and explore the unique points of each article prior to identifying how they 'relate' to one another, and by organising the categories, I was able to

---

[4] The interesting reader can find all CASP checklists available for free here: https://casp-uk.net/casp-tools-checklists/

compare, contrast and put in context participant quotes and research interpretations. According to Malpass et al. (2009), a systematic reading and interpretation of the articles requires a clear distinction between first-, second- and third-order constructs. First-order constructs are the original narratives within the selected articles that relate to the particular topic searched. Second-order constructs are the interpretations of the above narratives from the authors of the article, while third-order constructs are the synthesis of the review team. For this synthesis, first- and second-order interpretations were extracted and examined against each selected study one by one. For example, first- and second-order constructs from study 1 were compared with study 2 as a form of 'translating' to the other studies, and the same process was followed for all four studies (Merten et al., 2015). The 'translation' was conducted either by identifying similar concepts ('reciprocal translation') or opposite concepts ('refutational translation') supporting the building of a 'line of argument' (Walsh & Downe, 2004). By following the above whilst maintaining the original seven phases, as suggested by Noblit and Hare (1988) (see Table 2), I identified constructs across the studies and built on the insights they offered individually, albeit for a collective outcome (Walsh & Downe, 2004; Merten et al., 2015).

3.6. PROSPERO

A preliminary submission of the current study was published in PROSPERO with Ref.No.: CRD42021261018.

3.7. Reflexivity

Reflexivity is important in qualitative research since it allows the reader to understand the background of the research team and offer an insight into the unique perspective of the researchers (Walsh & Downe, 2006). As part of reflexivity, it is important to explain the roles of interpretivism and constructivism and the existence of multiple truths.

These epistemological frameworks challenge the idea of the existence of a single truth. On the contrary, they suggest that knowledge is not readily available in the world but rather is created through a dynamic process, actively constructed through our interpretations of the world and social interactions (Walt, 2020). Central to this notion is that the process of meaning is subjective and is developed organically through interactions, our various societal belief systems, personal experiences and culture. By following the above narrative, one can suggest that both the individual and groups of people create their own realities based on the collective meaning-making process. Interpretivism and constructivism emphasise the role of interpretation in our lives (Walt, 2020), and even though these concepts go together, there are subtle differences between the two.

For the interpretivism approach, I gathered and read multiple perspectives (truths) in connection to the research problem in the form of literature. The aim of this was to gain in-depth insight into the support workers' experiences during previous and current pandemics. This was followed by constructivism, which as a scholarly approach to my research problem is based on the notion that the reality of what I made sense was based on the assumption that my own behaviour or perception would transform based on my own beliefs, interaction with data, background, relationships etc. Therefore, as the researcher I had to always be aware of my background, history, and how I developed both as a professional and as an individual, reflecting on the above throughout my data collection and analysis. Below, I present an in-depth way of how I achieved this.

My research background is in psychology and health psychology as well as my professional experience has been continuously developed over the past ten years within the mental health sector, specifically in operations such as managing NHS mental health wards and care settings. This extensive experience within the healthcare system, alongside my personal experience as a frontline worker during the COVID-19 pandemic, has provided me with a deep understanding of the challenges faced by healthcare professionals and support staff.

However, this significant involvement with the subject (work and research) may introduce potential biases into the research. For instance, I might primarily focus on operational challenges, given my background in healthcare operations. Furthermore, my subjective experiences during the pandemic may influence the interpretation of the data, leading to an overemphasis on certain aspects of the pandemic's impact, such as anxiety and uncertainty, on healthcare support workers.

To mitigate these potential biases, I employed several strategies. Firstly, I consciously strived to maintain an open and balanced perspective (e.g., taking a lot of breaks after reading each article in order to give myself enough time to fully absorb the information), actively seeking out diverse viewpoints (trying to think outside of my experiences and trying to look at it through different lenses as if I was the staff member, manager or policy-maker) and experiences. Secondly, I engaged in regular reflexivity exercises, particularly journaling, critically examining my assumptions, beliefs and values, and how they might have influenced the research. Lastly, I sought feedback from peers and mentors to challenge my interpretations and ensure a more objective analysis. By acknowledging these potential biases and taking steps to address them, I aimed to enhance the validity and reliability of my research findings.

Furthermore, a second reviewer (NC) from a different school with a background in psychology and public health, as well as expertise in qualitative research and systematic review methodologies, was involved in the process as a second reviewer in selecting, screening and supporting with the manuscripts to maintain best practices.

3.8. Results of the database searches

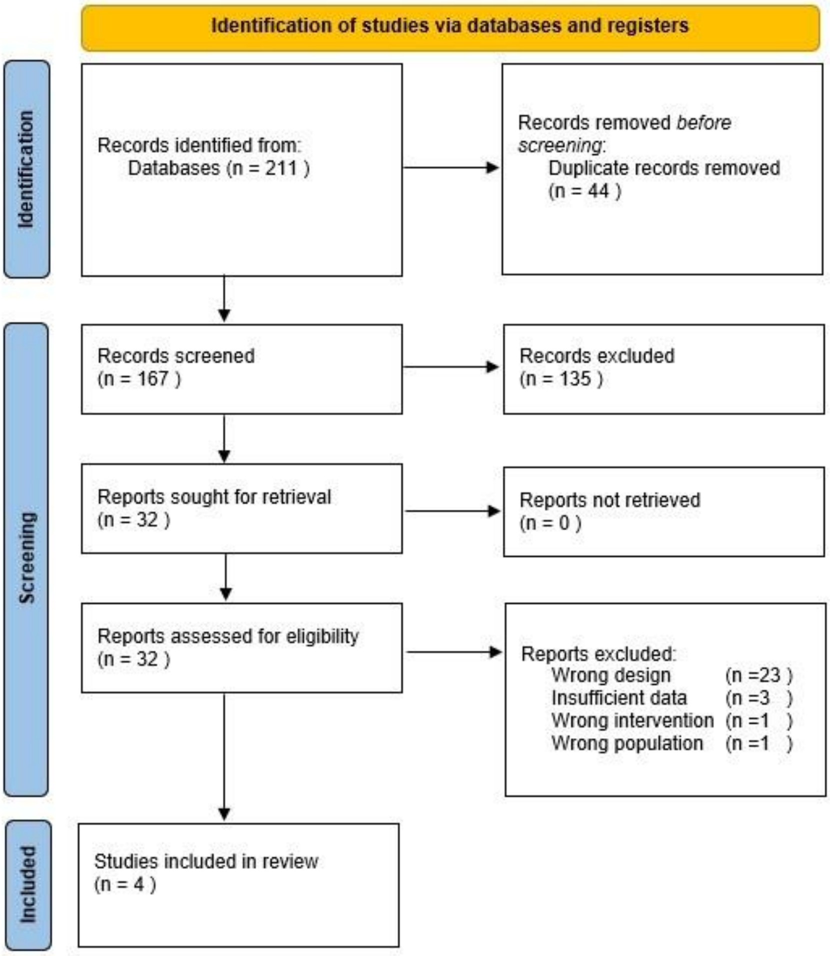
The study selection process is outlined in the PRISMA chart (see Figure 1).

A total of 211 records were identified through database searching and 0 records through other sources, and 44 duplicates were removed, leaving a total of 167 articles for screening. Of these, 135 articles were deemed irrelevant for this review based on the inclusion and exclusion criteria, and therefore 32 full-text studies were assessed for eligibility, 27 of which were excluded for various reasons: 23 for wrong design (quantitative), 3 for insufficient data (unspecified participants), 1 for wrong intervention (intervention for patients), and 1 for wrong population (doctors). This resulted in four studies (Figure 2).

The Joanna Briggs Institute (JBI) QARI Extraction Tool for Qualitative Research (Aromataris, 2020) was used in order to support the researcher in deciding which datasets across the identified studies would be extracted. A detailed analysis can be found in Appendix 1.1, and a table outlining the basic information of the tool can be found in Figure 2.

The study characteristics (see Figure 2) included four studies conducted between the years 2020 and 2021. All studies were published in English with two studies based in the UK and two studies in the US. Among the studies, the sample varied with three studies including purely support workers (various terms used) and one including support workers and nurses and managers; however, only the relevant quotes from the support workers were used.

Figure 1 PRISMA



Phase 2 of defining what is relevant and what is not for meta-ethnographic synthesis was completed, followed by phase 3, the process of reading selected articles.

Throughout this phase, 'conceptual maps' (see Appendix 2) were created for each paper to visually represent the ways each study is related to the others by identifying the common themes across the studies. This approach seeks to keep the structural connections between concepts within each study in line with the emphasis that meta-ethnography places on preserving contextual meaning, as highlighted by Britten et al. (2002).

3.9. Themes

The reading process resulted in phases 4 and 5 of the meta-ethnographic synthesis, which describe how texts are related to each other as well as the processes of ‘translation’, meaning the processes of observing inter-textual connections and differences as well as broader conceptual categories (Toye et al., 2017). Within the meta-ethnographic objective of conceptualising rather than simply describing, the study identified eight themes (see Table 7). The themes are explained below with accompanying quotes for each respective theme.

3.9.1 Job role

A major challenge in the health and social care sector is the definition and job description of support workers (see Table 8). All the selected articles defined the role differently with common traits between them, which creates confusion within the sector and between fields as to what these professionals do. It is important to put the role of support worker into a specific structure in order to provide them with the credibility they need and to create a distinct separation between healthcare professionals. The job role is important in relation to the lived experiences since support workers feel underrepresented and unappreciated due to this confusion.

Bandini et al. (2021) described them as home care aides that provide vital support for the elderly and individuals with disabilities, while Nyashanu et al. (2020a) described them as health and social care frontline workers and Sterling et al. (2020) described them as:

> *Home health care workers, who are composed of home health and personal care aides and home attendants, care for community dwelling adults.*

The role is diverse and it requires a vast amount of knowledge and sacrifice from the employees.

Bandini et al. (2021) examined the safety concerns and job challenges of homecare aides during the COVID-19 pandemic, describing their roles as including the following:

Figure 3 Study characteristics brief based on the JBI QARI Extraction Tool for Qualitative Research. Please see Appendix 1.1.

Author	Country	Data collection	Analytical approach	Participants	Study focus
Bandini et al. (2021)	US	Snowball sampling	Thematic analysis	16 home care aides	(1) examine experiences of agency employed home care aides during COVID-19 (2) identify ways to mitigate concerns
Nyashanu, Pfende & Ekpenyong (2020a)	UK	Via email to private care organisations (e.g., care homes)	Thematic analysis	40 (15 support workers, 15 nurses, 10 managers)	To explore the challenges faced by different frontline workers in health and social care during the COVID-19 pandemic
Nyashanu, Pfende & Ekpenyong (2020b)	UK	Letters and information sheet to nursing homes and domiciliary care agencies	Thematic approach with Interpretative Phenomenological Analysis (IPA)	40 (20 care homes, 20 domiciliary care)	To explore the triggers of mental health problems amongst frontline healthcare workers within private care homes and domiciliary care agencies
Sterling *et al.*, (2020)	USA	Purposive sampling technique	Grounded theory	33 home healthcare workers	To understand the experiences of home healthcare workers during the COVID-19 pandemic in New York City

Table 6 Downe et al.'s (2009) quality appraisal

1. Author		Bandini et al. (2021)	Nyashanu et al. (2020a)	Nyashanu et al. (2020b)	Sterlin et al. (2020)
2. Aims Clear?		Y	Y	Y	Y
3. Participants appropriate for question?		Y	Y	Y	Y
4. Design appropriate for aims and theoretical perspective?		UC	UC	UC	UC
5. Methods appropriate for design?		Y	UC	UC	Y
6. Sample size & sampling justified?		UC	UC	UC	UC
7. Does the analysis fit with the chosen methodology?		Y	Y	Y	Y
8. Reflexivity present?		N	N	N	N
9. Study ethical?		Y	Y	Y	Y
10. Do the data presented justify the findings?		Y	Y	Y	Y
11. Is the context described sufficiently?		Y	N	N	Y
12. Is there sufficient evidence of rigour?		N	N	Y	Y
13. Include?		Y	Y	Y	Y
Grade:		B	C	C	B

Y= Yes, N= No, UC= Unclear

Grade:

A: No, or few flaws. The study credibility, transferability, dependability and confirmability is high.

B: Some flaws, unlikely to affect the credibility, transferability, dependability and/or confirmability of the study.

C: Some flaws that may affect the credibility, transferability, dependability and/or confirmability of the study.

D: Significant flaws that are very likely to affect the credibility, transferability, dependability and/or confirmability of the study.

Table 7 Themes of meta-ethnography

Theme No.	Theme	Subtheme No.	Subtheme
1	Job role	**1.1**	Duty of care
2	Marginalised profession		
3	Impact of work	**3.1** **3.2** **3.3**	Change of caseload Uncertainty Fear of infection
4	Concerns surrounding PPE		
5	Transportation challenges		
6	Level of support and guidance	**6.1** **6.2**	Additional experience Working guidance
7	A higher calling & self-sacrifice		
8	Adaptation strategies		

Table 8 Job role description

Bandini et al. (2021)	Nyashanu et al. (2020a)	Nyashanu et al. (2020b)	Sterling et al. (2020)
COVID-19 – New York	COVID-19 – UK	COVID-19 – UK	COVID-19 – UK
Support for elderly	Care	Care	Home healthcare workers
Home stay			Personal care
Personal care			Assisting with daily living
Assistance with daily living			Bathing
Housekeeping			Dressing
Meal prepping			Preparing meals
Toileting			Cleaning
Dressing			Medical tasks
Emotional support			Vital signs
Companionship			Wound care

> *…assistance with instrumental activities of daily living including housekeeping, meal prepping, personal care, upkeeping family demands, and providing companionship and support. Some home care aides provide assistance with activities of daily living including bathing, toileting, and dressing. Aides also provide support beyond practical and clinical tasks, including emotional support and companionship. This support helps keep their clients safe, decrease hospitalizations, and cut health care costs.*

Sterling et al., (2020) explored the experiences of home care workers in New York City during the COVID-19 pandemic. The duties of the role include:

> *Home health care workers spend hours to days with patients, assisting with activities of daily living (e.g., bathing and dressing), instrumental activities of daily living (e.g., preparing meals and cleaning), and medically oriented tasks (e.g., vital signs and wound care).*

3.9.1.1. Duty of care

Duty of care was described in three articles as a concept that allowed professionals to keep working under the circumstances.

> *Even in the face of personal risk, healthcare staff are often assumed to have a duty to work. This duty is enshrined in the codes of conduct that guide professional healthcare workers. Nevertheless, an effective health system does not only depend upon the services and skills of healthcare professionals such as doctors and nurses; but also depends on the services of other professionals, such as HSCFWs.* (Nyashanu et al., 2020a)

High levels of stress and anxiety resulted from the dilemma workers faced feeling the need to keep working under adverse conditions, consequently risking their own health but providing care for vulnerable individuals (Nyashanu et al., 2020b). Furthermore, as described by Sterling et al. (2020), many participants reported the need to balance the ‘duty’ of care with their own health.

3.9.2. Marginalised profession

Three articles raised concerns that the profession was not given enough attention from the government, that it was marginalised with the focus primarily on other healthcare professionals such as doctors and nurses. For example, it was only after the social care sector raised its voice that the UK prime minister included the sector within the government agenda. It is important to recognise the contribution of the healthcare workforce as a whole and not just a particular group (e.g., doctors).

Many aides also wrote about their concerns around safety in relation to feeling as though their voices as marginalised home care aides were often forgotten in the broader discourse around the risks taken by other frontline care providers during the COVID-19 pandemic, such as doctors and nurses (Bandini et al., 2021). Even in the face of personal risk, healthcare staff are often assumed to have a duty to work that is enshrined in the codes of conduct that guide professional healthcare workers. Nevertheless, an effective health system does not only depend upon the services and skills of healthcare professionals such as doctors and nurses but also depends on the services of other professionals, such as frontline health and social care workers (HSCFWs) (Nyashanu et al., 2020a). The research participants felt that HSCFWs were not being recognised as contributing to the healthcare system, which impacted on their morale. The participants also attributed this lack of recognition to causing delays in receiving PPE and testing, which resulted in panic and anxiety (Nyashanu et al., 2020b).

3.9.3. Impact of work

Support workers face a lot of challenges when it comes to offering bespoke care during a pandemic. The current theme is subdivided into three smaller subthemes capturing these challenges: (1) change of caseload; (2) uncertainty; and (3) fear of infection.

3.9.3.1 Change of caseload

Aides described that they experienced an increase in tasks such as sanitising and additional cleaning, which was a particular challenge since the clients occasionally did not have enough cleaning supplies. Furthermore, shopping for clients became challenging due to social distancing and increased tension within stores (e.g., longer queues, contactless payment, social distancing within the stores). Wearing masks was reported as a big challenge since clients often experienced breathing issues or difficulties understanding the support workers when they spoke with their masks on. One participant said:

> *He* [client] *cannot lay on the bed on his own. He's in a wheelchair. It's a challenge for this coronavirus because you can't keep a distance from your clients; it's a direct contact.* (Bandini et al., 2021)

Since the profession was classified as an essential worker role, individuals kept working despite the social distancing policies. In addition to continuing with their daily tasks, the support workers had to manage the COVID-19 situation for the clients as well. On occasion, this involved management of the emotional health of clients that was worsening when watching the news due to either misinformation or too much information resulting in stress and anxiety.

> *Participants reported that the majority of their patients had several chronic conditions, which rendered patients high risk for COVID-19.* (Sterling et al., 2020)

> *Beyond monitoring their patients' physical symptoms, participants also tried to assist with their patients' emotional health. Many reported that this endeavour was worsened by patients watching the news.* (Sterling et al., 2020)

3.9.3.2 COVID-19 Diagnostic uncertainty and client interaction

Shortage of staff was reported in three studies (Nyashanu et al., 2020a, 2020b; Bandini et al., 2021) to have three main reasons. One was the uncertainty as to whether or not staff had COVID-19; secondly, individuals where not willing to risk their own health and be infected with COVID-19; and thirdly, there was uncertainty around whether the support worker's families had COVID-19. Nyashanu et al. (2020a) quoted:

> *The morale at work is sometimes low when you think of the situation. Moreso, many staff members are not taking up as many hours as they used to do due to self-isolation if any of their family members or themselves catch a cough.*

Uncertainty also comes from the reporting of false negative results. Nyashanu et al. (2020b) described the pressure of having to accept hospital patients who were not tested but were found positive the day after discharge from the hospital, resulting in the support workers having to take the responsibility.

> *We had one resident whom we sent to hospital with suspected COVID-19, they discharged him without testing on the same day.*
>
> *I had a resident on shift that I thought might have symptoms, I called the paramedics and when they checked him, they said there was nothing to worry about… The next day we took the resident to hospital and it turned out he had COVID-19.*

Uncertainty on the job in terms of daily tasks and decision-making was described in most of the articles. Nyashanu et al. (2020b) reported that care staff felt overwhelmed by the idea of dying or leaving dependents behind, resulting in feelings of anxiety. Additionally, the testing procedure was unreliable, particularly during the beginning of COVID-19, providing another stressor for the professionals.

The participants reported that staff shortages were a source of stress and anxiety. Sickness rates increased and some support workers used their leave entitlement, causing staff shortages and leaving other staff physically and mentally drained (Nyashanu et al., 2020b).

Owing to these challenges, participants described constantly navigating hard choices. For example, when patients contracted COVID-19, workers had to decide whether to continue caring for them, which meant potentially exposing themselves. Sometimes, however, patients fearful of contracting COVID-19 declined homecare services, leaving workers to decide whether they should accept a new patient who they did not know. Workers also weighed up whether they should remove themselves from cases they perceived to be risky. Support workers had to balance the risks of work with their own health and financial wellbeing (Sterling et al., 2020).

3.9.3.3 Fear of infection

The majority of the articles identified that professionals were significantly concerned with the safety of clients and themselves. Additionally, one article pointed out that the risks outweigh the benefits of the jobs during the pandemic (Bandini et al., 2021). Furthermore, the idea that COVID-19 has killed many of their colleagues resulted in experiencing feelings of fear and anxiety.

The professionals were experiencing a dilemma between keeping the people they were caring for safe and safeguarding themselves and, consequently, their families.

> *Many aides described the frustration that they had to put themselves at risk while only receiving minimal compensation for their work during the pandemic. Several aides also expressed concerns around putting their own family members at risk because of the possibility of bringing home the virus from their job.* (Bandini et al., 2021)
>
> *…their clients' family members who did not take proper precautions, putting aides at even greater risk.* (Bandini et al., 2021)
>
> *Many aides worried about the negative consequences of possibly coming in contact with COVID-19 on the job and having to miss work, ultimately not being able to provide for themselves and their families.* (Bandini et al., 2021)

Bandini et al. (2021) noted that the caseload changed due to COVID-19. Some staff had to work more hours due to staff shortages whilst others could not continue to work within the selected home because the family were afraid that they are going to increase the risk of infection to their loved ones. One participated said:

> *We're sitting there on pins and needles and if we cough or sneeze, they can have a whole panic attack. It had an impact on the way we communicated and how I can do my job.*

Fear and anxiety of having to cope with an untreatable disease was noted in Nyashanu et al. (2020a):

> *Feelings of anxiety and fear of the condition based on the notion that it is not treatable and that some HSCFWs had lost their lives were also reported.*

As quoted by two (2) participants:

> *I had this feeling of anxiety and fear every day when I wake up to go to work… it is mainly because the condition is untreatable and so many colleagues in the profession*

> *have lost their lives.*
>
> *Everyone at work is fearful and anxious we really don’t know what to do. No one has knowledge about this condition moreover; it is not treatable. With so many people losing their lives you really don’t know your fate.*

The fear of infection of the disease was a major concern for individuals, as Nyashanu et al. (2020b) reported:

> *Research participants reported fear of infection and infecting their residents and families. This was particularly severe for those who had vulnerable family members. Participants described the fear as being relentlessly at the back of their minds. High level of stress and anxiety was also described, stemming from the dilemma of performing their duty of care while in fear of cross infection.*

Furthermore, Sterling et al. (2020) reported that individuals lived in worry and they were constantly afraid of contracting the virus. Additionally, having to care for individuals who entered and left home each day added an additional stressor to the professionals:

> *Participants explained that providing care to patients placed them in a unique position with respect to COVID-19 transmission. They worried about their patients becoming ill in general and about transmitting the virus to them.*
>
> *Participants also worried about their own risk of contracting COVID-19, and nearly all felt that their dependence on public transportation increased this risk. Many participants reported using public transportation to get to their patients’ homes, to run errands for them, and to travel to their agency for supplies.*
>
> *Finally, many participants cared for a patient alongside other workers who entered and left the home each day. This added to their fear of transmitting COVID-19 to their patients and to one another.*

3.9.4. Concerns surrounding PPE

One major theme identified in the articles is feelings of safety associated with the personal PPE available at the time of the COVID-19 outbreak. Even though challenges regarding the supply of PPE were evident, it is clear that even the most prepared services (e.g., the ones who had adequate PPE prior to the pandemic) struggled to cope.

Bandini et al. (2021) reported that:

> *Aides reported feeling overwhelmed because they did not have access to an adequate supply of PPE including face shields, disposable gowns, and N95 masks. Some aides reported that they resorted to purchasing their own PPE because their employer was unable to provide PPE.*

with an individual quoted in the article:

> *It wasn't easy to get them* [PPE], *and they were limited. They made us reuse the mask which was not sanitary because the surgical masks that they give us clearly state one time use only. I personally went out and purchased my own reusable, cloth, washable mask.*

Sterling et al. (2020) reported that:

> *Many home health care workers also reported that they lacked adequate PPE from their agencies, including masks and gloves, which they felt was essential for care.*

Additionally, Bandini et al. (2021) captured the need for PPE before and after two intervals (during national PPE shortages and after):

> *…in journal entries submitted at the beginning of the pandemic in April and May during the national shortage of PPE. While entries received later in the data collection period in June and July 2020 referenced PPE as necessities to providing care safely to clients, there was much less concern around the availability of PPE during this later time.*
>
> *As noted earlier, accessibility to PPE was a challenge for most aides, and many agency representatives themselves recognized these concerns and described limitations in their own ability to supply aides with proper protections to be able to safely do their*

> *jobs. Even agencies that already had a stock of PPE prior to the pandemic faced challenges obtaining PPE, and some reported paying price gouges to be able to supply aides with needed protection, suggesting that further emergency preparedness planning may be needed for agencies.*

PPE shortages was not the only problem when it came to PPE challenges. Nyashanu et al. (2020a) described the situation:

> *All the research participants expressed that there was severe shortage of PPE making it difficult for them to discharge their duties. They also felt that in some instance the PPE was not fit for purpose.*

One individual was quoted in the article:

> *Most of the PPE we had ran out within two days and we had to wait for days to get some only to last for two days. Honestly, this was the most difficult time to work in health and social care. The few PPE available was not fit for purpose as everyone had little knowledge about COVID-19.*

Additionally, within the article it was reported that central governments reported consecutive updates for PPE and by the time the professionals were able to familiarise themselves with the policies, the government had already changed them, resulting in confusion and panic:

> *The research participants reported ever evolving PPE guidelines from public health authorities and central government. They reported panic among HSCFWs every time the guidelines were changed as they feared contracting COVID-19. (*Nyashanu et al., 2020a)

3.9.5. Transportation challenges

One article raised the issue of transportation during the pandemic.

> *In terms of transportation, some agencies provided vouchers for ride-sharing services for aides during the pandemic, despite aides' reported challenges with delays or wait times. One representative explicitly recognized these issues around unreliable*

> *transportation, stating that their agency has been more lenient in disciplinary policies for aides.* (Bandini et al., 2021)

The issues raised suggest that additional funding is needed for the sector in order to aid the planning and support the workers during an infectious disease outbreak.

3.9.6. Level of support and guidance

The majority of articles described the levels of support given to support workers during the pandemic from either their agency, local government or place of work. The outcomes can be categorised into two subcategories: (1) the additional experience they received during the pandemic, and (2) working guidance from the abovementioned bodies.

3.9.6.1. Additional experience

During the COVID-19 pandemic, Sterling et al. (2020) explored the level of support care workers received from their agencies with participants describing that they received some COVID-19 related information whilst others reporting that they did not receive any COVID-19 specific training but hoped that that would become available in the future. Agencies performed daily 'self- assessments':

> *They text a four-question screener every day. They want to know if something changes in our body. Do you have a fever? Do you have a cough?*

3.9.6.2. Working guidance

Nyashanu et al. (2020b) reported that participants found it challenging to work without any clear form of guidance from the central government, which caused distress amongst staff. Additionally, changing the guidance frequently lead to the operational concern and confusion, which triggered 'anxiety'. They quoted a participant:

> *I am really worried with ever changing information from government on how to act during this pandemic… Honestly it really makes me anxious.*

Sterling et al. (2020) described participants being given different levels of support that were dependant on the organisation the individual was working with. The level of support focused on COVID-19 related information, availability of PPE and COVID-19 training:

> *Although some agencies adapted quickly to the pandemic by providing workers with COVID-19–related information on a weekly or daily basis, others reportedly barely communicated about the pandemic.*
>
> *Participants reported that they had not received COVID-19–specific training from their agencies but had hoped that it would be offered in the future. Some agencies asked participants to perform daily "self-assessments." Self-assessments, which were usually automated by phone, were intended to screen home healthcare workers for COVID-19 symptoms.*
>
> *Owing to varying levels of institutional support, participants often relied on others for information and help. For example, if their agency did not provide information on COVID-19, participants turned to the news media, social media, government briefings, and their worker union.*

Bandini et al. (2021) suggested that partnerships through the health sector might have been able to reduce the understaffing issues and minimise some of the strain experienced during the outbreak of an infectious disease.

3.9.7. A higher calling and self-sacrifice

Two articles described the feelings of participants in relation to 'fulfilment in helping those in need' and 'the calling'. The 'calling' during a pandemic was something experienced by individuals via balancing the risk of caring for clients and the call of duty, 'the calling' (Nyashanu et al., 2020a; Sterling et al., 2020). One of the participants said:

> *I see a fire. Am I going to walk right into that fire?[…] If I have the backup, the proper gear, yes, I'm going to be there on the front lines to help that person.*

Nyashanu et al. (2020a) explored the concept of self-sacrifice by describing the importance of acknowledging the social shielding by staying at work in order to protect the clients as well as the families:

> *…traveling to and from work would increase their chance of acquiring the infection from COVID-19.*

3.9.8. Adaptation strategies

Nearly all articles identified adaptation strategies used by professionals in order to cope with examples including purchasing their own masks, policy and agency adaptation, cleaning, talk-walks, meetings with colleagues or within the company. The adaptation strategies aim at tackling emotional distress and raise the level of appreciation shown by society or organisations to the support workers.

Bandini et al. (2021) described the agency adaptation strategies employed in order to support aides during the pandemic and reduce stressors. Strategies included better communication channels between the agency and workers, better monitoring of symptoms to help prevent COVID-19 from spreading and ensuring reliable transportation methods. Additionally, as quoted in the report:

> *Lastly, agency leadership representatives also noted areas for improvement on a structural level in terms of policies to better support aides and strengthen the appreciation and recognition of aides as essential workers.*

An agency representative was quoted:

> *We're texting the aides every day and then calling them intermittently to see how things are going ... And then keep calling and tell them not to go to work if they aren't feeling well and to call a doctor. They aren't in it alone.*

However, it is unclear whether that helped the aides since no further information was given based on their experiences.

Organisations tried to adopt new ways of contacting the support workers in order to help them cope with the situation as well as provide them with assurance that they were present, as described by Bandini et al. (2021):

> *These communication strategies were designed to maintain regular contact with aides and provide support when needed. To minimize the spread of COVID-19 and help ensure safety of both aides and clients, some leadership representatives from agencies spoke of monitoring COVID-19 symptoms through the use of technology.*

Acquiring additional knowledge, having recourse to religion, and receiving support from colleagues were important factors when coping with and adapting to the situation, particularly when it came to stress:

> *Loss of colleagues and patients left HSCFWs fighting mental battles and turning to spiritual belief systems as coping mechanisms.* (Nyashanu et al., 2020b)

> *Owing to this concern, some participants tried to coordinate hygiene and handoff practices with the other aides caring for common patients.* (Sterling et al., 2020)

> *Some participants also relied on other home health care workers for advice and support or turned to religion.* (Sterling et al., 2020)

3.10. Line of argument synthesis

For phase 6, involving the synthesising translating processes, meaning creating a 'whole' out of separate conceptual parts, an argument was drawn from the points presented above in order to bring together the similarities and differences of the data extracted. The number of articles exploring the experiences of support workers, and consequently the data itself, was limited; however, this meta-ethnography provides a valuable insight of the existing empirical data in relation to these experiences.

After drawing first and second interpretations, leading to the themes discussed, I was able to identify a third-order interpretation as outlined below (see Table 9): (1) work identity, (2) challenging working environment, and (3) coping.

Table 9 Different order interpretations

Second order constructs	Third order constructs

- Duty of care	Job role Marginalised profession A higher calling and self-sacrifice
- Change of caseload - Uncertainty - Fear of infection - Additional experience - Working guidance	Impact of work Level of support and guidance
	Adaptation strategies

Work identity

A common problem was the different views of the job title and job role of support workers resulted in confusion as to the expected requirements of the job. The findings suggest that the support worker's duties are diverse and change depending on the population that the professionals are supporting, and there are no consistent definitions around what the role entails. Regardless of setting, staff consistently reported feeling marginalised when compared to other healthcare professions but retained a strong feeling that they have a duty of care towards clients. Support workers were also unclear as to what is expected from them during an infectious disease outbreak such as the COVID-19 pandemic. Across the studies, support workers expressed the feelings that they were underrepresented as professionals as well as unappreciated and often invisible since the primary focus is given to other healthcare professionals (e.g., doctors, nurses) by the government or public.

Challenging working environment

A pandemic creates additional anxieties and stressors in the form of changes to job role and fears for the health of themselves, their families and their clients. The fears and stressors may be compounded by lack of resources in terms of staff capacity, travel options, PPE, reliable and consistent testing, and guidelines available to support workers, and while it was acknowledged that a pandemic may be the instigator of additional training and opportunities for self-development, this does not address the support needs of workers who have taken it upon themselves and those around them to tackle their own emotional distress and feelings of underappreciation, which have been compounded by a pandemic. Physical safety was raised as an issue in the form of available PPE as well as the information shared by the employing organisation in relation to handling the infection. All articles documented that fear of infection was always prevalent. Support workers received different support levels within their jobs; however, their primary concern was regarding their skills and knowledge on how to combat the virus. Additionally, support workers had to adapt to the new expectations of the role, such as having to work even longer hours or self-isolate with clients, which directly affected their mental and physical health.

Coping

The findings identified adaptation strategies throughout the articles in the form of support workers being in charge of their own equipment (e.g., masks), coming up with new ways of releasing stress (e.g., talk-walks), better communicating between teams, better preventative techniques, safer transportation and religion. However, the effectiveness of some of the new strategies developed was unclear.

Additionally, findings revealed that support workers used their own experiences to build a peer support network rather than seeking support outside of the group.

3.11. Meta-ethnography discussion

This review used a meta-ethnographic approach to explore the experiences of support workers as a result of infectious outbreaks and what enabled the support workers to cope or help them adapt during the said outbreak within the care sector.

The results of the meta-ethnography are in line with findings from a review by Benfante et al. (2020), which examined traumatic stress in healthcare workers from China, Singapore and India during the COVID-19 pandemic. The authors found links between reported risk factors including psychological support, being a frontline member, having less work experience and a higher risk of exposure to infected people and negative outcomes such as traumatic stress. Additional sources of distress were found to revolve around concerns about the spread of the virus (e.g., spreading the virus to a family member), risks to their health (e.g., contracting the virus via prolonged exposure with positive clients) and changes in the work environment (e.g., constant policy and protocols changing).

The adaptation strategies identified in the current study are partly in line with adaptation strategies within other healthcare professions. Bender et al. (2021) analysed the responses of healthcare professionals in relation to their strategies to enable emotional connectedness during the COVID-19 pandemic, arguing that staff offering help or demonstrating empathy with each other supported their ability to cope during the pandemic, similar in effect to ‘talk walks’ (e.g., walking with colleagues around work premises just to have a chat). In addition, Ridge et al. (2021) conducted a secondary analysis describing the strategies of adaptation of clinicians during a PPE shortage: (1) rationing PPE; (2) purchasing PPE themselves; (3) asking patients to purchase their own PPE; (4) working with substitute PPE; and (5) working without PPE. The result aligned only with strategy 5, working without PPE; however, that was only described by one participant during the beginning of the pandemic when the market (e.g., buying masks) was volatile.

The results of this meta-ethnography answers in part the first part of the question examining the experiences of care support workers during an infectious outbreak as the studies identified did not cover the full scope of the role internationally. The title of support worker is neither protected nor clearly defined, and the needs of the role change based on the cultural and organisational expectations, which results in a borderline overlap with other professions and individuals (e.g., cleaning, nursing, family). However, there are common themes (e.g., living with anxiety and fear, role fulfilment, feeling undervalued) across our meta-ethnography and other studies (Bilal, Saeed, & Yousafzai, 2020; Plessas et al., 2021) outlining the experiences of healthcare staff in general.

Regarding the second part of the question of the meta-ethnography in relation to identifying the coping and/or adaptation mechanisms, the results identified adaptation factors that assisted the support workers in coping with the job demands during a pandemic. These included adaptation to the situation by policy-making, meeting with colleagues in order to discuss their experiences and offload the emotional burden, purchasing their own PPE, and cleaning in order to make sure they are in control of the environment. Support workers faced similar experiences and challenges as other healthcare employees working in hospital settings, and there is a need for properly identifying the job role so that clear guidelines can be drawn upon and followed.

Strengths and limitation of the meta ethnography

This is the first English review which clearly highlights the need for further research into the role of support workers internationally and particularly during pandemics, epidemics and other outbreaks of infectious diseases. A further strength of the review is that it paves the path for clarity regarding the role of support workers and the clear separation needed to differentiate them from other professionals. Additionally, this is the first time a meta-ethnography collated all available data to give a clearer view of support workers role, highlighting a large and underrepresented sector that is often left out when it comes to developing health services.

However, the research included only studies conducted in English. Given that major infectious outbreaks have taken place in the Asian and African continents (African countries 39.2%, Asia 23.5%, America 17.2%, Europe 16.8%, Oceania 3.4%) (Torres-Munguia et al., 2022), identifying reviews in other languages (e.g., French, Mandarin) would provide additional results.

During my research, I found only relevant articles from the COVID-19 pandemic, which poses a greater question as to how one can find evidence about support workers' lived experiences in other infectious outbreaks. Another limitation of the meta-ethnography was that articles including HIV were excluded. HIV was considered initially for inclusion, as it was considered a pandemic (Eisinger and Fauci, 2018); however, I decided to exclude these articles because, after looking the literature and after a discussion with the research team, it was found that HIV is now considered a long-term condition (Jelliman and Porcellato, 2017) and therefore it does not strictly fall under the criteria of this meta-ethnography.

What did the meta-ethnography reveal?

The meta-ethnography made evident the significant lack of research into support workers within the sector. Not only were the lived experiences of the above group not available, but the said experiences of working during an infectious outbreak were ongoing. Furthermore, the meta-ethnography revealed that only one study had focused on understanding the experiences of support workers, which was conducted in the US. This formed the grounds for the main research of this thesis, focusing on exploring the lived experiences of support workers during the COVID-19 pandemic in the UK, as these experiences address the gap in knowledge and will add to the wider foundation of knowledge for the care sector.

The next subsection, followed by the next chapter, focuses on the methodology and conduct of a qualitative approach in order to explore the lived experiences of support workers.

3.12. Informing the qualitative study

Support workers play an important role in the delivery of healthcare services; however, there was no evidence of the support they received during the COVID-19 pandemic. Furthermore, most of the research was either focused on healthcare professionals in general or COVID-19 patients; therefore, evidence suggested that support workers in the UK have not received attention from researchers, management and policy makers. Even though there was no robust evidence, it is logical to assume that they might face similar challenges as those faced by healthcare workers. Although the nature of their job is different to that of other healthcare staff, their role is equally crucial in managing the burden of the healthcare system.

All the above led to the research question, which was further enhanced by the meta-ethnography:

What are the lived experiences of support workers during the COVID-19 pandemic in the England?

In order to formulate the research question, I used and modified the traditional PICO tool (further explanation can be found on chapter 4.1 Qualitative research – research question). Given the scarcity of published primary studies in this field, the aim of this study is to explore the impact of the COVID-19 pandemic on the lived experiences of healthcare support workers by listening to individual stories, exploring their feelings and voicing their concerns.

Reflection for Chapter 3

After having built the skeleton of my research and having conducted the meta-ethnography, I felt both excitement and awareness of a big gap. A big change was about to happen in my life as well.

I have now spent a considerable amount of time as the Head of Psychology building the services abroad for my company, and they requested I return to the mother company. As a result of the lack of support workers (no one was applying, and a lot of people were resigning), I was tasked with the operational reports and tender applications, and since the company was quite big, the operational reports needed approximately two to three weeks full-time work just to extract the basic data into the master spreadsheet. Furthermore, they asked me to submit tender applications for different subsidiary companies (e.g., a housing agency). At this point, I was feeling really unappreciated because I was trying to improve my life, improve my knowledge by undertaking the Professional Doctorate and generally working on the path I would take in my life. After all, I was about to become a first-time father in a few months.

Having conducted the meta-ethnography, having explored how these individuals felt, and how they fought for both their life, their dignity and their service users brought me back into a state of both appreciation and clarity. Appreciation because I never had to worry about the things they had to worry about and clarity because of how they managed to cope. They created opportunities to support themselves when everything around them was not as supportive. Initially, I was worried about my results. I was asking myself, are they enough? Is this something novel? But then I reminded myself that this is a story, and this story is lacking from every side, and therefore I have to find out more. For me, support workers had a name. Having been a Head of Service a couple of years prior to the COVID-19 pandemic, this was my team, and I had exactly two team leaders, three senior support workers and 25 support workers under my care.

It was clear that there was nothing out there exploring support workers' experiences during a pandemic, either internationally or in the UK.

That led me to the next chapter of my journey with burning questions in my mind. What were their experiences during this difficult time? How do they do it when they are underpaid and burnt out? The meta-ethnography was the first step into the academic world as an independent researcher (even though I had previously been published as part of a larger team) as I had to conduct my own study but also experience all the steps of a publication from start to finish on my own. Additionally, the process of collecting data, screening articles, reading them and follow a particular process was quite enjoyable. I found a lot of similarities between this experience and working within the care sector, as you need to evidence everything and have the documentation and processes in order. The meta-ethnography helped me to go to conduct the next step which was the qualitative study. My confidence level increased, and after having published the meta-ethnography, I felt a sense of purpose and fulfilment. Furthermore, I learned the universal steps I needed to take when conducting a review (e.g., I had never encountered the word reflexivity before) as well as the importance of patience.

CHAPTER 4. QUALITATIVE APPROACH

This chapter describes the qualitative study exploring the lived experience of support workers during the pandemic while all the restrictions were still in place. It is divided into sections outlining the research question, methodology, participants, procedure and recruitment, data collection, analysis and outcomes of the study.

4.1. Research question, aims and objectives

In order to formulate the research questions, a modified version of the traditional PICO tool was used, the PCO (Population, Context, Outcome) or PICo (Population, Interest, Context), to promote the questions' precision, relevance and alignment with research objectives. The formulated research question based on the use of the tool (see Table 10) was 'What are the lived experiences of support workers during the COVID-19 pandemic in the UK?'

Table 10 PICo tool for questions

Population or Problem	Interest	Context
Support worker	Lived experiences	COVID-19
		UK

Aim

This research aimed to examine the lived experiences of support workers working in private care in the UK during the COVID-19 pandemic and while all restrictions were in place.

Objective

To achieve this, there are three objectives:

1) Interview support workers
2) Transcribe and analyse the data
3) Present the findings.

4.2. Methodology

4.2.1. Ontology and epistemology

At its core, qualitative research is related with a specific ontology and epistemology. A central question as far as ontology is concerned is whether or not a social reality can exist independent of human conceptions. For instance, a closely related question of ontology is whether a shared social reality exists or if there are only multiple, context-specific realities (Ritchie et al., 2014). Within this ontological framework, qualitative researchers embrace the belief that reality is inevitably socially constructed, and they seem to believe in a more fluid or dynamic nature of social phenomena and a reality that is not fixed but rather open to diverse interpretations (Fossey et al., 2002).

Epistemology concerns itself with the ways people understand or acquire knowledge about the world they live in. While ontology is concerned with how reality is perceived, epistemology is concerned with the way people acquire knowledge. Within this framework, therefore, an important consideration in qualitative research involves the researcher and the subject of study, and how this dynamic relationship actually influences what is considered to be ‘facts’ or ‘values’. For instance, for some researchers the phenomena under investigation are perceived as autonomous and not connected with the researcher’s actions, thereby allowing a level of objectivity in the production of knowledge. By contrast, other researchers suggest that individuals are inevitably influenced by the research process, making the relationship between the researcher, participants and social phenomena influencing one another equally. In such cases, maintaining objectivity in knowledge production is inherently impossible. Consequently, reflexivity in qualitative research is considered especially important (Ritchie et al., 2014).

As far as epistemology is concerned, qualitative research can be traced within the constructivist paradigm, where knowledge is viewed as actively shaped by individuals based on their experiences and unique interpretations of the world. Similarly, researchers accept that there is something inherently subjective in every attempt to understand, perceive or even explain the social world. Rather than accepting that fixed, pre-determined interpretations of social phenomena exist, researchers acknowledge diverse layers of meanings to simultaneously exist and be equally valid (Ritchie et al., 2014).

For methods, qualitative research encourages the use of a diverse range of data collection techniques, such as interviews, observations and content analysis. With the goal to better understand the phenomena under investigation, qualitative research exhibits methodological flexibility that is essential for researchers to engage freely in a more in-depth exploration of the subject matter. In any case, just adopting specific methods will not guarantee by itself that a qualitative research is qualitative in its essence, but most importantly, embracing the broader philosophy of the approach is needed when conducting qualitative research (Hennink et al, 2020).

For the present study, the qualitative research approach provided the needed theoretical and methodological background for researching the lived experiences of support workers during the COVID-19 pandemic, shedding light on their subjective experiences, their interpretations of the world and their unique constructions of meaning, while at the same time reflecting upon the researcher's role in the overall procedure.

4.2.2. Design

4.2.2.1 Qualitative research

Qualitative research is a methodological approach, interested in understanding the complex nature of human experience. Closely related with a philosophical foundation that values subjectivity, context, and interpretive depth, qualitative research is interested in the meanings people ascribe to social or human issues (Creswell, 2014). To study these specific social or human issues, researchers are interested in natural settings, often conducting an inductive as well as a deductive data analysis and finally creating a report consisting of the participants' meanings, the researcher's reflexivity, an interpretation of the researched problem and a broader placement and contribution of the conducted research to the overall literature (Creswell, 2014).

4.2.2.2. Phenomenology

Phenomenology was first introduced into the realm of philosophy by Husserl (1983), and it provides an important theoretical background for qualitative research. More specifically, phenomenology attempts to describe 'lived experiences' of individuals (participants) as experiences that only individuals themselves can actually communicate to the outer world.

For these reasons, phenomenologists appear interested in studying phenomena not through methods like categorisation, abstraction, counting, and similar techniques, but through allowing a phenomenon or a lived experience to reveal itself during the actual act of living through it (van Manen, 2017). Even though phenomenology has diverse applications in accordance with the theorist adopting or developing it, two major approaches stand out: the Husserlian and Heidergerrian approach; the first approach encourages a flexibility on the part of the researcher as an in-depth knowledge of the subject matter is not required (Mapp, 2008) and the researcher is to 'bracket' the data subjectively during data collection and analysis and create structural descriptions that form in a phenomenon of interest (Neubauer, Witkop and Varpio, 2019). The second one expects the researcher to have first-hand experience of the selected subject (Mapp, 2008) as the researcher reflects on the themes of the experiences while reflecting on his own experience; additionally, the reflections are robust and aimed at understanding how the data evolved the overall understanding of the phenomenon of interest (Neubauer, Witkop and Varpio, 2019). The present research followed a Husserlian approach in phenomenology for sampling and data collection. More specifically, sampling in phenomenology is purposive since participants are specifically selected because of their lived experiences in relation to the selected subject matter, and data collection encourages one-to-one interviews that require the researcher to put aside any preconceptions concerning the outcomes of the study.

4.2.2.3. Qualitative interviews

This is a qualitative semi-structured interview study.

4.2.2.4. Reflexive thematic analysis

Reflexive thematic analysis (RTA)[5] is a technique for qualitative data analysis that is simple to use and conceptually flexible and makes it easier to find and analyse patterns or themes in each dataset (Braun & Clarke, 2019). RTA is commonly used for analysing qualitative data to answer a wide range of research questions, and its versatility may be seen in the fact that it

---

[5] The interested reader can read more about TA in a quick guide that Braun & Clarke have created in collaboration with Auckland University with simplified steps, Q&A and other relevant resources regarding TA: https://www.thematicanalysis.net/

can be used for a wide range of datasets including Interviews, focus groups and documents (Braun & Clarke, 2021a). In RTA, themes are seen as meaning-based patterns that emerge from the extensive analytical work of the researcher, and in this sense, themes are not just ‘in’ the data, waiting for the researcher to identify them, but they are narratives about the data produced in a process of communication between the researcher’s assumptions and data themselves. For these reasons, the researcher’s role is placed in the centre of the RTA, as the researcher focuses on examining and comprehending patterns within the data. The coding method is spontaneous and iterative. RTA neither involves a codebook nor a coding frame, and therefore it is more flexible because the process of coding continues to include the researcher‘s evolving conception of the data (Braun & Clarke, 2021b). Thus, RTA offers a logical and convincing interpretation of the data. RTA is subjective and the researcher's scholarly expertise, theoretical presuppositions and cultural ideas serve as the foundation for the data's interpretation. Nonetheless, compared to another thematic analysis approaches such as coding reliability (e.g., establishing the reliability of data coding, developing early themes, themes wait in the data for the researcher to discover, themes are topic summaries) or codebook (e.g., use of a codebook or matrix, team coding different portions of data, often used in applied research) RTA is more aligned with the paradigmatic and epistemological assumptions of qualitative research (Braun & Clarke, 2023).

Expert qualitative researchers often prefer pre-established theoretically driven methodologies including grounded theory (GT), interpretative phenomenological analysis (IPA) and discourse analysis (DA) rather than RTA (Cuthbertson et al., 2020). They argue that these methodologies (GT, IPA, DA) provide a pre-prepared package of theory, analytic method and research design while RTA lacks analytic power and sophistication (Braun & Clarke, 2020). In response to these arguments, Braun and Clarke (2021) in their paper, explicitly explain the theoretically flexible position of RTA in the landscape of qualitative research (Braun & Clarke, 2021a). RTA is typically interpreted as a completely distinct approach from other theoretically driven qualitative research methodologies; however, the results that various qualitative analytic methods and procedures provide frequently overlap significantly (Braun & Clarke, 2022a).

Depending on how each analysis is undertaken, there is the potential for significant resemblance in the output from pattern-based approaches such as GT, IPA, and RTA. It is best to think of it as a family of methodologies, with some traits in common but also notable differences in the conceptualisation of key constructs (Braun et al., 2022b).

Note to the reader

For clarity purposes, in the next subsection (4.2.2.5. – IPA vs RTA) the reader is encouraged to first read Chapter's 4 reflection (see Reflection for Chapter 4). This thesis has undergone a rigorous and highly intensive rework in terms of its methodological inception, and this reflective piece adds clarity to the main methodological approach including the processes involved to select the most appropriate methods that cannot be included in the below section.

4.2.2.5. IPA vs RTA

Researcher subjectivity is a fundamental resource in both IPA and RTA. Generally, IPA aims at providing an in-depth exploration of an individual's lived experience as well as how the individual makes sense of the experience. This dedication to understanding each case is the essence underlying IPA. As a result, the research samples are small and use purposeful sampling techniques to capture the essence of the lived experience in order to be understood to the fullest extent (Smith, Flowers & Larkin, 2009). IPA is often adopted in the exploration of 'significant experiences' of individuals during their lives; therefore, it is considered appropriate when examining and exploring complicated issues (Creswell, 2014). The interpretation of IPA is quite similar to that of RTA; however, there are differences between them (Braun & Clarke, 2021a).

IPA incorporates two approaches for analysis: i) thematic orientation and ii) idiographic approach (Smith, 2011). The thematic orientation somewhat resembles the RTA because it is focused on identifying themes across cases, though the steps involved in the identification of themes are different in IPA and RTA. The idiographic approach implies attention to and interest in the particulars and differences of each case (Nizza et al., 2021). IPA begins with a thorough examination of each case's analysis before identifying common themes, while in RTA themes are developed across cases from codes. While IPA encourages a thorough analysis of each data before developing broader themes, creating a closer engagement with each participant's unique accounts, RTA encourages developing themes across data without primarily focusing on an in-depth analysis of each data. The IPA methodology is more theoretically grounded and allows for a lot more in-depth analysis of lived experiences (Peat et al., 2019).

A research study that used both RTA and IPA on one dataset reported that RTA produced breadth while IPA produced depth, though the final output may not have too many differences (Spiers & Riley, 2019). Braun and Clarke (2021a) recommend using RTA instead of IPA under the following conditions: if the sample is relatively large (i.e., ≥10 participants), the analytic focus is solely on identifying themes across the dataset, the research needs to have ‘actionable outcomes’ with clear implications for practice and the research interest focuses not only on personal experiences but on the ways these experiences are situated within broader socio-cultural contexts (Braun & Clarke, 2021a).

4.2.2.6. IPA vs RTA a brief summary

According to Braun and Clarke (2021), IPA is very specific in terms of (a) its theoretical framework of phenomenology – understanding and interpreting how individuals experience and make sense of the world; (b) the research questions, which are focused only on personal experiences in a very specific context; (c) the use of small homogenous purposive participants; and (d) use of interviews to collect first-person accounts. Additionally, IPA uses a dual analytics process by identifying themes across cases (thematic orientation) and by developing an interest in and focus on the particulars of each interview (idiographic) before developing the themes (e.g., encouraged attention to pauses, language, repetition tone). Themes are a small summary of the context (Braun and Clarke (2021).

However, RTA involves theme development directly from codes, with conceptualised patterns of a shared meaning across the participant interviews. Themes are developed organically as they cannot exist without the researcher, and in both methodologies the researcher plays a pivotal role. Coding is a subjective process that needs a reflexive researcher who can try and identify and reflect on their own assumptions and how these might affect the coding process (Braun and Clarke (2021).

Even though IPA was the method initially chosen as a more appropriate methodology when exploring lived experiences, RTA was finally selected as it allowed for an exploration of themes across interviewees in a more organic way as well as allowing the asking of specific open-ended questions that are relevant to the problem as opposed to IPA that all questions need to be as open as possible and focus on personal experiences in a very specific context (Larkin & Thompson, 2012). Moreover, RTA's focus, not just on personal experiences but on experiences within specific socio-cultural contexts, makes it suitable for the COVID-19 parameter of the suggested research. Additionally, the sample was larger than was suggested for IPA (e.g., less than 10) (Braun & Clarke, 2021), and therefore based on the recommendations of Braun and Clarke (2021a), I used RTA for the qualitative research study because the focus was to identify themes across the dataset, a relatively larger participant pool and on the freedom of asking more open-ended questions. Moreover, I also wanted to use the study as a stepping stone and identify 'actionable outcomes' with clear implications for practice.

4.2.2.7. Data saturation or information power?

The concept of saturation in qualitative research has undergone a semantic change. Initially, within grounded theory, it manifested as 'theoretical saturation' when no additional data could be identified (Glaser & Strauss, 1967, p. 61), and this rigorous concept referred to the point where data analysis yields no further insights into the properties and interrelationships between emerging categories, thereby enabling the development of a robust theory grounded in the data itself. Subsequently, scholars like Lincoln and Guba (1985) broadened the concept to 'information redundancy', meaning that no new codes, themes or any novel information could arise from the data. This latter definition represents a more generalisable notion of saturation applicable across various qualitative methodologies. Data saturation has been recognised as the most prevalent concept employed to justify qualitative research sample sizes within the domain of healthcare (Vasileiou et al., 2018).

Researchers (Guest, Bunce & Johnson, 2006; Constantinou, Georgiou & Perdikogianni, 2017) have tried to operationalise the concept of saturation within thematic analysis with the aim to provide a practical guide to decide an estimated sample size in advance of conducting the qualitative research (Clarke & Braun, 2021). In particular, Guest, Bunce and Johnson (2006) defined saturation as: 1) data saturation – 'the point in data collection and analysis when new information produces little or no change to the codebook' (p. 65); and 2) as 'thematic exhaustion' (p. 65) – when no new themes are emerging from the data. The above definition is consistent with the view that saturation is viewed as information redundancy (Clarke & Braun, 2021).

Bragaru et al. (2013) suggested that data saturation is a process that is achieved while data is simultaneously collected and analysed. In this example, data analysis is significantly linked to the interview process, allowing the exploration of new topics which lead to the detection of data saturation when no new codes could emerge from the analysis. Clarke and Braun (2021) argued that the usefulness of data saturation, even if conceptualised, defined, determined and clarified, is still debatable in reflexive thematic analysis, in line with Sim et al.'s (2018) claim that trying to determine the sample size in advance of a study is in itself problematic in qualitative research.

Clarke and Braun (2021) were in favour of Malterud, Siersma and Guassora's (2016) concept of information power when it comes to reflexive thematic analysis; information power is the concept that the more relevant information the participants (in the sample) hold, then the fewer participants are needed for the study. Information power is an alternative concept to data saturation for justifying the sample size in RTA (Clarke & Braun, 2021).

Malterud, Siersma and Guassora's (2016) information power model identified and explained the five items that contribute to the understanding of the sample size: (a) study aim, (b) sample specificity, (c) use of established theory, (d) quality of dialogue, and (e) analysis strategy.

Study aim

A study with a broader aim requires a larger number of sample size in order to offer appropriate information power, primarily because the phenomenon of study is more open and accessible. However, if the study is very specific and therefore specialised in a very particular area, this would in itself limit the sample number. Therefore, the study aim plays a significant role in terms of the information power and sample size (Malterud, Siersma & Guassora, 2016).

Sample specificity

Information power relates to the experiences and knowledge of participants, and offering information power can be achieved with either a smaller sample of participants with highly specific characteristic and knowledge, or a bigger sample of participants who hold knowledge and have characteristics that are not as specific. Specificity in this context concerns participants who belong to a similar group but have different variations in their experiences. Sample specificity cannot act as a sole predictor for information power; however, it is supported by suitable recruitment as it targets groups of participants that hold key knowledge (Malterud, Siersma & Guassora, 2016).

Use of established theory

A study that is empirically supported by an established theory that has been extensively tested would allow for a smaller sample size of participants in comparison to a study based on a theory that is not adequately tested and/or supported. For example, a study based on strong and clear communication and a dynamic relationship between researcher and participant can offer sufficient information power in comparison to a study that is generic with unfocused dialogues. As the data is dependent on the relationship between researcher and participants the quality of the theory and communication is key for information power (Malterud, Siersma & Guassora, 2016).

Analytic value

The analytic value of the data is highly dependent on the interviewer and his ability to navigate the interview, the participants clarity of the discussed topic and the overall dynamic of the interview between researcher and participant (Malterud, Siersma & Guassora, 2016).

Analysis strategy

Information power is also related to the analysis of the study. For example, an explorative cross-case analysis will require a larger sample of participants in order to offer more information in comparison to a study that adopts in-depth analysis of the interviews or details from a very small sample of selected participants (Malterud, Siersma & Guassora, 2016).

For the current study, I used the concept of information power in order to decide when to stop the data gathering as the study offered a unique explorative point into the lived experiences of support workers during an unpresented situation (COVID-19 and restrictions), adopting a well-established approach (RTA) and conducting in-depth interviews, and it is based on the interaction between researcher and participant. However, as Malterud, Siersma and Guassora (2016) advised, the sample size is dependent on the researcher's discretion based on the above concepts.

4.3. Participants

Inclusion criteria in the study were that the participants should be working within the private care sector for at least a year and be support workers or senior support workers in England. The one-year cut-off point was decided based on my expertise in the care sector, and it allowed for the shadowing of shifts, for the probation period to end (normally six months) and for another six months that allowed for the full experience of the role (e.g., supervision, case management, incidents, reports, potential safeguarding), leading up to the first yearly appraisal. The working experience of the participants was assessed based on self-reported accounts without asking for any relevant documents proving it (e.g., contracts, HR reports etc). Exclusion criteria included any managerial posts (e.g., registered managers and above), and this decision was based on the fact that registered managers do not often work shifts on the floor but rather they deal with the day-to day operations (e.g., paperwork is in place, rotas, quality checks). Additionally, RMs are able to work from home when they have to do a lot of administrative tasks; therefore, their job is much more flexible than that of support workers. Another reason was that the RM role is regulated by the CQC and therefore their job specifications are very specific and outlined in detail.

Participants were recruited from a large provider (1200 staff members supporting approximately 700 service users) of community care and supported living, specialising in the provision of mental health, autism and learning disability care recovery pathways. The organisation at the time of writing offered minimum pay to all support workers, and minimum pay on the pay scale to most of the managerial staff members. No incentives were offered apart from the refer-a-friend scheme. Additionally, the company had only one individual working on service improvements without that individual having any interaction with the said services (e.g., the improvement was more of a generic nature, guidelines etc). Furthermore, the organisation was not built organically but rather by buying very old and rundown services. Even though the company was under the process of upgrading, renovating and upskilling, it was challenging to find cohesion within the organisational group, particularly during COVID-19 when everything was slowed down. Normally, big organisations offer incentives, competitive pay and a good working station, by which I specifically mean the staff office, where applicable, including the sleeping area for night staff support workers. From My experience, the above is not very typical for big organisations (with more than 100 services) but rather with very small ones that do not have the budget to re-invest within the company.

Specific participant locations were not recorded in order to retain anonymity; however, the sample was from all over England since the care provider operates nationwide. Purposeful sampling technique was used to identify and select information-rich cases (Patton, 2020 p. 46) or ‘thick data’, as Schultze and Avital (2011, p. 3) suggested:

> *Thick description presents human behaviour in a way that takes not only the physical and social context into account, but also the actors’ intentionality. In a way, the meaning and significance of behaviours or events are made accessible to the reader. Rich data, like rich soil, is also fertile and generative, capable of producing a diversity of new ideas and insights*.

Purposive sampling is a technique that allows the identification of individuals that have a specific knowledge or have experienced a specific phenomenon of interest (Palinkas et al., 2015), which therefore have a higher likelihood of providing us with rich data. I approached individuals that work as support workers at a care organisation, and I chose this method since it allowed me to select this particular subcategory of employees from a larger pool of healthcare professions. However, within care there are a quite a few layers of workers: support workers, senior support workers, team leaders, team managers, registered managers, regional managers, regional operational managers and directors – depending on the organisation, as not all layers are present everywhere. For example, a service may have support workers and one register manager only. Normally, people up to the level of regional manager can do support work. However, I selected only support workers and senior support workers because they deal with the day-to-day needs of the service users. Generally speaking, every single employee within the company (even a director or owner) has to do support work if the abovementioned chain is breaking at all levels (e.g., mass resignations, not being able to provide alternatives e.g., bank shifts or agency staff).

4.3.1. Ethical considerations

Qualitative studies demand the application of careful ethical considerations to protect human participants. Rather than prompting for strict practical guidance, the relevant qualitative literature suggested broader guidelines should be followed throughout the research process. (Mohd Arifin, 2018). More specifically, ethical considerations in qualitative research take into consideration the protection of participants as well as the implementation of professional standards for ethical research. In medical research, the four principles of autonomy, beneficence, non-maleficence and justice may be implemented to ensure that research is ethical in its essence. Autonomy refers to the participant's freedom of will, choice and self-governance. Beneficence refers to the researcher's ethical responsibility to promote the wellbeing of participants and benefit society as a whole. Non-maleficence refers to the researcher's obligation to avoid any form of harm against individuals or society. Finally, justice refers to the fact that every subject should be treated equally and fairly (Pietilä et al., 2020). In order to ensure that ethical considerations were implemented and applied, the present study conducted the following steps. It received approval from the University of Central Lancashire's Health Research Ethics Committee (Ref:HEALTH0194) (see Appendix 3) and was conducted in line with the University Remote Research Guidance as data collection took place during the COVID-19 pandemic. Additionally, prior to the interview, I read to the participants the information sheet and consent form and the participants provided the researcher with their verbal consent (see Appendix 7). All research participants provided their verbal consent, and during this stage participants were informed that they may withdraw from the study at any time prior to anonymisation of the data, which was exactly five days after the interview, and this was clearly communicated to them. After the interview, I verbally informed them about the debrief form, what it includes and how they can seek support if they found themselves in distress from the discussion (see Appendix 8). The debrief form was also emailed to them after the interview. All identifiable information from the interviews was removed within five days of the interview and before the analysis, and all forms and recordings were saved on a password-protected computer that only I had access to. The data management and protection policies of the university were followed during the research process. Participants that met research criteria were given an equal opportunity to participate in research and freely allowed to decide whether or not they wished to participate.

4.4 Procedure and recruitment

I contacted the managing director of the care company explaining the research and the purposes behind it, contacted her via phone and online meeting and following these up with an email. I then received consent (see Appendix 4) to do research within the organisation, emailing the operations managers and the head of quality informing them about research and to pass the email to the staff team (see Appendix 5). The service managers printed the research information sheet (see Appendix 6) and put it in the staff office for advertising. Individuals who wanted to participate contacted me via email and a Microsoft Teams (video and audio) appointment for the interview was booked at their convenience. A brief procedure table outlining the whole procedure from the initial organisational consent to post interview can be found on Appendix 9. For anonymisation, participants were allocated a sequential two-letter code from the alphabet, e.g., AB, BC and CD.

4.5. Data collection

I collected basic demographic and working data (see Appendix 10) of the interviewees including age, role, years in care, ethnicity and gender. All participants were interviewed by the same researcher (me) with a background in health psychology, and interviews ranged from 60 (minimum) to 90 (maximum) minutes.

The interview questions (see Table 11) were produced by getting informed and adjusted accordingly following other qualitative approaches (Ivbijaro et al., 2020) (e.g., question 1) as well as collaboration with academics from different areas of expertise (e.g., psychology, medicine) within the University of Central Lancashire (question 6). In addition, some of the questions were created based on the findings from the meta-ethnography (question 5). Prompts and probes were used during the interview questions to further gain insight. I phrased the questions in a way that participants felt easy to respond, and in line with the best practices in qualitative research, I presented the questions to qualitative research experts to obtain feedback. After meeting with the experts online the feedback was positive; however, everyone present agreed that it was understandable that the way the questions were phrased during the ethics application and the time one was actually actively engaging in a conversation asking a question can be different. Moreover, I involved two support workers in refining the interview questions in order to gain insight into the relevance of the questions, and their involvement supported me in phrasing the questions in a particular way and I received feedback on how timely, effective and realistic the questions were. The reason for this feedback was to informally test if the questions were fit for purpose; they believed the questions were relevant, and it allowed them to express and explore their feelings appropriately for the situation. Furthermore, the questions were very precise (I presented them with the questions as outlined in the ethics applications but with an explanation that these were for guidance and the questions might differ slightly depending on the participant and the conversation), and the support workers felt that it allowed for an open dialogue whilst at the same time keeping them specific. For example, they said that the following question - what type of activities are you involved in after work and which of them are helping you to 'switch off'? – they both agreed that it is quite generic (e.g., exploring activities). At the same time, I recognised the fact that they need to switch off and both items were in one question. They continued and said that they found it frustrating when they have to answer questions one by one as if people removed the logic behind them. They said that this happens particularly during supervision, and while they understood this was research, they also felt that they were not bombarded with too many questions, which they felt was positive as they are often asked too many questions and to explain everything in such detail that it often leads to more and more questions (from an organisational point of view). The support workers involved did not participate in the study.

Qualitative questions, as described by Croswell (cited in Agee, 2009), are defined by their spirit of exploration and discovery. Creating discovery-oriented questions assists researchers in refining questions even further in order to create the basis for a rigorous exploration of the topic (Agee, 2009). Qualitative research explores how individuals' experiences, feelings or events result in the development of qualitative questions that would enable the exploration of the above (Agee, 2009). RTA aims to capture a rich understanding of the experiences of individuals, and the aforementioned research questions were formulated in order to explore the experiences of support workers according to the explorative themes discussed above. Furthermore, the questions followed previous research examples by expanding across the themes explored both from the perspective of COVID-19 as well as other pandemics such as SARS and Ebola (Chung et al., 2005; Raven, Wurie & Witter, 2018; White et al., 2021). The questions were based on previous COVID-19 research that examined psychological outcomes

(Ivbijaro et al., 2020; Moradi et al., 2020) albeit adjusted for the current project. Apart from the core questions, the interviewer tried to explore further the interviewee responses with probing questions such as ‘Can you talk to me a bit more about …?, ‘Why?’ and ‘How?’

Table 11 Interview questions as phrased during an interview

1	[…] so, what was the impact of COVID-19 on your mental health and overall wellbeing?
2	[…] and was there anything that helped you deal with this [effect]?
3	[…] so, if we relived this again, is there anything that you would like to see made available […] any ideas on resources, outcomes, anything at all?
4	[…] how was work-life balance? Any feelings on that […]?
5	[…] and anything that you do after work? Any activities, or something that helps you ‘switch off’?
6	[…] and prior to COVID-19 did you have the same activities that helped you manage your work-life balance?
7	[…] so, what would you say was or is your biggest challenge a) on a personal note b) on a professional level from COVID-19?
8	[…] is there anything else you would like to add? Anything at all?

4.6. Data analysis

The six-steps of RTA as proposed by the Braun and Clarke (2019) were used in order to analyse the data: familiarisation with the data; generation of initial codes; searching for themes; reviewing themes; defining and naming themes; and writing a report.

Each interview was transcribed verbatim. Self-reflective notes were taken throughout the analysis to assist me with further exploring the lived experiences, and the data were analysed using NVivo 10 with the interview files imported into the software after transcription. An inductive approach was used, and initial codes were identified from the initial transcripts. The codes were re-organised after each interview analysis to assess information power. After the twelfth interview, I observed that the level of information power was strong, as the discussions were rich and the experiences being discussed were full and detailed. However, I continued data collection until 15 interviews were completed. Malterud, Siersma and

Guassora (2016) argued that a bigger sample size is required to make sure information power is attained if the researcher is a novice. NVivo helped with organising the data and monitoring data saturation, and it also gave me the opportunity to share the analysis with the supervisors in order to assess the accuracy of the analysis. I provided the supervisors with a small sample of how I reached the said codes and how I categorised them into subthemes upon which I received verbal confirmation that the work followed the principles outlined by Braun and Clarke (2019) and were in line with the current approaches. Additionally, my coding and overall themes were engaging and transparent and captured the essence of the interviews.

Even though NVivo in this qualitative research enabled me to approach a dataset with relevant richness, several considerations arose. First of all, the software itself required some time to adapt, and using NVivo on its own will not guarantee in-depth engagement with the data as the researcher's interpretative skills are needed to ensure data organisation and monitoring. For these reasons, sharing the analysis with supervisors was considered necessary for ensuring final accuracy, and the initial coding was overwhelming with many codes that overlapped through different interviews. Overall, I was able to populate 276 codes within 15 interviews (see Appendix 11).

4.7. Trustworthiness, critical reflection and reflexivity

The trustworthiness of the findings was established by inviting two peer researchers to provide feedback on the overall study (AM and NC). Both were showed the results of the analysis and provided verbal feedback. The results included the analysis of themes as well as the overall structure of the codes and themes, and the researchers provided verbal feedback on the flow of the analysis and the take-home message as well as verbal feedback on how they felt about reading the analysis. A deep conversation took place exploring whether they believed that this analysis provided a ‘voice’ to the targeted group.

AM is a health psychologist and senior lecturer and lead for the social and behavioural sciences at UCLan School of Medicine. His research revolves around the study of motivation, personality and cognition as applied to health and wellbeing.

NC has a background in psychology and public health and is a lecturer in research methods at UCLan with extensive experience in quantitative, qualitative and systematic review methodologies.

I followed the Yardley criteria, as outlined below, as well as keeping a diary for all participants including my feelings and thoughts, analysing my own raw ideas and concepts as explained below under critical reflection.

4.7.1 The Yardley criteria

Yardley's (2000) criteria regarding sensitivity to context, commitment and rigour, transparency and coherence as well as impact and importance were adopted not in the form of predetermined strict rules, but in a more flexible way, as suggested by the author. More specifically, in order to ensure sensitivity to context, I first familiarised myself with existing literature on the suggested questions and conducting meta-ethnography in order to explore the existing knowledge and establish a baseline for the future study. I showed awareness of the socio-cultural context and the social context in terms of the participants and myself as well as any ethical considerations that might arise from it. For instance, while it was crucial to consider the viewpoints of all participants, addressing the inherent power imbalance between those selected for the study and the academic 'expert' was a challenging task. Typically, the academic expert plays a leading role in initiating and guiding the research process, creating an unavoidable disparity in power relations (Yardley, 2000), and I was consciously aware of possible power-relation differences and therefore decided to present myself in an approachable and flexible manner to create an environment where individuals would feel safe to talk and have an honest conversation about their experiences. Overall, the tone of my voice including my body language would reduce the impact of the conceptual idea that they were interviewed by an 'academic expert', as that would potentially have created boundaries. Additionally, I engaged in small talk and shared a bit of my experience within care so that they feel that I understood them and was not lacking empathy for their struggle and overall working conditions.

Commitment and rigour refer to my engagement as researcher with the topic. Commitment refers to relevant data, while rigour refers to the overall thoroughness of both data collection and analysis. This was influenced, in part, by the appropriateness of the sample — not in terms of its quantity but rather its capability to provide all the essential information required for a comprehensive analysis. For this study, I followed the steps as outlined by current best practices, trying to the best of my ability to minimise disruptions, and I prepared in great detail prior to the study, given the challenging situation (e.g., COVID, restrictions). I also identified the most appropriate sample of participants taken from different services, thereby having a more diverse sample group.

The criteria of ‘transparency and coherence’ refer to the overall clarity of both the research’s description and argumentation. Transparency refers to the extent to which every aspect of the research process is revealed, and for qualitative research, it is crucial for researchers to openly contemplate how diverse factors might have influenced the outcomes of the research inquiry. I was always transparent and shared the data analysis process with the supervisors, completing a personal handwritten diary to help myself focus, particularly after considering abstract ideas and codes. Three different samples can be found in Appendix 12. Additionally, the overall diary acted as a personal reflection to ascertain that the research process, techniques and best practices were maintained throughout the study.

Coherence refers to the ‘fit’ between the research question, the philosophical standpoint adopted and the chosen method of investigation and analysis (Yardley, 2000), which aligned in the current study.

Another crucial standard by which one must evaluate any research is its actual influence in the community or broader field of research. Even though influence itself appears in various forms, aspects of any research’s objectives or intended applications for the community or individuals can be considered (Yardley, 2000). The current study contributed to the development of the PSP to support supervision during the COVID-19 pandemic that would help supervisors with their approach (which will be discussed in section 6.3). Even though the PSP needed further exploration and validation including refinement, it fitted within the last category of the Yardley criteria of Impact.

The interviews were conducted by myself (PK).

CHAPTER 5. FINDINGS

Fifteen participants (12 female and 3 male) were recruited, 10 of them from a white background and five from a Black African background. Nine participants were support workers and six senior support workers, and the number of years working in care varied from 34 years to one year (see Appendix 10).

Using RTA, I identified five main themes: (1) challenging impact; (2) uplifting through exhaustion; (3) emotions and behaviours arising from the COVID-19 pandemic; (4) expressing interest in the support worker's health; and (5) taking message from the COVID-19 pandemic. Each theme is comprised of subthemes, and both are supported by participant quotes which are presented with the corresponding participant code (see Table 12).

THEME 1: Challenging impact

During the COVID-19 pandemic, support workers faced a lot of challenging experiences, divided broadly into personal, professional and interlapping challenges. The categories were broken down consecutively into smaller themes to capture in greater detail their experiences in order to understand the emotional processes during these difficult times and the impact COVID-19 had on their lives as support workers.

Subtheme 1. Personal Challenges

Family

Family-related issues was one of the biggest challenges faced by support workers with reasons including social isolation, travel restrictions and underlying health issues. Alongside work, the support workers' personal lives was taking their toll; however, this impact was to be expected without any major identification of extreme behaviours or outcomes.

Three participants emphasised the impact of not being able to meet with their family member(s) due to the pandemic:

> *I'm not being* [crying]*… I haven't been able to visit my family… all of them live outside of the UK.* (BC)

Table 12 Themes and subthemes of the qualitative study

THEME 1: Challenging impact

Subtheme 1: Personal challenges

- Family
- Felling the burden physically and emotionally
- Missing socialising
- Struggling with loss of life

Subtheme 2: Professional challenges

- COVID-19 at work and safety concerns
- Long hours
- I was there the whole way through
- Other

Subtheme 3: Interlapping challenges

THEME 2: Uplifting through exhaustion

- Family
- Faith and hope
- Engage with exercise
- General activities
- When I am off, I am off. Or maybe not?
- Little things to look forward to

THEME 3: Emotions and behaviours arising from the COVID-19 pandemic

- A lot of pressure
- Anxiety
- I love helping people
- The normal thing for COVID was going to work
- Realisation of how I feel my time

THEME 4: Expressing interest in support worker's health

- Supportive colleagues
- Check on us!
- Support by managers
- Support from others

THEME 5: Taking a message from the COVID-19 pandemic

- Changed perspective
- Different handling from the working organisation
- Quicker and firmer governmental response

Another participant was facing difficulties seeing family, in particular spending time with his nephew:

> *It's quite hard to see my family and my nephew. When I had to kind of wash my hands and be very careful that I don't touch him too much, you know what I mean?* (PQ)

At the same time, he was worrying that, because of his job, he might take the virus home or to his family:

> *I would see that had an impact of, you're sitting there, you're constantly worrying, and you know, take it home. I've got to do with obviously vulnerable parents or vulnerable, you know I mean, it was quite emotional… I'm not gonna say nothing* [about the virus] *to my friends […] even to my parents and I don't want them to worry*. (PQ)

EF could not visit her mother because she was classified as being in a high-risk category, and this was difficult since she could not interact with her:

> *I couldn't go visit my family because my mom was high risk. So, it was that as well of not being able to even see your loved ones, and that was difficult.*

From the above passages, the importance of family members and their interactions with the participants is clear. Even though not everyone had access to that support, it was still one of the factors that increased their worry and potential anxiety levels.

Two participants faced challenges; however, they decided to keep the feelings to themselves so that they would not ‘hurt’ or worry their family members:

> *I don't want to worry my wife with stuff. She's got her own issues, I'm feeling sad or I don't know why I'm feeling sad, I'm happy with you and it's learning to try and communicate more, talk more because there was nothing else that I felt I could do. I want you to understand it wasn't her, it was me…* (CD)

JK was diagnosed with long COVID. Because she did not want to upset her family, and in particular her sister, she decided to withhold this information from her, thus protecting her in her own way:

> *because I know my sister, I can't stand it when my sister cries 'cause I haven't seen her for a year and I… don't tell her because I can't stand it when she cries.*

Putting their family member(s) first and not sharing their own difficulties was a form of self-sacrifice and their way of protecting their loved ones at the expense of receiving support and being able to share their feelings.

Four participants associated their biggest personal challenges with their children in the form of social isolation, activities and mental and physical health:

> *I'm a single parent to two children that I fostered, so I think on these last few months I've just got really drained. Uhm, yeah, like mentally and physically. Quite drained and*

> *really tired and trying to home school, childcare* […]*, a lot harder than last year.* (NO)

IJ's son was born during the pandemic which was the 'toughest' personal challenge:

> *My son was just born. I'm into, like, I just got a little boy and I need to raise my boy in this pandemic* […] *Yeah, I think that's the hardest challenge.*

Meanwhile, FG faced different kinds of challenges surrounding her children, the most important of which was having to deal with her child's surgery during the pandemic. As she described, the personal life was more difficult than the professional life during the pandemic:

> *There were more difficulties in my personal life than work life; in work life, you have some guidelines to go by. Uhm, obviously not seeing your family. Uh, in October my kid was in hospital 'cause his appendix burst* […] *he was there for two days and you don't have any communication from anyone.*

Parenthood is a challenge on its own; however, adding the COVID-19 pandemic and having to work at the forefront of this new virus could be a scary experience. Participants had to adjust completely to this new reality and had to find new ways of keeping their children busy but at the same time physically and mentally engaged.

Feeling the burden physically and emotionally

Support workers exposed themselves to COVID-19 either directly or indirectly on a daily basis by providing their services. COVID-19 affected support workers in different ways, from contracting the virus, to being diagnosed with long COVID, to isolating with service users in order to safeguard themselves, their families and the service users. Additionally, some of the participants contracted long COVID, which was a life-changing experience, particularly since this is an ongoing disease. In these cases, the doctors were not able to help them, since no current medication worked as a cure, and the process of having to adapt from a healthy individual to someone with a long-term diagnosis presented a significant challenge.

Two participants were diagnosed with long COVID, described how it affected their quality of life. CD provided the most detailed experience in relation to contracting long COVID:

> *In January I contracted COVID, uhm, and have suffered, UM, and I'm still suffering now from COVID, um, physically. Through headaches, I'm under neurology at hospital and GP, various medications and they still can't get on top of it.*

Being diagnosed with long COVID, unable to cure it or manage his symptoms, took a toll on his physical and mental health, resulting in him having suicidal thoughts:

> *I felt a burden* […] *probably two days in* [following the diagnosis with COVID-19] *and I went from being, ohh, this is going to be nice and easy to being, like, what am I doing here* [suicidal ideation]*? What's the point? And you know? it was only fleetingly, probably 30 seconds or something like that, I'd have been happy if COVID took me.*

CD contracted long COVID from one of the service users he was providing care for in a supported living service. The long-term effects could be easily recognised by the way he described his circumstances:

> *I'm going through more mental health now because of my physical headaches and conditions* […] *and it's like getting to a point where you know, I'm not saying I'm depressed, but it wouldn't surprise me if they said you are. Because it's every time I wake up in the morning and it's like migraine, like headaches and dizziness.*

Adding to the abovementioned issues, his mental health was worsening because no one was able to provide a solution for him. In fact, he was living the same day over and over again without knowing if the next day was going to be pain-free or not:

> *I wake up tomorrow and I've gotta do it all again and it doesn't seem to be an end in sight. No medications are working. I've had all my blood tests as they've come back all fine and all these scans, and it's just like I almost don't want to take the tablets now because every time they say oh, we're gonna try you on a new one.* (CD)

Further to the above, his weight is linked to how he feels, and his experience following being diagnosed with COVID-19 affected his eating habits:

> *My weight is linked to my mental health as well. I think if my weight balloons and I do.*

> *I yoyo a lot with my weight and then that can get quite low.* (CD)

The second participant diagnosed with long COVID (JK) described how it affected her life in different ways. Similar to CD, she was experiencing various symptoms due to her diagnosis:

> *So, my life has completely changed. Not for the best. Uhm, it sucks because I have long COVID now.*

Then she continued with describing her symptoms in more details:

> *Every week it's different. Um, so they're pretty good if I need a rest here* [in the work office], *I can just shut my eyes for 15 minutes and I'm fine. But outside of work, um? I go to the beach. I, uh, just well, I did have a dog, but she died so that, that, she did help me. So, yeah, and I can't read anymore 'cause I can't concentrate.* (JK)

When asked about her symptoms she explained that they were different depending on the day. No symptoms were the same; they were quite random when they appear since they never completely leave:

> *They vary. I can't sleep, I've got terrible chest pains. I can't breathe sometimes, I can't feel my hands sometimes, so I drop a lot of things. My legs give away, my concentration is well, my memory is terrible. Uhm, I can't do my gardening anymore for more than 10 minutes? Uhm, yeah. I used to be able to walk for hours a day. Go for a walk for 10 to 15 minutes. And then I'm done.*

FG described her experience with contracting COVID-19 as:

> *Yeah, that was really hard. I had it. I had it really bad down to hallucinations from the fever and I don't think I got out of bed for about four days.*

One participant reported that COVID-19 made her slower than usual, affecting her life in different ways. However, it is worth noting that she did not contract COVID-19 at any point and the effects were purely psychological:

> *… before this I would probably be able to do tasks much, much quicker than I can now.*

> *I don't know whether it's just… UM, consistent worrying and anxiety, UM, about the situation*. (EF)

PQ described a different experience, explaining the discomfort he was experiencing with the mask since he had breathing problems:

> *The masks. The mask and the fact that we wasn't very well supported* [with the masks].

It is evident that support workers experienced major quality of life changes due to COVID-19 with some unable to manage their new lives since the unknown factors were too great.

Missing socialising

Isolation was another personal challenge for support workers. It was clear that they did not want to believe that this would continue longer than expected, even though no one knew exactly what the expected day of the measures being lifted would be. Support workers wanted the restrictions to be lifted because they felt suffocated in the current situation. It is worth noting that they only went outside in order to work, and their work was surrounded by a constant fear of infection, given that they exposed themselves on a daily basis to COVID-19. Additionally, they had to expose themselves mentally to COVID-19-related information. As AB described:

> *The lockdown shouldn't continue forever. It can't, it can't. That's not … that won't be life, so yeah, it was locked up, but yeah.*

Two participants described how the isolation was difficult regardless of personal preference:

> *Uhm? Realising that I am even though I'm an introvert, I still missed. I still miss socializing. Can you believe? Yeah.* [NM]

Even though restrictions were imposed in the UK, GH described how it was a matter of perspective regarding how to handle it, regardless of the difficulty:

> *Your normal days after without COVID and even then it was boring 'cause you couldn't*

> *do nothing. Stay* [inside] *and it's just ... It's just a fact of nobody had any motivation to do anything 'cause there's nothing they can do about it. So, it was just the fact of get on, get ready.*

A multifactorial perspective was offered by KL, who described it as:

> *I think probably speaking off from work and the worry, 'cause like I said, you know, I couldn't go to the gym, I couldn't see my friends. I couldn't see family so that was quite difficult, quite isolating.*

On another note, PQ focused on traveling and when that would be allowed again:

> *And information for me, like, I wanna go on holiday soon but I'm frightened to go away because if I go away you'll have to stay in isolation. Do I have to pay for COVID tests to go abroad and come back?*

Struggling with the loss of life

Another personal challenge faced was the loss of life. Either a family member, a colleague or an acquaintance passed away, resulting in the experience of various feelings such as frustration and sadness.

Three participants experienced loss of life by either losing a family member or a colleague.

For AB, COVID-19 not only restricted her from flying back to her country in order to be able to be there for her sister and create more memories, but it also took her away:

> *The one that really, really, you know ,pained me was the fact that I couldn't attend my, my sisters 50th birthday … She turned 50 October last year and I couldn't go 'cause the COVID situation. Unfortunately, COVID killed her in January.*

Even though there is a hint of regret of not going, there is also the understanding that she could not fly:

> *I'm still struggling with that because I wish I had gone. You know, for that, but I couldn't because of the situation and everything you know it was just… What COVID did to me*

> *wasn't good at all.* (AB)

IJ also described his experience of losing a colleague. Working at the forefront of health during the pandemic is a stress on its own; however, adding the risk of getting infected and losing your life increases the anxiety levels and puts pressure on having to feel well at work because you are dealing with people diagnosed with depression and other conditions:

> *But I've seen people die people. I've been lost people at work. Got COVID, and end up passing away, like literally it was kinda bit tough mentally, physically, but all I had in my mind was just have to stay strong. When there is a pandemic, if you get nervous or anxious or whatever, agitated or whatever, like it can lead to even* [affecting] *your job 'cause the people we look after they are vulnerable people and you cannot go to work feeling all depressed or down or whatever thinking about the negative part.*

The loss of life is a tough experience and difficult process to accept under normal circumstances. Adding COVID-19 and the governmental restrictions to the grieving process makes it more difficult to be able to cope. When it happens unexpectedly, the sadness remains:

> *It was really sad we lost a lot of people. I know people who lost loved ones and I know somebody I really care about and I lost her. A lovely woman at work* [service user]. *I always say to people like at the end of the day we're all gonna go.* (IJ)

Subtheme 2. Professional Challenges

COVID-19 at work and safety concerns

Adding an outbreak within the service (e.g., care home, supported living) increases stress and anxiety levels, and stress, anxiety and uncertainty are emotions that stayed with the support workers throughout the support they provided to the service users. The support workers felt overwhelmed by fear of infection but also felt the obligation to safeguard everyone (e.g., service users, their own family) the best way they knew.

> *Once we had an outbreak, it quite quickly shuts service down. And that's where I caught it from.* (CD)

CD described how she contracted COVID-19 by helping the service (supported living scheme), since they had to shut down everything within the service (e.g., visitations, agency staff). Additionally, she explained the situation in relation to staffing issues due to the COVID-19 pandemic as well as what they had to do in order to safeguard the vulnerable adults under their care:

> *And we had staff members that moved in for 10 days and almost felt isolated within service and if it wasn't for that … these are hero people there. We could have been talking about, you know, things a lot differently. You know, what would have happened? Who could we have sent in? Because we're running out of people, because legally we have to isolate, you know, sort of thing and but we have a duty of care because we're protecting vulnerable adults, you know, uhm.*

Some support workers moved in with the service users in order to safeguard themselves, their families and the service users. KL moved in with a service user in order to protect everyone around her:

> *So because we had a flat upstairs, I said, well, look, I'm, you know I'm gonna need to stay in the flat so that I can keep the lady I lived with safe* [private carer] *and then as it happened, because obviously a lot of people got tracked and traced, it worked quite well, that if I moved in for 10 days I could isolate with him* [the client from her full-time job] *for 10 days, so I guess also keeping him safe and making sure that he had stuff but also making sure that I kept my own like my own family, it's safe.*

Another challenge was that of uncertainty. DE described her fear of going into the service because she did not really know what to do in case a service user got diagnosed with COVID-19:

> *I can remember sitting in the car park crying before I had to do some waking nights. we had the only outbreak* [in the company]*, it taken out quite a lot of staff and um, obviously you know nobody really knew what we were ever gonna do If a client got COVID.*

COVID-19 measures, while applied to everyone, according to JK, were not followed by everyone in the care services resulting in her getting infected with long COVID:

> *I mean, I do find I do find it difficult with obviously some of the residents, because they didn't, they don't wear masks and that, and that's what I found difficult when they're quite capable.* [the service users] *taking drugs and going shopping but not to wear masks and I got COVID, I swear this is just my opinion, because of one of them.*

Long hours

Long hours of work, managing tiredness and having to provide good quality care represented a significant challenge. The support workers had to provide care whilst they were understaffed, and everyone was working over their capacity; however, they continued to work since other people were relying on them not only to do their job but to maintain some aspect of normality (for service users who have no control over their own lives under the most ideal of circumstances, let alone during a pandemic).

Three participants described the impact of having to work long hours with less staff within the services:

> *and then I had to do even long hours at work because some of the you know service users went home. So it's just, it just wasn't OK for my mental… you know health, it wasn't good.* (AB)

IJ described how, due to staff issues, they had to work with less staff in order to support service users that needed normally two or three support workers per shift just for one individual:

> *Uhm, I guess extra support at work would have been great, but having more staff on would have been better.* (MN)

NO described the impact of understaffing, calling sick and having to work within these conditions:

> *Staff calling in sick and working 80 hours a week. 'Cause some staff obviously at the beginning, panic, sort of, went into self-isolation. Then we like we were working like 14-hour shifts. Pretty much moving in with our guys* [service users] *just to keep them*

> *safe.*

I was there the whole way through

A support worker's role is to care for vulnerable individuals as well as communicate effectively within the services with other colleagues in order to deliver good care. However, during the COVID-19 pandemic, the need for support workers having to support service users and their colleagues was increased.

AB described how she kept working during the pandemic because of the support she received from her colleagues:

> *job itself, yeah, I carried on because I had support of, you know, my colleagues. They were all very supportive and everything, so I was still able to do the job.*

Equally, BC described the amount of energy needed in order to keep working to support her colleagues:

> *It was tremendous. I had to work a lot. Sometimes more than I could, 'cause I had to support my co-workers.*

Most support workers felt that they had to do their part in order to support the service users and their colleagues. Even though at times support workers were scared, they kept going:

> *I was here the whole way through. I never, kind of, cancelled or changed my mind about being here. Obviously, I'm in this house permanently on this side that there was the cases, so other people were able to go next door, but I wasn't. I was here so that was quite scary, yeah.* (PQ)

Being conscious of the virus in order to prevent it from spreading as well as providing good quality care was the focal point of some support workers:

> *It's still worrying knowing that I could be carrying and taking it back and forth from work and home, but that was just the risk you take being a support worker, don't you? Having to keep them safe and keep your family safe at the same time, really.* (GH)

Other

Other professional challenges included support workers not receiving enough support from management, lack of PPE, difficulties with service users and feeling lost on how to approach the COVID-19 situation.

AB felt overwhelmed from a variety of challenges, starting with the support she received from management:

> *Yeah, unfortunately, you know, one didn't even, I mean, I'm not too keen on my employers. I must say that I'm not too keen on them. Even without this happening to me. The way they handled the whole thing, I wasn't happy with.*

She followed that by describing how they 'didn't even have any PPE'.

The most difficult challenge was handling the service users and introducing them to this new reality:

> *the biggest challenge was no, no activity, for, you know, the service users. You see, because they, they had a full life, they were, you know, clean out, doing different things and there was nothing else but just go for walks. That was all you are offering to them, so it wasn't fulfilling within that period*. (AB)

Two participants described the difficulties of having to explain to non-verbal service users the pandemic, what it was and what the new measures meant for their life:

> *when people do not listen to you 'cause they think that they know it all. trying to get away* [from restrictions]*, mental health was primed during that time. Uhm, I was able to cope* [with work] *'cause I have mental health training. I was able to deal with them in some kind of interactions.* (BC)

When it came to family members, one participant described the difficulties of having to put boundaries down with the service users' families since they wanted to visit them all the time and the support workers had to explain over and over again the dangers involved, not only for the service user but also for the other residents as well:

> *Professionally … biggest challenge ... telling the relatives no. Yeah, by telling them no, that they can't come, that their person can’t go home. That was really hard ‘cause I obviously, I've worked there for such a long time. I have good relationships with their families, but that was, uhm, that changed…* (FG)

Support workers needed extra support themselves, either in the form of emotional support, or additional information from the organisation regarding service users and their health status in relation to COVID-19.

> *And even if it's really about nothing you know, just come have a drink, have a cup, have a biscuit, have a chat, you know, unload, whatever. ‘Cause this job is stressful and I think my other biggest struggle was, is, was, was working with a client that had COVID.* (DE)

One participant described the difficulty of challenging colleagues who did not believe the virus was real or that they would get infected:

> *Some people don't believe there was a pandemic going on, that was kind of a bit tougher as well, but I'm seeing people that I work with, some of them I've known them for like a year or two, some of them for like three years, that was kind of a bit tough.* (IJ)

Other experiences described were balancing the quality of life, feeling undervalued by society since the priority was given to NHS staff and having to work in a challenging environment:

> *there was a lot of pressure for me to obviously support the residents and still maintain my own mental health as well.* (MN)

COVID-19 created different problems at work that could be quite unique to the profession. Some problems were practical, such as the lack of support from employers or the lack of PPE, whilst others were more emotional/behavioural e.g., explaining to service users that do not communicate properly the current state of the country while finding appropriate activities for them. Last but not least, some problems revolved around information with some support workers not believing the virus was real, which was potentially dangerous.

Subtheme 3. Interlapping challenges

In additional to the personal and professional challenges, support workers faced challenges that had an immediate correlation between life and work. Because of the restrictions and measures imposed due to the COVID-19 pandemic and the nature of their work, they had to adjust and live 'different' lives from their family members. Furthermore, during the beginning of the pandemic they did not know how to act, since both governmental and organisational guidelines were changing all the time:

> *I mean, the COVID itself, the pandemic itself for a long time for weeks or months we didn't even know what to do? We didn't.* (AB)

Support workers faced difficulties that interlapped between personal and professional life:

> *I've had to pick up an awful lot of shifts, I haven't had to, but I've felt like necessary to pick up a lot of shifts to ensure there are enough staff to give the right level of service to our service users, which has meant that my work-life balance has taken a hit.* (OP)

One participant described in great detail the interrelationship between the effects of work and life by starting with the importance of talking to each other:

> *They [colleagues] come to tell you a lot more and you get more productivity out of them in work as well.* (CD)

They also talked about the necessity to de-stigmatise talking about mental health in general:

> *If you started saying, wow, you know, I've got, you know, I'm having a bad mental health day or stuff like that, um, personally, I don't think it will be looked upon greatly. Uh, physically, they can see something is wrong, or there's a note from the doctor or stuff like that. But whenever something mental, and I think it's not just within this company, I think it is still.*

CD continued with the argument that people cannot see mental health issues, and therefore it was more difficult for people to believe in it:

> *Well, I'm gonna say mental health or I'm feeling down … People use that because I can't prove, you know, to the manager that you're off lying. Whereas if someone says I can't come in 'cause I've broken a leg, I'd expect to see a leg in a cast, you know, or something like that. You can't cast your mind, you know, sort of thing, and try and heal it.*

Additionally, COVID-19 changed his plans to run in a marathon, something that had personal value, after he had often trained in order to run:

> *I'll try and train for bigger rides, like, I had a ride plan for September. That was 100 miles, but it's not actually being done. Has been postponed because of COVID, so next year in June and my first reaction was ugg.*

As a result of COVID-19, he found it very difficult to switch off from work, resulting in checking his phone and e-mail even when out of work and when on annual leave:

> *I don't think I could ever if I'm honest, I, if I truly switch off, even when I'm on annual leave, I don't think I ever truly switch off.*

The reason CD was not switching off his phone was because he was constantly worried he would be called in for a shift since they were understaffed and COVID-19 put pressure on the service:

> *coverage shift or I'm going to someone call in sick and, you know, and that just worry that this is always going to happen.*

Participants were mindful that they did not wish to expose others (e.g., managers) or themselves to COVID-19; however, they had to because of the nature of their job. Exposing themselves would result in affecting the entirety of their lives, including their home lives:

> *For the manager to go in and do it and then potentially take it home to her kids? But the feeling before I sat in the car park and I probably cried for about an hour because in all honesty I was absolutely petrified to know that you are going in with someone with COVID who you cannot social distance from, you know, that you have to do*

> *personal care with and all of that, it is absolutely petrifying and I did three waking nights, and I felt the same every single night. Now, thankfully, I came out of there not getting COVID, which was great. But at that time…* (DE)

Participants debated whether to shield or not as some belonged to a risk category and others had their family to consider:

> *Personally, there was many arguments, disagreements at home. Uh, because my job entitled me to, you know, to be there. I was a frontline, keyworker. Uhm, I needed to, and my personal character is I don't care if there that bombing the place and all that. I've got to go and help. I'm physically able to. I have to go and help.* (CD)

On a service-related matter, CD had to manage service users when explaining the new measures since they panicked and he had to de-escalate situations between themselves:

> *When you told them, you know, people would have to wear masks, panic ensued, you know, and it's like trying to control like mass hysteria. You know, because this killer disease was coming, you know, and it's over here now and because it happened close by was uh, Oh my God, Oh my God, you know, and it's like.*

A participant described her difficulty, not only because she got infected, but because when her partner got diagnosed as well, she had to work and take care of the family:

> *My own partner got COVID as well. That was hard for me here in my household and I have to look after my two kids for like a week by myself, which was kind of tough, a one-year-old boy and a four-year-old girl. It was very hard for me, but I've gone through that.* (FG)

JK described how her life was destroyed because of long COVID. She believed that she got infected from work and particularly from one of the service users she was caring for. She explains how she had long COVID and how her life has changed completely:

> *Ummmm, I just, I don't get angry, I just I just think it's frustrating. Because they, they know like what they're doing* [the service users]. *They are quite capable of knowing*

> *what they're doing. But there's nothing you can do about it, because the law, you know. So, my life is ruined because I've tried to help people.*

Days before getting diagnosed she was working with a service user who was COVID-19 positive:

> *So, obviously at that time, but my stress levels were way higher than they were at any other time working during COVID because he obviously had COVID. So, at that moment in time, that was the most stressful because it was trying to weigh up how much time you spend around that client. And you know, without risking yourself, if that makes sense.*

At the beginning of the pandemic, she was not informed about any action plans in case someone is diagnosed with COVID-19, since it was very new for everyone and safeguarding policies were not in place:

> *So, the plan was that we were going to carry on as normal, but I live with a lady who works in elderly care, so I didn't feel comfortable coming in working with COVID, going home, coming in and going home. I wanted to keep her safe and obviously the residents that she works with because I felt like if I had taken COVID home and it went into her work and all these elderly people started passing away, I would have felt incredibly guilty and like it was my fault, if that makes sense. So, when it happened I suggested maybe doing block shifts at night shift so that, you know, we were in flight a couple of days.*

The statements reveal the process that support workers had to undergo in order to measure and put in perspective the health of their families as well as their own and that of other support workers. They all decided to provide their support; however, the underlying emotions and in some cases the aftermath of that support proved to have a significantly detrimental effect on their own health.

THEME 2: Uplifting through exhaustion

Support workers used various coping mechanisms in order to handle the pandemic. The mechanisms were used either consciously or subconsciously and helped them cope during the pandemic, and they were further divided into smaller categories that allowed a better understanding of the experiences. The subcategories were family, faith and hope, exercise, general activities, work-related coping and non-traditional coping.

Subtheme 1. Family

Participants described how the concept of family (either by spending time or interacting with them) helped them cope with the pandemic. They decided to focus on their immediate family members and spent quality time with them, which allowed them to build a stronger relationship as well as distract them from both the pandemic and the pandemic at work:

> *So, I spend as much time as possible with my son, he's eight years old, and my wife as well. Obviously, uhm, we play video games and board games. We go out the back garden and play football or cricket so we keep as physically active as we can. We watch films on Disney Plus.* (OP)

One participant described how she had mixed feelings about having her parents live close to her during the pandemic. She was glad that she was able to see them but also worried because they had to maintain social distancing whilst providing her with food:

> *I'm very fortunate my parents live around the corner so they would obviously drop dinner off and bits and pieces, but then that would put a strain on them and having to drop it off every day and then make it extra.* (PQ)

Subtheme 2. Faith and hope

Faith and hope were described as the main coping mechanisms for six participants.

Three participants (AB, BC, IJ) described their relationship with faith, giving emphasis to praying and believing that God will intervene. Additionally, some participants described the need for faith as well as emphasize the life without one.

> *if I don't believe in God, I probably will not* [cope] *because I know those who don't believe in God … in time of crisis, you know, they fall apart.* (AB)

> *Friday prayer helps*. (BC)

Faith was described as an integral part of life since it had developed into a coping mechanism surrounding acceptance of inevitability and dealing with challenging situations:

> *Like I said, it comes down to just my faith and family and friends who, who rallied around* […] (AB)

Two participants focused on hope by describing the need to return to normal pre-pandemic life and the strength to not give up:

> *Umm, it gets exhausting, that's for sure. And I do get, UM, quite tearful from time to time. UM, because one, I get so frustrated with myself 'cause I'm not one to give up. I refuse to, you know, if I'm in pain, I'm not a pill popper. But I, you know, I get upset when I've got to take them*. (JK)

Subtheme 3. Engage with exercise

Four participants engaged in exercise during the pandemic as a form of coping, which allowed them to navigate their energy and focus on activities like walking and general exercise rather than thinking about the pandemic. Participants found exercise useful but also utilised it effectively for bonding or switching off. They also signified the need to release the energy built up from work-related issues.

> *I think that's become after COVID* [to engage with exercise] *um, before COVID I would probably have another meeting or something immediately to go to after work, UM, but then post-COVID those things weren't really happening, so I fill that time with going for walks, if that makes sense.* (EF)

Subtheme 4. General activities

Participants engaged in different activities that would help them cope during the pandemic. Some stayed within their comfort zone and tried pre-existing mechanisms, whilst others tried to find new ways of coping.

Three participants actively engaged with online platforms in order to stay connected. According to them, this was beneficial overall; however, a few weeks after the lockdown, conversations started to gradually become less, since no one had any news to share. Furthermore, conversations did not focus on how people are handling the pandemic but rather on general discussions, and this created a need to share their mental wellbeing status and coping strategies since this was a new experience for everyone:

> *Like, a Skype, email, text, WhatsApp, Instagram, Facebook.., so social media got me through the pandemic actually.* (MN)

One participant described how she could identify the gaps in her needs by explaining that it would have been positive if there was a support group where people can exchange experiences of the pandemic and how they adapted:

> *Oh, uhm, I guess most support, like, more, like, groups report in a way. Like online, maybe an app or something where you can meet new people and talk about your feelings and stuff, would be quite a good invention.* (MN)

It was worth noting that MN was not aware of any online platforms that offered an exchange of experiences during the pandemic. However, the social media at the time including the local news and TV provided different kinds of information, leaving individuals like MN feeling lost and confused about where to find a forum to express their anxieties and feelings (e.g., a mental health app that connects people or professionals).

Three participants used either gaming or mobile apps in order to cope with the pandemic. They described how it helped them maintain their mindfulness via these activities:

> *I'm a gamer so when I get home from work the PlayStation goes on because it's completely mindless. It doesn't give you the opportunity to think about work stuff because you're concentrating on that.* (DE)

Additionally, EF was practising mindfulness by knitting scarves and blankets:

> *Some crocheting and knitting scarves, knitting blankets, found that helped quite a bit and I later learned that, actually, that it, it's a mindfulness and task because you have*

> *to concentrate on what you're doing and you're not flooded with thoughts and things of that nature.*

JK tried to engage in pre-existing coping tasks such as cooking, gardening and walking; however, she found these activities extremely challenging since she was diagnosed with long COVID as it affected her performance:

> *I do some cooking with my partner. If I'm having a good day I do it all, If I'm not having a good day If my hands are funny, he'll do a lot, but I'll tell him what to do and I try and do a little bit of gardening and I try … my first thing I tried to have a little walk to get some fresh air.*

Two participants found a new way of coping during the pandemic. Their statements revealed that being open to and accepting new ideas as well as finding one's strength is a journey that can unravel under the most extreme of circumstances:

> *Um, so reading was sort of a habit that I did take up during, obviously, COVID, it's become my new favourite thing.* (LM)

Subtheme 5. When I off, I am off. Or maybe not?

Four participants described how their coping strategies were affected, either directly or indirectly, by work. Work-related coping was either in the form of leave, new procedures or just focusing on work because there was nothing else to do.

The following statements reveal the differences between participants who overworked and participants that learned how to put in boundaries in order to maintain work-life balance. Additionally, it is worth noting the human 'survival instinct' for perseverance and moving on regardless of the challenges in life:

> *Taking time out of work like I had today, day off from work and that was completely shutting myself out* […] *Take little breaks if you need. I can't remember the last time I had a day sick. That one day it would help me go on for the next, you know, six months or a thing or whatever, then surely that one day is crucial, you know, and it's, and it's very much needed sort of thing.* (BC)

FG described how work kept her busy whilst she put all the other responsibilities on the side until she finished what she needed to do:

> *I'm not sure, I think I just got on with it in the end. Yeah, obviously we've not a lot going on at the service as well because of COVID, I think that helped. It gave me time to just get through what you needed to get through. And focus on everything else later.*

However, she learned how to switch-off from work during a managerial meeting describing the importance of being off in order to balance work and life:

> *When I'm off, I'm off. And that is just because of a meeting we did and it was said that you need to keep the work life separate. No, just, just coming home and just being at home just helps you switch off from work. Also, I also always have in the back of my mind about keeping your work life and your personal life separate.*

From this statement we can understand the process she underwent in order to learn how to consciously 'switch off' from work. It is clear she was not doing it in the past; however, through becoming self-aware and taking small steps at a time, she was able to learn how to assert her boundaries (e.g., having a work phone instead of a personal one, switching it off).

Subtheme 6. Little things to look forward to

Participants described various activities and processes they adopted in order to cope with the pandemic that did not fall under any of the traditional coping mechanisms.

Three participants described how being close to nature helped them. From the sea to a walk in nature or camping. Nature played an important role in their respective coping, allowing a deeper connection to the self and a comfort that could not be found elsewhere:

> *I would take a walk by the sea because of the sea and the smell of the sea, as I grew up by the water, has been great help for me. It's giving me the ability to calm down. And think about other stuff apart from work […] Swimming, but I couldn't swim over winter.* (BC)

> *When it comes to the weekend, you know, I just get out and about. I've got a camper van.* (DE)

Two participants found help in maintaining or returning to a form of stability that previously to pandemic was a given:

> *And as may be, my worry is a little bit less, because obviously now* [COVID-19] *it's not* [as severe] *it's still around, but it's not as you know, serious, as it was, so now it's kind of got a little easier. And now that we can see family and friends outside, and the gyms are back open. Now it's a lot easier to deal with, I think.* (KL)

> *Uhm, so I'm a bit boring [my life], actually, um, all I do is read, cook and be a mum those are three things I do outside of work.* (LM)

One participant described in great detail his way of thinking and his process of breaking the boundaries that kept him within his comfort zone:

> *I now give myself, trying to give myself little things to look forward to. Like, come tonight, you know the football's on and, you know, I can have some wine or fizzy drink or, you know, whatever it is or I've got, I've gotta get to the weekend and I'm having a takeaway and I like my food or whatever it is. It's to give myself little goals to get through.* (CD)

> *And even if I don't want to walk with my wife, she likes to walk. I'm not a big fan of walking if I'm honest, but I forced myself to get out and she's like, well, I don't need to do things you don't like, I said, but I need to at times. Or walking the dogs. Sometimes I'm like I can't be bothered, but I need to get out, do it because if I sit indoors, uh, my mood will drop, and I'll try and go, you know, and pick it back up again.* (CD)

Furthermore, CD described how maintaining the appearance of being mentally healthy – when in reality he was not – was something he would like to unlearn. The pandemic gave him the time and experiences needed to challenge himself on behavioural patterns that he consciously knew were unhealthy. Maintaining his approach, he recognised that he was putting boundaries between himself and his wife, making their communication difficult:

> And I think it's still is in myself trying to convince myself it's OK to do that [to look like everything is fine] because there's other people [wife and child] that rely on me. And if I'm seen as weak, you know, it's, I think it's that you're biologically sort of hardwired into thinking and believing and stuff like that and what actually is learned and you could just go, well, if I can learn it, surely I can unlearn it. I can learn something different something new, a different way of thinking and stuff like that.

THEME 3: Emotions and behaviour arising from the COVID-19 pandemic

Support workers experienced a lot of feelings and new behaviours whilst working during the COVID-19 pandemic. They represented the difficulty of adjusting to a new working environment, anxiety, caring for others, increased self-realisation and using work as coping.

Subtheme 1. A lot of pressure

All participants described how during the beginning of the pandemic they faced difficulty adjusting to the new norm, and social distancing rules and isolation were the most prevalent reasons accounted for.

> *The main effect is* [that] *I really miss my family. I miss friends. I miss talking to people, you know. When it first started … I didn't like it at all. I was … it just didn't sit down well with me.* (AB)

> *Not being able to go to for a walk or do things like that I'm, I will try and find something and an alternative, like or watch a movie. Or try and speak to my family so he had to win and stuff like that.* (BC)

> *I haven't been able to see my friends and go out. It's been very hard on me. I mean, I'm not a very social person, but even me being an introvert, it did affect greatly 'cause I do like to see my friends and go out and do things … like socially affected me.* (MN)

Furthermore, the pressure of doing their job whilst adjusting to the new reality was difficult, and loneliness was a big factor; however, being able to work (since care jobs do not stop under any circumstances) somewhat counterbalanced the effects.

> *It was when we first went into national lockdown. It got a little bit worse because I was like … oh here we go, we're gonna have, you know, umpteen people, they can't come here, I've got to isolate* [because of the job] *that's gonna mean more shifts to cover, you know, and I think in fairness, as we've, we've, we've handled it quite…* [within the services]. (CD)

> *I'm just the same as everyone else is really 'cause I'm just having to be on lockdown and just stay in your home. I've been quite lucky still working because care doesn't stop because of COVID. Uhm, but yeah, same as everyone else really, just really lonely and isolated, you can't really do much about it, it was just, yeah, it seems everyone else just feeling lonely and having to stay in 24/7. Well, I was fortunate to work, so I wasn't completely lonely.* (GH)

> *Because, obviously, we felt really restricted. We can't go out, you know, we can't go out. We couldn't meet people. So, our normal routine was completely disrupted.* (MN)

At the beginning, family, friends and colleagues were putting a lot of pressure on their respective circle because no one new how to handle this situation, given that the western world does not have any experience dealing with a pandemic of this scale:

> *At the beginning, yeah, 'cause it* [the pandemic] *was obviously quite big, new. A lot of people put a lot of pressure on people, not intentionally, but it was a lot of pressure from everybody at the beginning, wasn't it?* (GH)

Subtheme 2. Anxiety

Four participants described their worries and anxieties throughout the pandemic. All of them described work as the main contributory factor of their anxiety:

> *I try and switch off but I just can't get to a point where I'm like. Oh, there you go. Oh, I haven't thought for work, not thought about work for four days, you know, or whatever it is. There's always something that's popping up in my head or I wonder*

> *what that's going on or wonder what, you know? Or I must check that, so I haven't got that to come back to or, you know, that sort of thing.* (CD)

> *But the services that I work with, they also have different staff. We've come from different places and you don't know what they've been doing or you don't know who they've been interacting with, so I was very concerned about getting COVID from work.* (EF)

> *It made me feel, well, some sort of depression, of course, and a lot of anxiety mostly as well.* (MN)

> *I know that, you know, we are required to do the correct things when we do go into work. PPE hand washing, face masks and things like that. So yeah, there is always a worry.* (NO)

One participant described how she managed her anxiety by using anxiety medication. The contributing factors that led her to medication were the loneliness, anger and sadness felt because of the pandemic in addition to the fear of infection:

> *Just* [a] *few anxiety meditation, some SOS* [multivitamins]*, some specific meditations on how you might be feeling. Anger or sadness or loneliness. Things of that nature, 'cause I do live on my own and that's another thing. With the pandemic is that I did not see, I didn't see anyone until I went to work, right?* (EF)

> *At the start I was worried about. Uhm to be honest with you, I was, I was quite afraid, it was quite frightening. I don't really, I wasn't really going out much, so I wasn't really interacting with anyone who I can get it* [COVID-19*] from.* (EF)

Subtheme 3. I love helping people

Participants shared their experiences of how they cared for or received support from colleagues, friends, family and health professionals, and their experiences accounted for different circumstances and covered a range of needs. All of the passages reveal the caring nature of the individuals that prioritise their work, primarily because of its sensitive nature. The support they provided was an integral part of who they were rather than just a job that paid the bills.

Two participants described the importance of responsibility during the pandemic. The statements illustrate both collective responsibility and personal responsibility: both are needed in order to safeguard ourselves and everyone around us in relation to the pandemic:

> *We just have to be responsible, but unfortunately not many people are thinking that way, like the youth, they are not that responsible when it comes to this COVID thing.* (AB)

> *I just used to look after myself and make sure that I look after my body, wash my hand, do all the writing. So, I was just trying to do the right thing and just, yeah, maintain more hygienic* [responsibility]. (IJ)

Five participants described how they cared for either their colleagues or services users in order to safeguard their safety and health. Their statements inform us about the selflessness and caring nature of the individuals working within this sector. Paraphrasing one of the participants, one must care to work in care:

> *I ended* [working] *two or three waking nights and I chose to do them because the manager that oversees that service has got children and I was like, well I've got no dependents, you know, so I would rather go in and risk getting it* [COVID-19]. (DE)

> *I really like the job. I do really love going to work. I love helping people. That's my biggest strength, to be honest. If I'm being honest to you, like, a full life uplifting people makes me happy. It makes me feel like a better person. I mean, like I help people, I go to work. Vulnerable people, literally some of them they can't even talk, they don't remember, so it's like, yeah, that was [a] bit hard for me.* (IJ)

> *Keeping everyone here happy, you know, 'cause they all have different needs, and try not to let people panic. Just being calm, you know, that was trying to be calm and understanding.* (JK)

> *Yeah, you can't do this job, I assume, if you don't, if you're not a caring person, generally either in your personal life or… right?* (KL)

> *I'm completely fine, actually, I, uhm, I, obviously, work with a service user who has a disability, and my son has a disability at home. So, there's no real difference between being at work and being at home.* (LM)

Two participants became mindful of themselves and of others. Understanding their own needs as well as understanding the circumstances of other people allows for a deeper appreciation of the caring nature of individuals. Both passages described a realisation of different experiences and a potential recognition of self-help:

> *The doctor who's trying to get to the bottom of my headaches, and he said to me, uhm, you know, are you stressed? And I said, well, I don't think so. I don't believe so. I know we can be a stressful job, but I believe I'm alright. But people come to me by nature, you know, and all this and he said to me, who do you go to? And I was speechless, and I didn't know who, you know. And that's when it was another sort of same mental health moment* [of realisation]. (CD)

> *Purposeful talks with individuals. UM, so, talk about issues in the world or, and talk about, I don't know, what we watched on television, talk about work, even though a lot of people didn't go to work, there is a bit of a tricky situation because you don't wanna make them worry about their finances by, you know, talking about how you can still go to work when they can't, kind of thing.* (EF)

Subtheme 4. The normal thing for COVID was going to work

Three participants described how the COVID-19 pandemic did not change their lives significantly and did not affect them, since the job continued as normal and it was secure because the need for care was significant at the time (e.g., furlough) and they did not have any personal life prior to the pandemic. Work was acting as their medium of stability:

> *The pandemic didn't actually change anything for me. I didn't have a social life before,*

> *so, it was like very little difference, only the fact that I had to stay at home, not come in contact with people.* (BC)

> *To me not much changed because I was working 'cause I had to still get up in the morning…* (GH)

> *Uh, so it was obviously, very seclusive, it was literally going to work and then, that was it, kind of thing. The only normal thing for COVID was going to work.* (LM)

Subtheme 5. Realisation of how I [feel]

Two (2) participants described the positive effect lifting the restrictions had on them since they were allowed to interact with others again, and one (1) participant described the difficulty of having to be forced to live with the restrictions:

> *happy that say some restrictions are lifted, at least now we can see each other.* (AB)

> *the second that we were allowed back in the office, just trying to be as sociable as possible*. (DE)

> [Restrictions] *actually took its toll and I'm somebody that, I'm quite a solitary type figure anyway, and I like a lot of my own space and to spend time on my own. When you're forced to do it because you've got no choice, puts a different perspective, was really quite difficult.* (DE)

In AB's case, her sister had passed away prior to lifting the restrictions; however, she was able to accept the inevitability of her loss:

> *I think it was just her time because this is someone who had battled with sickle cell* [disease].

Three (3) participants described how the pandemic allowed them to achieve a higher realisation for the self which enabled them to understand more about themselves. Participants explored how they used to behave in comparison with during the pandemic, and this provided them with a better insight into their behaviours:

> *It was like that realisation by me filling all my time with other people, I don't focus on me. I didn't, you know, I don't focus on what helps me get through and that's how I sort of tried to get through.* (CD)

> *Especially with men. Uh, I think it's even harder because we are almost programmed that, you know, we don't cry. We don't do this. We don't talk. We don't do that. You know we're soldiers, everyone comes to us. We don't do that. But who do we go to? When, you know, it gets too heavy... My moods are low, and I saw one that said something along the lines of, you know, it's OK to cry because even the clouds crack when they become too heavy, you know, it rains.* (CD)

> *I think it's made me a healthier and happier person. I think that's about all I can really say, which is a horrible, horrible thing to say about something that's killed so many. And I do feel guilty for feeling it, but it has improved my situation but also managed to save money.* (OP)

Three (3) participants described their respective experiences in relation to the pandemic and how it affected them.

EF explained how using social media helped her to keep in touch with her friends; however, after a while they had nothing to talk about, resulting in having less online presence:

> *You know, with friend groups, you'd be like, Oh yeah, well, WhatsApp call video call all the time and then, uhm, yeah, we soon learned that because we were not doing anything, we actually didn't have much to talk about.* (EF)

PQ shared an example of people being scared of being close to him when he coughed because they thought he had COVID-19. This perception of others was based on him being a support worker:

> *All those sitting there* [friends] *and then, and it was barely a cough, I coughed, and there was like COVID, COVID, and I’m like, it got to be a little bit* [of an extreme

> reaction]. (PQ)

KL described her experience as something good since she never contracted COVID-19, even after being exposed to service users diagnosed with COVID-19:

> *I think I've done, I've done quite well 'cause I personally haven't had COVID, and obviously that you know, getting through up until now and not contracting it. It's obviously been right, really good.* (KL)

THEME 4: Understand what I am going through

Support workers are an integral part of the care sector. During the COVID-19 pandemic, they described their experiences, the support they received and gave and their take on how appreciated they felt. They described the support from colleagues, the company, their managers and others.

Subtheme 1. Supportive colleagues

Three (3) participants described how they offered or received support from colleagues throughout the COVID-19 pandemic, when the focus was on building trust and making oneself available to provide support during these times:

> *Uhm, me naturally, uhm, I've always been the person that people come to even in work. I found that, you know, it's because if I can help people at times and not sound weird, but even in their private lives or whatever, and say look, this is what you need to do or what you know, you get a lot more out of people they trust you a lot more.* (CD)

> *I think actually being able to access your team, team managers and things is, it makes all the difference, so I think we've realized that now as well, that, you know, we have to kind of become available and be accessible in order for people to feel supported.* (DE)

> *I think, obviously, supportive colleagues. Obviously, they've been going through, you know, we've all been in this, in the same position. And I think, keeping each other safe,*

> *you know, and following all the guidelines is, obviously, we've obviously done well.* (KL)

Subtheme 2. Check on us!

Four (4) participants mentioned that they would have liked to have additional support in terms of mental health and offloading all the emotions building up during the pandemic:

> *Advice that we usually get is you should go and speak to this person or that, and they're mainly not available when you are.* (BC)

> *I think, more support. Most support UM? Oh, more opportunities to speak to other people, I think. I think that would be useful.* (EF)

> *I didn't get anything from HR to check how I was. Or, you know, this is a new thing for everybody, so surely they should have, you know.* (JK)

> *People who maybe aren't within the service checking in a bit more, or like maybe an email. During COVID, I don't think I've been asked other than by people within the home how I'm coping or feeling, you know, during COVID.* (KL)

Subtheme 3. Support from managers

Participants described the support and direction received from the home manager or team leader as significantly positive. They explained how the management team led the way through the challenges arising from the pandemic, both on a personal and professional level. One (1) participant diagnosed with long COVID described his experience of having to manage the disappointment of taking new medication that was not effective and how his manager was supporting him throughout this journey:

> *Uhm, so, I almost don't wanna take a new tablet* [medication] *because I get my hopes up that this tablet is actually going to work. And then when I take it and it doesn't work, it drops me even lower the other side. And yeah, I've just, you know, it's frustrating and these like people like, you know, it's been great at work. Look, if you need to work from home or you struggle on this or that, you know, your health comes first and they've been like, my managers have been really supportive.* (CD)

Four participants (4) described how their managers always checked for their mental and physical wellbeing and provided them with the necessary tools (e.g., PPE) in order for the team to be safe:

> *I don't know because I had pretty good support from, you know my registered manager at the time, you know, and she would always check in and we'd stay in and she make sure that we were all right.* (DE)
>
> *This management* [was] *helpful at work, like they've been bringing us PPE stuff like I'm washing and they used to even give us like face masks. It's like boxes of face masks for us to look after ourselves and our families and stuff now, and they give us antibacterial wipes, hand sanitisers, so we still have a lot of stuff coming to workplaces and helps us as well.* (IJ)
>
> *That was particularly difficult, and in that moment, you know, the staff. And like my manager, was really, you know, they were really supportive, really helpful, like checking in.* (KL)
>
> *I think the home lead and seniors here have been absolutely incredible. They've certainly, the home lead has known most of the service users for, if not a decade, then more um, and she's been through a lot with them and understands it, so she's been able to point us, so how to get around things? So yeah, I feel, I feel like we have been adequately supported by the management.* (OP)

One (1) participant described how she had to go and live with a service user for 10 days in order to safeguard her family and the service user. She felt supported by her manager; however, she would have liked to be recognised more at a company level for her contribution:

> *In the 10 days I stayed I felt really, really supported. But I probably would have liked to have maybe heard from some higher senior management or other than being mentioned in a newsletter by, just not even by name, was the only kind of recognition I've, that I've I felt I got for, you know, moving in for 10 days, which obviously is quite*

> *a, quite a big thing to do. It is away from your own home, you know, and not being able to actually leave a property for ten whole days.* (KL)

Subtheme 4. Support from others

One (1) participant described her experience with her being diagnosed with long COVID and having to use the NHS services to receive support and guidance. She explains the disappointment on using these services and that she felt lost. Her GP was able to help her only because his wife was diagnosed with long COVID and therefore had a personal experience on the effect on one's quality of life:

> *Someone to actually understand what I'm going through to actually not pawn me off and keep making me* [wait]*. I've had to wait for so long 'cause I got COVID in January and it's taken till now* [July] *for them to say I've got a long COVID. So, bit more understanding, a bit more training* [for the doctors]*, not for me, but yeah, so that we could fix it, sure, but luckily my doctor's amazing 'cause his wife got it as well.* (JK)

Additionally, she explained that she needed to apply for governmental support; however, in order to receive it she had to experience a 'humiliating' process. She further described that she had been paying her taxes and was a law-abiding citizen who needed to use governmental support for the first time in her life; however, it took too long to receive support as she was still waiting:

> *I was told that I should apply for, um, PIP* [personal independence payment]*. Because I need help 'cause I can't do all the things* [cooking, walking, grocery shopping] *at the moment. I applied for PIP, yet it's taking months and they said they wanna see me to discuss … Why should I have to go through all that? When I've been diagnosed with it and I'm not, and I'm not asking for it forever, it's only to help me so I can recover quickly, hopefully, to get back to normal life. I have worked for 35 years plus, I've always paid my taxes and never pounced. Yet this one time when I need it, I can't have it, but people I know* [service users]*that have PIP spend it on drugs and all sorts. How is that fair when people like me that really need it can't have it? And you have to go through all the humiliation of being asked what's seven minus two* [7-2]*?* (JK)

THEME 5: Taking a message from the COVID-19 pandemic

All participants shared their experiences in order to send a message either to government bodies, their companies, themselves or others experiencing the same emotional processes. Participants raised their voices and expressed their needs, and support workers explained the importance of vaccination and overall quality of life and placed emphasis on their mental health support since they felt it was significantly lacking. Support workers during the COVID-19 pandemic changed their perceptions of a variety of topics and criticised what could have been better from their working organisations and the UK government.

Subtheme 1. Changed perception

The pandemic led participants to change their approach to work and interpersonal relationships with two (2) participants highlighting the importance of taking control of our safety by vaccinating and maintaining proper hygiene standards:

> *I will say everybody that could be vaccinated should do it. Everybody should do it because I believe what they are saying is that once you have vaccinated, it's not that you won't have it, but it will not result into hospitalization or death* […] *Yeah, so I will say to the world that please, let's all do it and then be more responsible with the way we do things* […] *just take responsibility for your life.* (AB)

> *It's probably become, it's like I'm more like hyper aware of things, but hand washing and spacing from other people and just being in rooms with no ventilation,* [I am a] *little bit more anxious than I normally would be around other people when going to new places and things of that nature and also as well I think it's affected my ability to focus on things.* (EF)

Three (3) participants described the importance of providing mental health support to colleagues and others as well as the importance of raising awareness in relation to people with hidden disabilities:

> *That your life is more, Uhm, is worth it. You don't just throw it away in the bin 'cause you're tired and stressed and being emotional and everything, and you can't stay anymore inside. My thing would be that we need to be prepared for more people with*

> *mental health issues after this. So, it is to not to deal with them but support each other, that's all. BC*
>
> *You know professional and personal boundaries, but at that time I think it goes past the point of, you know, I'm your manager or you're my manager and stuff like this and we as humans need to check on each other and say, you know, because I've had someone come to me not long ago and I said, how are you?* (CD)
>
> *I would say probably a bit more um, awareness of people maybe being a lot more unique than others. People still don't understand hidden disabilities as such, and, you know, people's own unique talents.* (LM)

One (1) participant described how COVID-19 changed his life for the better since he had to quit his job in hospitality and find a job in care. During COVID-19 his life had structure and he was working less than working in his previous role:

> *It feels horrible to say it, but it's actually, this pandemic's been one of the best things that happened to me.* (OP)

Subtheme 2. Difference handling from the work organisation

Participants described the importance of guidance and mental health, describing how the organisation should have had appropriate infrastructure or trained professionals that would deal with their mental health issues and provide them with around-the-clock support.

> *Support, mental health support of the care workers* […] *And maybe with a small office or somebody if he's not and just talk about and say hey, have a nice, just a small conversation. So, there should be somebody on site.* (BC)
>
> *So, I even thought about it at one point but just never got anywhere about like mental health, first aid or stuff like that. Or like someone within the company that was a mental health trained person that people that had issues could you know like a support group for people that were struggling* […] *You can speak freely because once you speak freely and sort of off the record and all that, you know, you find out a lot more of what*

> *people truly feel and stuff like that.* (CD)

Participants felt that there was no clear guidance in place that they could refer to in case there was a service outbreak or a positive case. Initially, this was a big problem since the approach had to be dealt on a case-by-case basis since the underlying conditions of service users were different; however, later on, the advice to call the NHS national helpline (111 or 999 emergency services) was rolled out. Additionally, information about service users' COVID-19 status was not passed over to all the support workers:

> *I think I've learned that even now I don't even think that I could give an answer of what we would do if they got it now because I think it's dependent on the client, the service, the sort of staff that you've got, you know, it all depends in that particular service.* (DE)
>
> *I felt that there wasn't much information coming from management. I felt like OK, so I'll explain this situation … A service user had been tested for COVID on a particular day and then four days later, whilst we're waiting for the results, I was working with that service user up quite closely. […] And if you think it's getting really bad, call NHS 111, 999 and things of that nature. So, at that time on my shift I did not know that, actually, it was suspected that they had COVID and a test was sent off and I only found out the next day and I just felt a bit of a betrayal because I should have been told, Uhm, that this person was and it did come up positive that they did have COVID, uhm. So, I think I would have done things a little bit different if I knew that, so I did feel like there wasn't….* (EF)

One (1) participant described how the organisation did not offer new job opportunities during the outbreak, resulting in her experiencing difficulties with her development:

> *Uhm, I would say, uh, more opportunity as, um, you know, within service, let's say either like development today or some sort progression, basically.* (LM)

Subtheme 3. Quicker and firmer government response

Participants described their frustration with the handling of the pandemic and how it was affecting them on a daily basis due to the ever-changing new guidance. Participants emphasised the importance of collaboration and proper information sharing in order perform their job effectively, but provisions for the support workers and for the service users they took care of were minimal. Organisations had to follow the guidance and advice of the government when it was rolled out; however, the response was delayed and the sector felt this at its core.

> *With the, with the data changing so quickly. So, it was daily at one point. So, by the time we've got out and spread that information, we already had a new set of information coming in.* (CD)

Furthermore, participants described the need for a more accurate and quicker response from the government in order to handle the situation prior to escalating to the extent that it did:

> *I do believe that maybe, obviously, certain events should have been shut down almost immediately to avoid the spread of the virus*. (NO)

> *I think a quicker and firmer response from the government would be necessary* […] *We need to recognise the risks earlier. We need our Prime Minister to go to COBRA meetings and actually take things seriously prior to the event rather than being reactionary, we're, you know, one of the richest countries in the world and we weren't ready for something that we have a department in the government specifically to deal with. It unacceptable uh, from a national point of view, from a care worker's point of view the provisions put in place for service users has been terrible.* (OP)

> *And also a little bit more support from the government, a little bit clue clearer that have given us, wondering if once somebody says one thing and then another says another thing is no direct, you know?* (PQ)

> *I think they were too late to tell people the truth and they didn't act fast. If they acted fast like, I think this could have been like, probably, we could have lost people, but not as much, as many people died of COVID-19.* (IJ)

5.1. Outcomes

This qualitative study aimed to explore the experiences of support workers in the UK during the COVID-19 pandemic within the care sector. The pandemic affected support workers in a variety of ways, including general difficulties with contracting the disease, isolation, bereavement, a lack of support staff, coping mechanisms, opinions about how their employer could have handled the situation differently and the UK government's inadequate response. Working in care during the COVID-19 outbreak was a transformative experience for most support staff, and many of them struggled with their mental health. The lessons learned included the realisation that support workers required emotional support that was readily available, that better ways of communicating and passing information should have been defined, and that support workers needed the appreciation from society and their work organisations for the jobs they did. In particular, key findings regarding resilience, transformation of illness and loss and agency stood out. Some of the abovementioned quotes demonstrate how resilient the support workers were, as they depleted and, in some cases, exceeded their emotional resources to provide support not only to service users but also colleagues. This was a primarily an internal need to help, care and effectively support another human being. Resilience was also enhanced by supporting each other, given that they were facing the same dilemmas and emotional struggles.

Transformation of illness and loss took place throughout the COVID-19 period. It started as something that the support workers had no control over, given that they had to follow the guidelines set out by government, policies set out from the work organisations and directions as instructed by registered managers. Furthermore, risking their own health, and in some cases getting infected themselves, was a transformative experience, given that (a) they had to face a new illness although they were the ones being diagnosed with it, and (b) they had to willingly and knowingly expose themselves in order to support vulnerable adults (e.g., by staying at the service users' homes). At the same time, for some support workers the experience of loss was a significant one, particularly for those that used faith as their coping mechanism, as the loss made the focus on their faith stronger.

Regarding agency, support workers made decisions and arrangements to manage their own workload to the furthest extent permissible, with their own households also deciding to take action regarding self-sacrifice. They demonstrated significant agency in continuing to work despite the conditions, primarily because they cared and wanted to support vulnerable individuals, which resonated very closely (e.g., family members with learning disability). Support workers wanted to provide the best care possible even though they explicitly expressed their feelings of disempowerment and professional marginalisation.

The next chapter focuses on the stories brought forward during the qualitative study, the comparisons with the available research and the suggestion of a PSP for improving staff experience directly and, indirectly, quality of care.

Reflection for Chapters 4 and 5

The particular chapter has been quite challenging for me to structure. The primary reason behind this is because during my initial Viva for the current project, the feedback I received was not in line with what I thought I had created. This chapter forms the primary part of my research and as such I was very excited to present my findings. After all, this was all about my practice and my career development. However, after I received the feedback and having worked extensively on it, I could see that my emphasis was previously on the practical side only (e.g., interview, listening their stories, analysis) leaving behind the development of a robust methodological structure. I was so eager to 'give a voice' to support workers, as I used to say, that the way I previously presented my methodology felt as if I had just started my research training.

Upon reflection, I believed that I could trace this issue as far back as 2016 when I was employed at Anglia Ruskin University as a research assistant for the first time in my life (outside a degree). I was conducting the analysis for a project using interpretative phenomenological analysis, and when the time arrived to conduct my own Professional Doctorate, I was debating between thematic analysis and IPA. My familiarity with IPA gave me a sense of confidence, therefore, and upon comparing the two methodologies, I decided to choose IPA, thereby potentially overlooking some other methodological discrepancies. My reasoning was primarily because I was exploring the lived experience of healthcare staff, and IPA is a textbook approach when it comes to lived experiences. However, when I performed the analysis, my interpretation of the interviews was closer to the principles of RTA, although my line of questions, even though as open as possible, did not fit the model as outlined by

IPA.

At the time I could see IPA working as my preferred methodological approach. I believe this was due to the fact that both approaches made sense, and this was something I was able to validate during my exercise of comparing some passages between RTA and IPA, disregarding all other aspects (for example, if the research questions were fit for purpose for both approaches). I believe both approaches during the results intertwined to an extent with what I wanted to explore that it became quite evident to me that I had focused too much on analysing the passages so that I had slightly left behind the proper justification and approach of my analysis. Even though a big task, re-examining the interviews and therefore the codes and themes in order to make sure they reflected the nature of RTA increased my confidence in the sense that I really tried to give a voice to the support workers and consecutively build my methodological approach in such a way that the essence of the results was transferable. RTA allowed me more flexibility whilst remaining true to my purpose, and I believe I grew as a researcher as I am now more confident regarding the background work I need to do in order to develop quality work. Additionally, this supported me in understanding the amount of work needed in order to publish work on my own as well as take enough time away from the research work in order to be able to look at it with a fresh perspective.

This, in fact, led me to question whether I should use an approach just because I am familiar with it, as I started questioning my own practise. Do I keep using a certain approach in my work just because I am familiar with it and I have had positive results? What if there is an even better approach, or a more suitable approach, but because of my pre-existing knowledge I cannot challenge myself? Most importantly, what if I am set in my ways, and I cannot unlearn or re-learn?

By the end of the qualitative study, as it was deep in 2022, I was able to publish both the meta-ethnography and the qualitative study in a peer-reviewed journal. By that time (March) I had resigned from my previous company, and I was working as a healthcare consultant for a private care organisation whilst looking to find where I could go from there. The publications supported me with evidence that I did have knowledge of the struggles underlying staff members and I was continuously working for the improvement of the care sector. During October 2022, I was officially appointed as a lecturer of psychology at the University of Bedfordshire. When I received the phone call with the job offer, the Head of the Department said that (among other reasons) I was selected because I had publications which other candidates did not. Up until this point, the Professional Doctorate not only improved my job prospects but opened up career doors that I was not actively considering.

CHAPTER 6. DISCUSSION

6.1. Chapter breakdown

The first section of this chapter discusses the findings of the qualitative study aiming at providing a valuable insight into the research question that explores the lived experiences of support workers during the COVID-19 pandemic. This is then followed by an analysis of the strengths and limitations of the study, before the next section provides the reader with a proposal to support those support workers, followed by an examination of the strengths and limitations of the current thesis as a whole.

6.2. Summary of qualitative approach

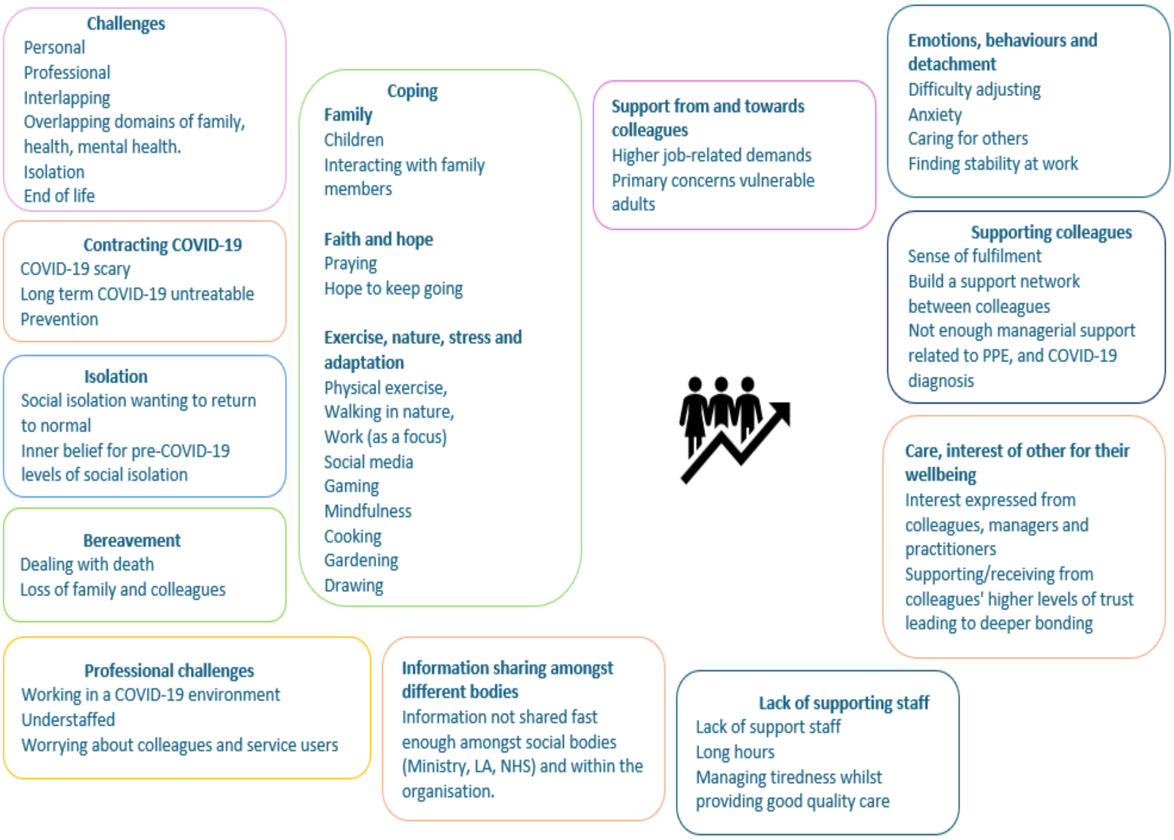
In order to simplify the process of information-sharing in this chapter, I have created a table of summaries that would help the reader process the amount of information outlined below (see Table 13), given that the thesis research question was to examine the lived experiences of support workers during the COVID-19 pandemic. Each summary is linked with the information presented in Chapter 2.

6.2.1. Challenges

The COVID-19 pandemic taxed the resources of support workers in the care sector who faced issues ranging from personal to professional and interlapping challenges. Additional challenges were related to the overlapping domains of family (e.g., not visiting family to safeguard them), general health (e.g., maintaining hygiene, not contracting COVID-19), mental health (e.g., stigma, suicidal thoughts due to contracting COVID-19), isolation and coping with and death of service users and colleagues. Support workers had limited opportunities to interact with their social networks including family members because of the COVID-19 restrictions but also because they had to safeguard their personal contacts from COVID-19 since they were potentially risking cross-contamination.

The findings are in line with a qualitative study by Sterling et al. (2020), in which they interviewed 33 home healthcare workers employed by 24 different agencies in New York City that aimed to understand the experiences of workers caring for service users during the COVID-19 pandemic. The study identified that heavy reliance on public transportation and lack of PPE increased fear of infection. Additionally, if support workers contracted COVID-19 either from transport or the lack of PPE, the feeling of fear was becoming greater since they worried about transmitting it to their servicer users, colleagues and family members. Additionally, participants reported that they did not want to put an extra burden on their family members by sharing work-related fears. This resulted in the need to withdraw from home activities (e.g., playing with their children, movie nights) and self-isolate. There is a plethora of research that highlights the interaction between work and home domains. The crossover-spillover model in particular theorised the notion of the reciprocal impact of the home-work domain and the cumulative effect this can have in turn on work and mental health outcomes (Bakker, Demerouti & Burke, 2009; Bakker et al., 2014).

Table 13 Table of summaries for qualitative study



Challenges
Personal
Professional
Interlapping
Overlapping domains of family, health, mental health.
Isolation
End of life

Contracting COVID-19
COVID-19 scary
Long term COVID-19 untreatable
Prevention

Isolation
Social isolation wanting to return to normal
Inner belief for pre-COVID-19 levels of social isolation

Bereavement
Dealing with death
Loss of family and colleagues

Coping
Family
Children
Interacting with family members

Faith and hope
Praying
Hope to keep going

Exercise, nature, stress and adaptation
Physical exercise,
Walking in nature,
Work (as a focus)
Social media
Gaming
Mindfulness
Cooking
Gardening
Drawing

Support from and towards colleagues
Higher job-related demands
Primary concerns vulnerable adults

Emotions, behaviours and detachment
Difficulty adjusting
Anxiety
Caring for others
Finding stability at work

Supporting colleagues
Sense of fulfilment
Build a support network between colleagues
Not enough managerial support related to PPE, and COVID-19 diagnosis

Care, interest of other for their wellbeing
Interest expressed from colleagues, managers and practitioners
Supporting/receiving from colleagues' higher levels of trust leading to deeper bonding

Professional challenges
Working in a COVID-19 environment
Understaffed
Worrying about colleagues and service users

Information sharing amongst different bodies
Information not shared fast enough amongst social bodies (Ministry, LA, NHS) and within the organisation.

Lack of supporting staff
Lack of support staff
Long hours
Managing tiredness whilst providing good quality care

The current findings showed that participants diagnosed with COVID-19 decided to withhold information (e.g., COVID-19 diagnosis, long-term symptoms) and not share it with family members so that they would not upset them. This resulted in isolation and thus neglecting part of their personal wellbeing, namely, their mental wellbeing. The most prevalent challenge regarding family matters was reported to be around their children's physical and mental wellbeing and adjustments to the 'new normality' (e.g., remote learning). An expert-opinion-article by Bruce-Barrett et al. (2007) highlighted the unique considerations of pandemic planning for health administrators and policy makers and supported the notion of 'gaps in preparedness' during pandemics for children and adolescents and the emotional complexities arising for parents and children coping with this relatively unknown life event. The current study participants did not identify any supporting networks (e.g., pandemic preparedness) that helped them deal with the arising challenges as described by Bruce-Barrett et al. (2007). Therefore, there is a need for implementing strategies and concepts derived from research. For example, apart from identifying a problem or a need, researchers should also try to focus on creating small interventions in order to build up a library of tools readily available for use if the need arises. Governmental bodies need to use this knowledge to tailor evidence-informed policies in order to be better prepared for future pandemics so that the healthcare system (e.g., NHS) is not in a place where it is overwhelmed and thus unable to sustain the necessary levels of care.

6.2.2. Contracting COVID-19

Another major personal challenge was around contracting COVID-19 including long COVID-19, which at the time of the pandemic was untreatable. It is imperative to recognise the importance of prevention not only for physical but also mental wellbeing (e.g., organisations to include training on how to cope if someone gets infected with a new infectious disease, a step-by-step guide that was built based on previous pandemic research).

Support workers exposed themselves on a daily basis to COVID-19 and the associated risks. Some participants were diagnosed with long COVID, which is defined as when the symptoms last longer than the expected recovery time, which in turn had a negative effect on their lives, either by restricting their daily routines (e.g., daily headaches and dizziness, cannot cook, read or walk) or by affecting the quality of their work (e.g., care quality etc.). Additionally, long COVID is not associated with how ill someone was when they first contracted COVID (NHS, 2022). Most support workers who got diagnosed with long COVID were infected at work, which is in line with previous research exploring healthcare professionals and identifying that fear of infection is a common ongoing feeling that health and social care workers have to live with during COVID-19 (Nyashanu, Pfende & Ekpenyong, 2020a, 2020b). A meta-synthesis by DeJean et al. (2013) suggested that when individuals are confronted by an unknown pandemic, which is untreatable during the first wave, they are often overwhelmed by feelings of fear and anxiety. At the time the interviews were conducted, no effective long COVID treatment existed, and in a similar situation it is very difficult to develop a medication that would be able to treat the condition.

6.2.3. Isolation

Isolation was also identified as a major personal challenge. Participants commented on the social isolation aspect and how they would like to return to normal. Overall and irrespective of category (e.g., introverts-extroverts), individuals revealed an inner belief system that allowed a focus on the future by believing that the only way forward was back to pre-COVID-19 levels of social interaction.

Perceived social isolation (PSI) is a deficit in day-to-day social interactions linked with overall negative outcomes. The factors underlying the negative effects of PSI on human health are currently unknown. Overall, there is a well-established association between PSI and different etiological pathogeneses of illnesses such as cardiovascular, inflammatory, neuroendocrine, cognitive and affective disorders (Bhatti & Haq, 2017). Isolation is perceived differently from individuals being categorised as either extroverts or introverts. Participants who self-identified as introverts described how hard it was not to interact with anyone, which was something that would normally be expected from extroverts. The current findings add to research suggesting that irrespective of category (introvert–extrovert), isolation was equally difficult for either group to handle (Frąckowiak-Sochańska, 2020) during the COVID-19 pandemic.

6.2.4. Bereavement

COVID-19 had an impact on all aspects of life, including experiencing death, as participants experienced both the loss of family member(s) or colleague(s). As mentioned in the discussion in subsection 5.2.2 – Contracting COVID, it is important to include this in the training of support workers during a period such as a pandemic.

Participants described how it felt to experience seeing people passing away and how it resulted in feelings of sadness and mental exhaustion. During the interviews there was no information in relation to training or support surrounding bereavement due to COVID-19 from either the government, work organisations or any other third parties. Bereavement is part of the human experience; however, it is intensely painful with a significant impact on physical and mental health. One (1) in ten (10) adults develop prolonged grief disorder (PGD), which includes experiencing grief for more than six (6) months after a loss, separation anxiety, feelings of distress, emptiness and hopelessness (Selman et al., 2020).

6.2.5. Professional challenges

Professional challenges included having to work in a COVID environment, being understaffed and constantly worrying about colleagues and service users.

Due to COVID-19, support workers had to deal with increased anxiety and stress levels. For example, support workers decided to live in the same house as their service users so that they could safeguard both the service users and their own families. This caused high anxiety levels since they did not know if they would eventually contract COVID-19, risking their health in exchange for their families' or service users' health. Previous studies investigating uncertainty during a pandemic (e.g., SARS) identified that during the outburst of a pandemic, anxiety-related disorders are prevalent with reported effects still active 30 months after the outbreak (Lee at al., 2007; Mak et al., 2009; Taha et al., 2014).

6.2.6. Lack of supporting staff

Another major professional challenge that resulted from the pandemic was the lack of supporting staff. Long hours of work and managing tiredness whilst maintaining good quality care was very difficult to maintain. This is in line with the results of the meta-ethnography as discussed in section 3.9.7. – A higher calling and self-sacrifice, as support workers wanted to go above and beyond for their service users, often disregarding their own safety.

Research shows that fatigue is a significant risk factor in patient safety amongst healthcare professionals and higher levels of fatigue can lead to more mistakes, resulting in poorer quality health service (Kunert, King & Kolkhorst, 2007). From the interviews it was identified that everyone was able to cope overall at a functional level., and the reason for this was reported as related to the belief that support workers wanted to cover extra shifts wherever possible since they knew that vulnerable individuals were relying on them for their day-to-day needs. For example, non-verbal or severely disabled individuals would not be able to take their medication, eat or drink without the support workers' ongoing support.

6.2.7. Supporting colleagues

Care was the core that underpinned the support workers' ethos and culture, as supporting colleagues and service users filled them with a sense of fulfilment. Furthermore, they were able at that time to build a supporting network between themselves. This collegial network contributed to daily support like covering shifts and taking additional sleep-ins to spend the night within the service or at service users' homes. Despite this positive experience received from co-workers, there were less favourable evaluations of the care home management, as support workers initially felt that they did not receive enough support from the management. Reasons for this were mostly related to lack of PPE and guidance on how to approach a COVID-19 diagnosis.

The more the support workers knew and the more knowledge they were given, the more confident and competent they felt, resulting in them providing a better service as well as feeling more confident with themselves. Support workers often reached their limits; however, they did not seek advice in relation to their mental health, even though they self-identified as a group that needed extra support. This came as a surprise since they already worked in the healthcare sector with a strong emphasis on mental health (e.g., learning disabilities, anxiety, depression); however, they did not use the links provided to them or spoke up when they felt emotionally depleted. According to Centers for Disease Control and Prevention (2022), over 20 million health workers in the US are at risk of developing a mental health problem with mental health issues that can be developed include stress, burnout, depression and anxiety. Greenberg et al. (2020) suggests that healthcare professionals were already experiencing the above mental health issues; however, they were intensified by the COVID-19 pandemic. Additionally, staffing and PPE issues, as well as fatigue, were added to the already difficult working environment. Taking into consideration the above would suggest that support workers did not have the emotional energy to seek out support given that they gave all their emotional resources to family and work.

Previous literature examining both COVID-19 and other pandemics identified that around one in three healthcare professionals exhibit emotional exhaustion (Barello et al., 2021), which is alarming since studies have demonstrated that emotional exhaustion is associated with negative work outcomes including patient safety and a decrease in overall work performance (Braquehais et al., 2020; Giusti et al., 2020; Barello et al., 2021).

Portoghese et al. (2017) suggested that burnout de-associates professionals from engagement, the positive state of mind divided into three categories: (1) being able to invest physical and mental energy to a task, (2) being committed and involved in work and (3) concentrating on tasks. Additionally, burnout represents the overall lack of energy towards a particular task or job.

Support workers were not able to switch off from work since there was consistent worry and anxiety about being called during their ‘resting’ or ‘time off’ hours. Additionally, some workers were left in a moral dilemma of whether to turn up to work at all, given that they self-identified as high-risk (e.g., asthma, cancer). Switching off from work, as further described in section 2.5, is important since it helps to recover emotional resources used during work, and a meta-analysis of 198 articles exploring recovery from work suggested that recovery is correlated with job performance. Additionally, recovery acts as a buffer mechanism restoring consumed energy and helping the body to return to a state of homeostasis (Steed et al., 2021). If restoration is hampered, then the emotional resources are depleted, and this results in emotions crossing over from private to work and vice-versa, as described in section 2.5.

6.2.8. Coping

All participants had used some form of coping mechanism in order to manage COVID-19 at work. The mechanisms identified in the current research included family, faith and hope, exercise, general activities, work-related coping and non-traditional coping mechanisms.

The findings surrounding coping were partly in line with other research evaluating coping mechanisms during the pandemic. Chew et al. (2020) identified that seeking social support and positive thinking helps reduce stress levels and depression whilst others suggested that using avoidance as a coping mechanism (e.g., avoiding dealing with emotions) supports reduction of psychological distress whilst allowing healthcare workers to focus on their work (Vagni et al., 2020; Maiorano et al., 2020).

6.2.8.1. Family

The concept of family, e.g., having children or interacting with family members, allowed participants to focus on their time spent with family rather than worrying about work or COVID-19 in general. This is in line with previous research suggesting that COVID-19 allowed families to come closer together whilst at the same time allowing the younger generations to develop their problem-solving skills (Schoeni et al., 2021). Additionally, Mariani et al. (2020) suggested that family members provided extra support to other family members, resulting in positive effects on mental health, which affected coping.

6.2.8.2. Faith and hope

Faith was another mechanism that was used for coping. Praying and leaving everything in God’s will was part of their coping strategy, and it is important to note that faith was not a coping mechanism developed during the pandemic but rather a pre-existing one. Hope in general was identified as a key mechanism that allowed individuals to ‘keep going’ until everything returned to normal.

In line with previous research, hope was found to be a mediator reducing psychological distress under challenging circumstances. According to Laslo-Roth, George-Levi and Margalit (2021), both hope and psychological distress share common properties within an individual; both include a transaction between the person and the environment, both rely on the concept of time to take effect, and they are based on individual appraisal and affect wellbeing under difficult circumstances. Individuals with high levels of hope can set goals to direct their behaviour and manage challenging situations.

6.2.8.3. Exercise, nature, stress and adaptation

Another coping mechanism was exercise. Participants found it helpful to either exercise at home or by engaging in daily walks in nature. They used work as a means to focus in order to avoid thinking about COVID-19 or deal with other COVID-19-related issues. Participants ranged from those who overworked to those who, gradually, learned how to set their boundaries in order to achieve a healthier work-life balance. However, work acted as a coping mechanism to avoid thinking about COVID-19 and as a cause of stress resulted in an interlinked relationship where coping and stress were intertwined. Surprisingly, the participants who overworked knew that they had to take small breaks and understood the importance of work-life balance; however, the circumstances did not allow them to do so. Furthermore, analysis revealed that nearly all participants engaged in general activities that helped them cope, such as using online platforms (e.g., WhatsApp, Calm), online gaming (e.g., PlayStation, PC), mindfulness apps, knitting, cooking, gardening and drawing. Interestingly, during the pandemic, participants identified key skills they had but never developed, and COVID-19 gave them the time to discover them.

This is in line with research suggesting that exercise is beneficial in order to achieve a stable psycho-physical wellbeing amongst healthcare professionals (Cocchiara et al., 2019). Participants also used nature (e.g., sea, walking in the fields, gardening, camping) as a means of coping since it gave them the inner peace they needed.

Nature is positively linked with maintaining positive mental health when facing difficult situations (e.g., the COVID-19 pandemic) as well as promoting psychological resilience (Tomasso et al., 2021). Barnes et al. (2019) suggested that spending time outdoors is a key factor that helped people cope with stress and anxiety, such as during the COVID-19 pandemic. Specifically, visiting parks and green spaces supported individuals to cope better with feelings of stress and isolation (Barnes, et al., 2019), and spending time in nature is found to have significant positive results for both mental and physical health (Bratman, et al., 2019). Cox et al. (2017) suggested that the quality of interaction within nature positively contributes to an individual's overall wellbeing, and individuals who are more connected to nature are found to be happier and more likely to self-report their life as meaningful. Being connected to nature instils individuals with feelings of joy, calmness, and creativity. Additionally, this connection promotes better mental health by reducing depressive symptomatology and anxiety levels (Vujcic, et al., 2017). Hansen et al. (2017) suggested that spending time in nature has a positive impact on the overall emotional wellbeing and cognitive function of depressive students, and White et al. (2019) compared individuals spending different amounts of time in nature, suggesting that spending 120 minutes per week resulted in a higher rate of self-reporting positive health and wellbeing. Being connected to nature, and particularly green and blue spaces, has been linked to a variety of health benefits, including improved cardiovascular and respiratory health, decreased psychopathology (e.g., eczema) and overall better psychological wellbeing (Wendelboe-Nelson, et al., 2019). The current findings are in line with previous research associating recreational activities with positive stress and mental health outcomes (Kerr, Dattilo & O'Sullivan, 2012).

6.2.9. Emotions, behaviours and detachment

The initial emotions and behaviours arising from the COVID-19 pandemic included difficulty adjusting, anxiety, caring for others and finding stability at work with the results indicating that social distancing and detachment measures (as described in Chapter 2) were fundamentally challenging for support workers. Individuals were able to satisfy their need for relatedness when they had face-to-face interactions and occasionally interactions with the use of technology (e.g., Facebook Messenger, Viber, WhatsApp)

Humans need to socialise to maintain their psychological, emotional and physical wellbeing (Holt-Lunstad et al., 2015) and therefore it created a need for family, friends and colleagues to explore new ways of communicating. The above is in line with core notions of self-determination theory and basic psychological need satisfaction: autonomy (sense of making a choice), competence (changes in desired situations) and relatedness (feeling accepted from one's social circle; Ntoumanis, 2020).

The core element of self-determination theory (SDT) is to explain how people are motivated to act, if they believe that their actions will have an impact on the desired outcome. Even though the need to maintain an action is born (e.g., in order to achieve an outcome), SDT suggests that this needs ongoing work from the individual in order to be sustainable (Ryan & Deci, 2017). Human interaction is affected to a great extent by the social environment one is exposed to, leading to personal growth and certain actions that would lead to the expected outcomes. During COVID-19, SDT was explored in relation to human connections and autonomy, and Schwinger et al. (2020) investigated the psychological impact of lockdown during the pandemic in Germany, exploring any changes in need satisfaction, wellbeing, anxiety and depression. Results indicated that individuals had lower psychological wellbeing, and that the restrictions affected the individual's ability to relate and socialise with others whilst affecting the perceived control of their own lives.

Studies such as Entwistle et al. (2010) and Catharina-Lindberg et al. (2014) argued that the ability to support patients to take control of their own health comes from recognising the patient's role in their own healthcare decision-making. This way healthcare professionals (e.g., nurses, support workers) can assist a patient into making progress and moving towards recovery.

Tsoy et al. (2021) suggested that aiming for autonomous goals (e.g., 'I want to be well') resulted in greater satisfaction and improved wellbeing in contrast to controlled goals (e.g., 'you need to socialise more with people'), which had a negative outcome (e.g., lack of motivation, effecting wellbeing). Additionally, being motivated affected happiness and job attitudes. However, a recent repeated survey assessment conducted by Dimmock et al. (2022) explored the relationship between social interactions and basic psychological needs and wellbeing during the COVID-19 pandemic with data collected over four months and across six different time points. The sample comprised 127 students with 483 assessments, and the results indicated that wellbeing was associated with satisfaction from within the self and by comparison to healthy 'others'.

6.2.10. Support from and towards colleagues

The current study identified that during the beginning of the pandemic, the job-related demands were higher since safeguarding the lives of vulnerable groups was the primary aim. This in turn led the support workers to experience high self-reported anxiety levels related to work.

Throughout the pandemic, support workers gave their support to service users and gave and received support from colleagues. A distinction between collective responsibility (e.g., maintaining clear areas within the services) and personal responsibility (e.g., practising good hand hygiene) was identified, demonstrating that both were needed in order to safeguard service users and the support workers themselves when working within care services. Furthermore, support workers took extra shifts in order to cover for colleagues who either had to self-isolate or could not do more shifts due to mental health matters. It has become clear that support workers performed their duties at service users' homes in an un-secured environment, which was in contrast to hospital staff that worked in a more structured environment with longstanding policies and procedures.

The difference lies within the concept of the general health provision in the UK, which fundamentally opens a discussion about the approach society takes to public care (e.g., NHS) and social care (e.g., schemes: care homes, supported living, domiciliary care). Even though healthcare is far from perfect, competition can be indeed beneficial within the sector. Due to competition, private providers optimise efficiency whilst public providers focus on the administrative and political stresses. Alonso et al. (2015) argued that the public healthcare sector is not under any competitive pressure, and therefore the resources are up to management and the overall direction of the NHS and down to the Ministry of Health. Private care, on the other hand, relies heavily on care funding and has to drop their prices in order to become competitive.

6.2.11. Care, interest of others for their wellbeing

A significant finding was the impact of the interest others expressed or lack thereof for the wellbeing of support workers. Significant others were identified as colleagues, the work organisation, direct managers and general practitioners, and supporting or receiving support from colleagues resulted in higher levels of trust, which led to deeper bonding.

When it came to organisational support, there was a clear lack of supporting procedures, particularly during the beginning of the pandemic, with a common focus on the absence of human resources (HR) involvement. When asked what kind of support they would have liked to receive, participants described some general support: for example, in a form of a thank you letter. In contrast, all participants described how they felt completely supported by their managers and that they had received the direction needed during the pandemic. The difference was identified in the presence of management as well as guidance from the manager, even though a structured procedure was not available at the time for the whole organisation. Support workers that described how management did not handle cases properly (e.g., giving clear instructions on handling a COVID-19 case) also described that after raising their concerns, management changed the information-sharing methods and potential problems were averted. One would raise the question that if they were receiving adequate support from management, why did they seek the support from the general organisation as described above? To answer this, we need to explore the emotional needs of the individuals, since the support-seeking behaviour derived from the fact that (1) they wanted their immediate network (e.g., line manager, colleagues) to know of their work, but also (2) the wider organisational network (e.g., HR, operations managers, managing directors). This was their way of seeking appreciation from the work organisation in general since support workers feel constantly unappreciated (Nyashanu, Pfende & Ekpenyong, 2020a; 2020b).

6.2.12. Information sharing amongst different bodies

Additionally, another major finding was that information was not shared fast enough amongst the different social bodies (e.g., the ministry to local authorities to the NHS) and within the organisations (e.g., board-level decisions reaching down front-line staff members).

From the government (Department of Health) to NICE, the NHS or within the individual companies, a lot of information was changing constantly because of the nature of the virus and the fact that the Western world had no prior experience of this. Additionally, a lot of information coming from the media affected the perception of staff members about the virus (e.g., coughing means you have the virus, vaccines are ordered from multimillion companies to controls us). This is in line with Wang et al.'s (2019) findings that identified trends of misinformation during pandemics (e.g., Ebola, Zika virus) and around vaccination.

6.2.13. An overview of resilience, emotional transformation and agency

Resilience during the COVID-19 pandemic was crucial in order to support mental wellness and ensure healthcare staff were providing good quality care. Evidence provided by a systematic review by Delgado et al. (2017) suggested that resilience is a significant intervention that can be used to address emotional burnout, which is in line with the findings of the current study, where support workers had to show a high degree of resilience in order to be able to continue to work. Furthermore, Labrague (2020) suggested that healthcare workers experienced moderate to high levels of resilience when managing stress during the pandemic, primarily by utilising various coping mechanisms. The concept of emotional labour, the process by which one is managing their emotions within a professional setting, was the cause of significant stressors. Resilience acts as a protective factor against the potential harmful effects of such stressors including burnout and depletion of emotional resources (Delgado et al., 2017; Delgado et al., 2020). It is quite important to emphasise that support workers kept building and maintaining their resilience for one another, in a way recycling the emotion so that they could carry on.

Emotional intelligence is necessary for healthcare professionals, as it allows one to care for their patients and manage stressors. Different practices that are based on emotional intelligence (e.g., mindfulness) lead to less exhaustion and better emotional regulation (Nightingale et al., 2018; Jimenez-Picon et al., 2021). The emotional transformation support workers had to go through during the COVID-19 pandemic conflicted with the level of emotional intelligence they had developed up to that point. On the one hand, they cared for the service users and they wanted to provide good quality care, including keeping them alive. At the same time, they wanted to protect themselves, but in order to do so, they would have had to reduce the quality of care they provided to service users. The results showed that this did not happen, and support workers went above and beyond to support service users, often at the potential expense of their own health.

When one makes actions, the outcomes of those actions are not based on luck but rather primarily on one's decision, given that one is in charge of those actions. The sense of agency refers to this emotion/feeling of one driving a course of action (Moore, 2016). The current study showed that support workers took various actions and decisions, not only for the service users they supported but also for their own lives. They had significant agency over the choices they made; something that was intensified by the COVID-19 pandemic, fear of contracting the virus and, in most cases, the conscious willingness to self-sacrifice to support both users and colleagues. Musto et al. (2021) argued that healthcare professionals in acute care mental health settings show significant moral agency by choosing to become vulnerable themselves, balancing professional obligations, professional expertise and the organisational process in order to maintain ethical practice and provide good quality care.

6.2.14. Strengths and limitations of the qualitative study

One of the most important strengths of this study is the fact that it was very timely. Not only does it examine the lived experiences of an underrepresented group, but it also examines the said experiences during a pandemic. I believe that this is a unique point of this study as it is very difficult to capture experiences during a disaster, as explained in section 2.5 - The disaster effect. Additionally, the staff interviewed working for the organisation were located throughout England, reflecting not only what happened in the company but also their role in a wider societal group. The staff were recruited specifically for their experiences as according to my experience, they would represent many of the support workers' working conditions within the sector.

Furthermore, reflexivity took place, not only in the form of verbal feedback from experienced researchers but also through introducing the Yardley criteria to support and shape the context, rigour and transparency of the study.

Another strength of the study is that, after analysing a very small portion of data with both IPA and RTA lenses as a form of exercise, I was getting similar results (see Appendix 13). Getting similar results validated my belief that the core coding and the essence of the support worker's experiences would not be lost.

Additionally, the study raises awareness on the lived experiences of support workers during the COVID-19 pandemic in England, as it is the first of its kind in clearly separating support workers from other healthcare professionals.

Furthermore, I believe that making a clear distinction between data saturation and information power, as well as using the second technique (refer to section 4.2.2.7 and see Figure 3) to inform the sample size, gave the study a novelty strength as it follows a different, yet more appropriate, approach to reflexive thematic analysis.

Information power: Study aim

The interviews undertaken were based on the lived experiences of support workers in England working in the care sector. Additionally, these experiences were explored during a pandemic (COVID-19) and when all the government restrictions were in place, which offered a unique situation as the experiences would be explored while still raw and un-processed, which would therefore enhance their 'uniqueness'.

Figure 4 Information power

Criterion	**Present study**	**Rating**
Study aim	Narrow	Higher information power
Sample specificity	Dense	Medium to high information power
Use of established theory	Applied; researcher with limited experience	Medium to high information power

Quality of dialogue	Strong	Higher information power
Analysis strategy	Multiple cases	Higher information power
Information power = Medium to high		

Information power: Sample specificity

Target participants for this study were support workers working in a private care company in England, who were recruited for their specificity and targeted for their knowledge. However, two factors that affected the information power of this sample would be that (1) no participants were invited as support workers working for another private company, charity or NHS trust, and (2) the sample was recruited from England as Scotland, Wales and Northern Ireland have different regulatory bodies and not the CQC (Care Inspectorate, Care Inspectorate Wales, Regulation and Quality Improvement Authority (RQIA), respectively). However, participants were narrowed down to a very specific sample (support workers, care company, England).

Information power: Use of established theory

According to the concept of information power, a smaller sample size is required if there is an established theory to support the research in exploring and building on the findings. The current study used transcendental (descriptive) phenomenology to build on this study, referring to Husserl's work that asserts that reality is fundamentally internal to the individual and that the researcher has to consider the experiences from different perspectives. However, information power also suggests that the less experienced the researcher is, the larger the sample size required.

Information: Power of dialogue

The majority of participants opened up quite quickly and it really helped that they wanted to share their experiences. I explained my background, both as a student and a professional, explaining what the purpose of this research was and what I hoped it would achieve. At the end, participants were asked if they wanted to add anything to the conversation that they had not covered so that I could give them the opportunity to express/raise something that they found important but had not been included as part of the research questions. There were only two interviews that were slightly different from the others. The first one was with a participant who did not really engage as strongly as the others but still revealed quite a lot of information, and the second one was with a participant who was struggling a lot and, during the interview, felt he had the opportunity to offload his emotions (e.g., cry, yell). After the second interview, I clarified that this interview was not in any way, shape or form a therapeutic space and advised him to seek support from management and counselling services and check the debrief form that I would send with various resources around mental health.

Information power: Analysis strategy

Analysis strategy focuses where the study is interested in participants' experiences across cases (multiple participants) or a case study (one case analysed in greater depth). For the current study, a cross case approach was necessary as experiences were gathered from multiple participants, therefore requiring a higher sample size.

One limitation of the study is related to its sampling technique. Even though purposive sampling is a commonly used sampling technique in qualitative research, it can lead to limited external validity (Andrade, 2020) and selection bias (Tongco, 2007; Sharma, 2017; Obilor, 2023), and thus the participants recruited might have a specific perspective regarding the research question under consideration. Even though, purposive sampling allows researchers to select participants based on specific criteria relevant to the research question, and it is in line with the phenomenology's ways of sampling that potential limitations may exist. For instance, in this study, the selection of support workers occurred without gathering additional information (results primarily related to the meta-ethnography that were known to be impact factors such as pay, company policy, communication etc.). This information was affected by my subjective opinion as researcher on the definition of support workers itself within the said company, based on both my experience and knowledge. Therefore, purposive sampling possibly limited the transferability of the findings of the research study.

Another limitation of the study was that the participants selected were from a single organisation, therefore making it difficult when it comes to transferability of their experiences. Furthermore, given that the current project was part of a Professional Doctorate, I had to act primarily alone making it difficult to cross-reference or engage in different thematic meanings, apart from the various samples sent to the supervision team.

Framework proposal

As care organisations dealt with rapid adaptations to new protocols and guidelines during COVID-19, a potential solution to their stressful environment might include a framework that allowed effective debriefing and communication; therefore, I proposed the below protocol as a way of providing an extra tool to both supervisors and supervisees during pandemics by providing specific topics of discussion as well as overall conversation flow. Even though this theoretical protocol proposal was developed during COVID-19, a lot of similarities (see Table 14) can be traced with other pandemics (Lehmann et al., 2015; Xiong et al., 2020; Dutta et al., 2021; Magnavita et al., 2021; British Medical Association, 2022), potentially making the protocol a transferable tool.

Table 14 Similarities between infectious diseases

Feature	COVID-19	SARS	MERS	EBOLA
PPE	N95 respirators, gowns, gloves, eye protection	Similar to COVID-19	Similar to COVID-19	Full body suits, multiple layers of gloves
Stigma	Widespread, due to asymptomatic spread and fear of unknown	Significant due to limited knowledge and severity of infection	Moderate	Severe, due to high numbers of mortality and limited understanding of the virus
Workload	High volume of patients with various symptoms	High but lower volumes than COVID-19	Moderate	Moderate but primarily focused in areas that infection was prevalent
Mental Health	Long hours, uncertainty, high mortality rate	High due to fear of unknown	Moderate	High, due to witnessing severe illness and limited resources
Burnout Syndrome	Yes – still forming data	Yes	Yes	Yes (but not included in the final results)

6.3. A proposed supervisory protocol for support workers

Taking into consideration the findings of the current study, I propose a theoretical tool for the supervision of support workers that may bridge the communication and support gaps between the line managers and the support workers. Additionally, taking into consideration the importance of documentation and its significance within the sector, as discussed in section 1.3, the proposed tool would potentially strengthen the team and provide additional resources that could act as evidence. Supervision in health and social care is when a line manager (e.g., team leader, registered manager) has a dyadic communication with a member of staff, and these structured meetings can either be of a generic or specific nature addressing matters around workload (e.g., working hours, care plans, risk assessment, behavioural incidents), work wellbeing (e.g., anxiety, pressure), shared information flow (e.g., updates on new policies, communication around contracts) or set key performance indicators (KPIs; e.g., completing training, updating support plans, no missing signatures on the medication administration record (MAR sheet)). Supervision is mandatory for regulated providers as set out by the Health and Social Care Act 2008, and for support workers it comprises a combination of management and clinical supervision.

In order to develop the protocol, I used Kolb's reflective learning cycle adjusted to the current needs of my research in order to reach 'active experimentation'. The four distinct stages are (a) concrete experience, (b) reflective observation, (c) abstract conceptualisation and (d) active experimentation (Murrell and Claxton, 1987; Morris, 2019). Concrete experience is experiencing anything new or unusual and, in this case, I had to process both studies after finishing them as this was my first time conducting research on this level. Reflective observation is when one reflects on the said experience, observes themselves and evaluates the process of approaching the said experience. In this case, I was reflecting on my journey and what I learned from the research and trying to identify the outcomes. Abstract conceptualisation is when one is starting to build a mental picture of what they experienced (that is based on the reflection of the previous stage), and it allows one to see the bigger picture. In this instance, I was able to see which area of the meta-ethnography and qualitative study could be used for an actionable outcome. Lastly, active experimentation is when one tests their ideas by actively experimenting (Murrell and Claxton; 1987; Morris, 2019). At this stage, I was able to formulate the PSP.

This PSP was informed organically as part of the-meta ethnography and the qualitative study but brought together by my professional research experience (see sample example Figure 4). After I finalised the qualitative study, I revisited the meta-ethnography to identify potential connections, and as a result of my research background, I was able to start 'seeing' a pattern. For example, a marginalised profession, the impact of work and the level of support and guidance would be topics routinely addressed during supervision sessions. Similarly, from the qualitative research, the professional and personal challenges faced by the support workers alongside their coping strategies would also be typically explored during supervision. 'Seeing' the data through my professional lenses, I was able to formulate some questions using the research but also using my experience as a catalyst. I was then able to ask a few questions that formulated the PSP. How do support workers feel if they are marginalised? How does this affect their work? Do they receive enough or any support from family, friends and management? How do they cope? What are the dynamics between work and life? Is it possible to establish clear pathways of support since this will be able to help them further? The above formulated the PSP in turn by (for example) combining the marginalised profession, how they felt, the effect of work and how they coped into the support workers' 'current feelings'. For a detailed mapping of which aspect of study and/or experience formulated the five (5) PSP topics, see Figure 4.

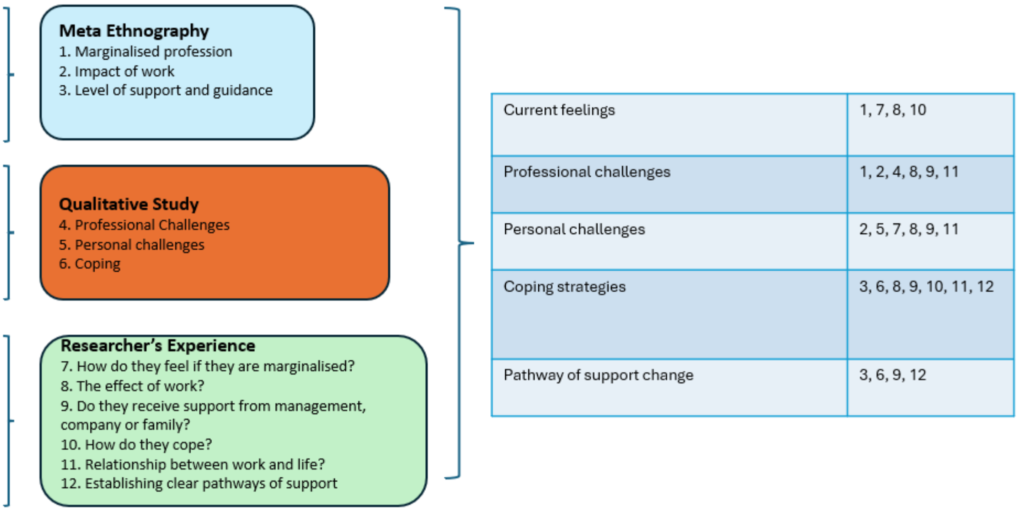
My experience within the NHS and private care companies allowed me to bring together the above evidence and reflect on service needs (e.g., supported living schemes), what was missing and what could be done. Having worked as a registered manager and knowing the fast-paced environment as well as the necessity of supervision guidance, I proposed the PSP. Moreover, the PSP also came into fruition as an idea because of a major observation I made during COVID-19 whilst I was employed, which was that services did not have the capacity to perform supervisions or follow the supervisory protocols properly, mainly because of the workload, lack of resources and complications around shifts.

6.3.1 What does it do?

What I suggested regarding this PSP was that supervisors can focus on five (5) distinct areas that form the focus on work wellbeing and are directly linked to work outcomes. The main areas are current feelings, professional challenges, personal challenges, coping strategies and pathways of support or change.

What I proposed with this PSP was that supervisors can focus and direct the conversation only on the above areas so that they can do a fast-track supervision while exploring the core issues faced (see Appendix 14). The above areas may initially seem quite open and vast; however, they provide a direct pathway and structure for a conversation. They are open enough to start a conversation but direct enough to focus on specific issues.

Figure 5 Building protocol: (1) based on meta-ethnography, qualitative study, experience, and (2) mapped sections of the protocol



Current feelings	1, 7, 8, 10
Professional challenges	1, 2, 4, 8, 9, 11
Personal challenges	2, 5, 7, 8, 9, 11
Coping strategies	3, 6, 8, 9, 10, 11, 12
Pathway of support change	3, 6, 9, 12

This addresses two core issues during an emergency like the COVID-19 pandemic. Firstly, it addresses the issue of time when services are overwhelmed, and staff supervisions are not conducted, and secondly, it provides a template for a brief but meaningful conversation with clear outcomes.

This pandemic support workers' PSP aims at complementing and improving the normal supervisory meetings by supporting management teams to explore the core areas identified as having an impact on the support workers' lives during a pandemic, based on the findings of the previous studies and my own field experience.

As a way of asking feedback on the PSP, I approached a different care provider to provide some initial feedback on the PSP.

6.3.2. Feedback for the PSP

The PSP received an amendment's approval from the University of Central Lancashire Health Ethics Review Panel (Ref: HEALTH0194 Amendment) (see Appendix 16) to allow it to be distributed it within a care organisation. The care organisation that provided feedback was different from the care organisation in which the qualitative study took place. Initially, I created a simple questionnaire asking five (5) questions on a Likert scale rating 1=strongly disagree to 5=strongly agree and a sixth question for written feedback (see Appendix 17). I then e-mailed the managing director of the new care company with the request to distribute the questionnaire to her team members that conduct supervision, and I received five (5) replies from the team (see Figure 5).

All responses were mostly positive for all five (5) questions, but it is important to note that none out of the five responders had received any guidance on how to perform supervision from their current or previous employer. The written feedback received was promising, and it gave me a better understanding of the potential next steps for further research/improvement. For example, Respondent 1 mentioned that the PSP did not add any topics that they would not discuss anyway with their team members; however, they acknowledged that it provided them with a template of what to discuss. Respondent 2 mentioned that, as they did not receive any training, they could use this template to maintain a discussion without having to deal with ‘awkward moments of silence’. Respondent 4 mentioned that it would have been helpful to include more information, in particular on how to perform supervision and how to deal with different responses. As this was a very early stage for testing the feasibility, implementation or use of the PSP, this was something that I may continue to investigate in post-doctoral study.

6.4. What is new?

This thesis was able to establish a more concrete structure for the role of support worker via explaining the job description and what was expected from them. Additionally, the lived experiences from the qualitative study were unique because this was the first and only study qualitatively exploring the lived experiences of support workers in the UK during the pandemic and while all the restrictions were in place. The emotions, thoughts and feelings were the closest representation we could get during a pandemic, and the findings of the

Figure 6 Replies from the protocol questionnaire

	Participant 1	**Participant 2**	**Participant 3**	**Participant 4**	**Participant 5**
I have received training on how to perform supervision (either from current employer or in the past)	Strongly Disagree	Strongly disagree	Strongly disagree	Strongly disagree	Strongly disagree
The current protocol is providing a helpful structure on the topics I need to discuss.	Agree	Strongly agree	Strongly agree	Agree	Strongly agree
Following the pathway presented is easier for me to discuss what I need to discuss. (Please consider this only based on the structure of the protocol since you have not used it)	Neither agree or disagree	Strongly agree	Strongly agree	Agree	Strongly agree
Overall, I find the protocol useful in times of a pandemic since it gives me the relevant pathway.	Neither agree or disagree	Strongly agree	Strongly agree	Agree	Strongly agree
I feel I can focus on the content of the conversation since the protocol provides me the structure	Agree	Strongly agree	Strongly agree	Agree	Strongly agree
Any additional feedback (feedback on usability, how well (or not) it can be integrated into current practice, whether it highlights new issues that would not otherwise be asked in the supervision etc.)	Overall good, but nothing I wouldn't discuss with my team at some point. Yes, it provides structure better than our current template and you know what do discuss next.	Never received training, so I picked up how to do supervision naturally. Very good template to use. I can focus on the discussion rather than awkward silence moments.	Very good	It's ok. I can see myself using it. I would have liked to read more about supervision how it's done, how to deal with different responses etc.	Nice guidance. I would like to use it if I get the chance.

qualitative research explicitly demonstrate that support workers were mentally and physically stressed during COVID-19 and there was minimal support available to these workers at that time. The study raised the voice of the support workers during the COVID-19 pandemic as generally support workers do not receive robust attention and therefore are often neglected. As support workers are an important part of the UK healthcare system, it is imperative to support them and highlight their needs. The current study was the first that highlighted the unmet needs of support workers during the COVID-19 pandemic and created a clear separation between healthcare professionals (e.g., doctors, nurses, physiotherapist, psychologists) and healthcare support workers.

The current study proposes a model of supervision specifically tailored to support workers and their needs. Currently, there is no supervision model that covers these needs apart from the one presented in this thesis, and therefore this PSP has the potential for scale-up. Though the proposed PSP was specifically designed for pandemic situations, it has the potential to be adapted for non-pandemic scenarios.

One unexpected finding was from the feedback from individuals that participated in the PSP, who stated that they had not received any training on how to do a supervision. Considering that this was the first time this came up during the thesis as a whole, this needs further investigation, as that may be an organisational issue rather than a sector one. Furthermore, this feedback on its own is a crucial piece of information for improving upon the PSP by, for example, creating a training guide for supervisors. Additionally, as no training in supervision is given, the topics discussed within the PSP may be potentially appropriate for circumstances outside of an outbreak of an infectious disease. However, this claim needs deeper exploration as this is something that came up from five participants from a single organisation.

6.5. Strengths and limitations of the current thesis

The thesis has strengths as well as limitations. As far as strengths are concerned, the present thesis contributed to the scarce research on support workers, conducting a meta-ethnography of existing literature as well as qualitative research and adding new insights into support workers' experiences during the COVID pandemic.

Their voices, perceptions, struggles and experiences were given the opportunity to be expressed, shedding more light on what seems to be an ‘invisible’ profession. It gives a valuable first-hand account of support workers’ emotions, thoughts and feelings as well as highlighting a critical issue.

Furthermore, the current thesis raises awareness of the mental and physical stressors experienced by support workers as well as various coping strategies. The research is one of its kind as it was very timely; it took place during a pandemic and took into consideration the social isolation, lockdown and overall government restrictions. Additionally, I was able to discuss and incorporate part of my thinking and emotional process into the steps I took during my personal reflection and diary notes, resulting in an in-depth journey into the process of the researcher.

One limitation of the current study is that the sample was gathered only from one specific organisation in the UK. For this reason, transferability of the findings of the current study to other settings is questionable. Even though all care companies need to follow the regulations set out by the CQC, it would be beneficial to see the differences between organisations and compare them in relation to preparedness, support and pay.

Moreover, another potential limitation is represented by the lack of methodological triangulation, as introducing document analysis (e.g., note-taking process) could strengthen the overall research.

Additionally, further exploration of the care organisations would be needed to provide for a more holistic understanding of the support worker’s experiences. For example, it would be beneficial to explore different organisations in terms of pay, structure, benefits, support, preparedness etc and then conduct a similar study to explore the lived experiences taking into consideration a multifaceted approach.

Another limitation is that I was unable to assess the feasibility and effectiveness of the PSP; therefore, I might not be able to recommend its implementation in practice until and unless its feasibility and effectiveness were established.

Furthermore, the PSP was developed for the COVID-19 pandemic situation and therefore it might need significant changes in non-pandemic or other pandemic events. Lastly, the proposed intervention focused on the work environment and work-related stressors and did not consider family and other related factors, which again highlights the need for further refinement of the PSP .

Furthermore, there are limitations regarding resources and time that apply on account of being a single researcher. For example, with a multi-language team, the meta-ethnographic review could have been explored in different ways, but this was not possible due to the nature of the current project (e.g., Professional Doctorate).

6.6. Conclusion

This thesis set out to explore the lived experiences of support workers during the COVID-19 pandemic and to propose a protocol-intervention that would potentially help them. More specifically, the thesis contributed to the overall knowledge of the profession of support workers, including their job descriptions and roles, via a meta-ethnographic review. This was followed by interviewing support workers during the COVID-19 pandemic. Using a reflexive thematic methodological approach, this research identified that that the support workers did not feel supported throughout the COVID-19 pandemic by their work organisation in the emotional and practical domains. They all had pre-developed coping mechanisms with the exception of a few that developed new skills during the pandemic to cope. Furthermore, establishing an effective method of clear communication is key for dealing with pandemics as well as maintaining open channels that would allow for important changes to take place, given that new data is received on a daily or even hourly basis. During the interviews, participants shared their experiences of the dynamics between the work and personal domains and explained their journey whilst the pandemic was ongoing.

As a result, this research has highlighted the stories and a way that to address and contribute to our understanding of support workers experiences by proposing a PSP that could add value to organisational supervision. However, this needs further and deeper exploration prior to being implemented. The PSP might provide the way forward for optimal supervision of support workers during pandemic conditions; however, there is a need to assess the feasibility and effectiveness of the PSP before its implementation in real-world practices. The PSP might provide the opportunity for effective internal communication and thus might enhance working performance of the support workers.

Overall Reflection

As I am writing this last piece of the thesis, I realise the importance of my journey and where it has led me. The project as a whole started from an idea, from a conceptual perspective, and in a way, from my need to understand more about support workers. One may ask why. I believe the reason or my 'why' was that I did not know anything about this profession prior to starting my job at the care company. This is when I was meeting all these individuals, and all had very similar stories about their roles: no pay; the job is hard; we cannot find something else; we are not just support workers. It took me a long time to realise my company's terminology as they used different job titles but for the same post, depending on the location. This started mu journey towards applying for my Professional Doctorate.

I still remember when I had to present my research proposal to the UCLAN team, and I still remember the excitement I felt. From that point until I established a robust proposal, it took at least a year. The professional doctorate is a two-year programme, but my journey lasted for three years plus an extra year to make the appropriate changes to improve on the thesis.

When the time came, and I had the skeleton ready, it was time to take the first step for my research, which was the meta-ethnography. It was not a popular method within the School of Medicine and yet, I was able, with the guidance I received, to start this journey and make it happen. It was fascinating as I had to structure everything in such a way that someone could replicate it. In fact, that was one of the aims when I was writing it, and I always had in mind two readers: first, the ones who are not from academic background and may have found it useful; and the other, researchers. I had to keep in mind all of the above whilst conducting the meta-ethnography, but I believe that at some point, I got lost. When someone creates a theory, you can follow the said steps, but how can you be certain that it is based on their steps the way they understood it in the first place? I was always trying to maintain authenticity throughout this thesis. After all, this is a project that could, and did, help me in my professional life.

While conducting my main study, I was able to dive into the role of support worker and further my knowledge of their experiences. This in turn helped me to bring back the knowledge from my Professional Doctorate training, not only to my organisation but also other care providers that faced challenges that I had already familiarised myself with (e.g., not feeling appreciated, communication issues), allowing me to advise and formulate plans with them to resolve the issues they faced. The Professional Doctorate contributed to me working as a healthcare consultant and develop a long-lasting partnership with a private care organisation. It was in that organisation that I was able to distribute the PSP and receive feedback. It was quite a surprise when I read that nobody had received training on how to do a supervision, and the fact that it had not come up anywhere else until now was important, given how difficult the job is and how important supervision may be for the staff members. Overall, I believe that every part of the Professional Doctorate led me to experience different emotions, gave me different opportunities and enhanced my career prospects greatly.

I believe the Professional Doctorate taught me how to be specific, how to search about how to approach research methodologies (e.g., IPA, RTA) and new concepts (effect of pandemics) and how to present them to a wider audience (e.g., publications). It also provided me with the confidence to question and improve my work practices (e.g., burnout) and to follow best research practices (e.g., Yardley criteria) in order to inform my own approach/research. Last but not least, I believe it gave me the clarity that even though I had read a lot about an issue/topic, knowledge is constantly evolving and shared, and therefore my journey just begins rather than ends. I understand that this may sound like a cliché; however, I genuinely believe that the journey starts now that I have built the foundations.

6. REFERENCES

Adult Social Care Practitioner Guidelines (2011) ‘The Royal Borough of Kensington and Chelsea’. Available at: https://www.rbkc.gov.uk/pdf/Practitioner%20guidelines%20PDF%20Section%20101.pdf (Accessed: 14 December 2022).

Agee, J. (2009) ‘Developing qualitative research questions: a reflective process’, international journal of qualitative studies in education, 22(4), pp. 431-447. doi: 10.1080/09518390902736512.

Aiken, L. H., Sermeus, W., Van den Heede, K., Sloane, D.., Busse, R., McKee, M., ... & Moreno-Casbas, M. T. (2012) ‘Patient safety, satisfaction, and quality of hospital care: cross-sectional surveys of nurses and patients in 12 countries in Europe and the United States’. BMJ, 344, e1717.

Alonso, J. M., Clifton, J., & Díaz-Fuentes, D. (2015) ‘Did new public management matter? An empirical analysis of the outsourcing and decentralization effects on public sector size’. Public Management Review, 17(5), 643-660.

Amaratunga, C. A., O'Sullivan, T. L., Phillips, K. P., Lemyre, L., O'Connor, E., Dow, D., & Corneil, W. (2007) ‘Ready, aye ready? Support mechanisms for healthcare workers in emergency planning: a critical gap analysis of three hospital emergency plans’. American journal of disaster medicine, 2(4), 195–210.

Ammar, A., Chtourou, H., Boukhris, O., Trabelsi, K., Masmoudi, L., Brach, M., Bouaziz, B., Bentlage, E., How, D., Ahmed, M., Mueller, P., Mueller, N., Hsouna, H., Aloui, A., Hammouda, O., Paineiras-Domingos, L. L., Braakman-Jansen, A., Wrede, C., Bastoni, S., Pernambuco, C. S., … On Behalf Of The Eclb-Covid Consortium (2020). ‘COVID-19 Home Confinement Negatively Impacts Social Participation and Life Satisfaction: A Worldwide Multicenter Study’. International journal of environmental research and public health, 17(17), 6237. https://doi.org/10.3390/ijerph17176237

Andrade, C. (2020) ‘The Inconvenient Truth About Convenience and Purposive Samples’. Indian Journal of Psychological Medicine. https://doi.org/10.1177/0253717620977000

Andrews, A., St.Aubyn, B. (2015) ‘If it’s not written down; it didn’t happen…” Journal of Community Nursing, 29, (5), pp.20-22

Anicich, E.M., Foulk, T.A., Osborne, M.R., Gale, J. and Schaerer, M. (2020) 'Getting Back to the New Normal: Autonomy Restoration During a Global Pandemic', Journal of applied psychology, 105(9), pp. 931-943. doi: 10.1037/apl0000655.

Aromataris E., Munn, Z., (Editors) (2020) ‘JBI Manual for Evidence Synthesis’. JBI, 2020. Available from https://synthesismanual.jbi.global.

Atashi, V., Abolhasani, S., & Afshari, A. (2022) ‘Health-care workers' experience of stressors and adaptation strategies for COVID-19: A qualitative research'. Journal of education and health promotion, 11, 34. https://doi.org/10.4103/jehp.jehp_314_21

Babore, A., Lombardi, L., Viceconti, M.L., Pignataro, S., Marino, V., Crudele, M., Candelori, C., Bramanti, S.M. and Trumello, C. (2020) 'Psychological effects of the COVID-2019 pandemic: Perceived stress and coping strategies among healthcare professionals', Psychiatry research, 293, pp. 113366. doi: 10.1016/j.psychres.2020.113366.

Bakker, A. B., Demerouti, E., & Burke, R. (2009) ‘Workaholism and relationship quality: A spillover-crossover perspective’. Journal of Occupational Health Psychology, 14(1), 23–33. https://doi.org/10.1037/a0013290

Bakker, A., A., Demerouti, E., Sanz-Vergel, A., I. (2014) ‘Burnout and Work Engagement: The JD-R Approach, The annual review of organisational psychology and organisational behaviour’ doi: 10.1146/annurev-orgpsych-031413-091235

Bakker, A.B., Du, D. and Derks, D. (2019) 'Major Life Events in Family Life, Work Engagement, and Performance: A Test of the Work-Home Resources Model', International journal of stress management, 26(3), pp. 238-249. doi: 10.1037/str0000108.

Bandini, J., Rollison, J., Feistel, K., Whitaker, L., Bialas, A., & Etchegaray, J. (2021) ‘Home care aide safety concerns and job challenges during the COVID-19 pandemic’. New Solutions: A Journal of Environmental & Occupational Health Policy, 30(5), 20-29. doi:10.1177/1048291120987845

Barello, S., Caruso, R., Palamenghi, L., Nania, T., Dellafiore, F., Bonetti, L.,a Silenzi, A., Marotta, C., & Graffigna, G. (2021) ‘Factors associated with emotional exhaustion in healthcare professionals involved in the COVID-19 pandemic: an application of the job demands-resources model’. International archives of occupational and environmental health, 94(8), 1751–1761. https://doi.org/10.1007/s00420-021-01669-z

Barnes, M. R., Donahue, M. L., Keeler, B. L., Shorb, C. M., Mohtadi, T. Z., & Shelby, L. J. (2019) ‘Characterizing nature and participant experience in studies of nature exposure for positive mental health: An integrative review’. Frontiers in psychology, 9, 2617.

Barnett-Page, E., & Thomas, J. (2009) ‘Methods for the synthesis of qualitative research: a critical review’. BMC Medical Research Methodology, 9(1), 59. https://doi.org/10.1186/1471-2288-9-59

Baumeister, R.F. and Leary, M.R. (1995) 'The Need to Belong', Psychological bulletin, 117(3), pp. 497-529. doi: 10.1037/0033-2909.117.3.497.

Bavel, J. J. V., Baicker, K., Boggio, P. S., Capraro, V., Cichocka, A., Cikara, M., Crockett, M. J., Crum, A. J., Douglas, K. M., Druckman, J. N., Drury, J., Dube, O., Ellemers, N., Finkel, E. J., Fowler, J. H., Gelfand, M., Han, S., Haslam, S. A., Jetten, J., … Willer, R. (2020) ‘Using social and behavioural science to support COVID-19 pandemic response'. Nature Human Behaviour, 4(5), 460–471. https://doi.org/10.1038/s41562-020-0884-z

Bender, A.E., Berg, K.A., Miller, E.K., Evans, K.E., Holmes, M.R. (2021) 'Making Sure We Are All Okay: Healthcare Workers' Strategies for Emotional Connectedness During the COVID-19 Pandemic'. Clinical Social Work Journal 49, 445–455.. doi:10.1007/s10615-020-00781-w

Benfante, A., Di Tella, M., Romeo, A., & Castelli L., (2020) 'Traumatic stress in healthcare workers during COVID-19 pandemic: A review of the immediate impact'. Frontiers in Psychology, 11, 569935. doi:10.3389/fpsyg.2020.569935

Bethel, A., & Rogers, M. (2014) 'A checklist to assess database-hosting platforms for designing and running searches for systematic reviews' *Health information and libraries journal*, 31 1, pp. 43-53. https://doi.org/10.1111/hir.12054.

Bhattacharjee, P., & Nath, S., (2022) 'A Systematic Review & Meta ethnography of the lived experiences of long COVID patients'. Available at: https://www.researchgate.net/publication/361272452_A_Systematic_Review_Metaethnography_of_the_lived_experiences_of_long_COVID_patients (Accessed 02 August 2024).

Bhatti, A. B., & Haq, A. U. (2017) 'The Pathophysiology of Perceived Social Isolation: Effects on Health and Mortality'. Cureus, 9(1), e994. https://doi.org/10.7759/cureus.994

Bielicki, J. A., Duval, X., Gobat, N., Goossens, H., Koopmans, M., Tacconelli, E., & van der Werf, S. (2020) 'Monitoring approaches for health-care workers during the COVID-19 pandemic'. *The Lancet. Infectious diseases*, *20*(10), e261–e267. https://doi.org/10.1016/S1473-3099(20)30458-8

Bilal, A., Saeed, M. A., & Yousafzai, T. (2020) 'Elderly care in the time of coronavirus: Perceptions and experiences of care home staff in pakistan'. International Journal of Geriatric Psychiatry, 35(12), 1442-1448. doi:10.1002/gps.5386

Billings, J., Ching, B. C. F., Gkofa, V., Greene, T., & Bloomfield, M. (2021) 'Experiences of frontline healthcare workers and their views about support during COVID-19 and previous pandemics: a systematic review and qualitative meta-synthesis. BMC Health Services Research', 21(1). https://doi.org/10.1186/s12913-021-06917-z

Blake, H., Bermingham, F., Johnson, G., & Tabner, A. (2020) 'Mitigating the Psychological Impact of COVID-19 on Healthcare Workers: A Digital Learning Package'. International journal of environmental research and public health, 17(9), 2997. https://doi.org/10.3390/ijerph17092997

Bonanno, G.A. (2004) 'Loss, Trauma, and Human Resilience', The American psychologist, 59(1), pp. 20-28. doi: 10.1037/0003-066X.59.1.20.

Boylorn, R., M. (2008) 'Lived Experience', in Given, L. M. (ed.) The Sage encyclopedia of qualitative research methods, Vol. 2, p489. Thousand Oaks: Sage.

Bragaru, M., C. P. van Wilgen, J. H. B. Geertzen, S. G. J. B. Ruijs, P. U. Dijkstra, et al. (2013). ‘Barriers and Facilitators of Participation in Sports: A Qualitative Study on Dutch Individuals with Lower Limb Amputation’. PLoS ONE 8 (3):e59881. doi:10.1371/journal.pone.0059881.

Brand, S.L., Thompson Coon, J., Fleming, L.E., Carroll, L., Bethel, A. and Wyatt, K. (2017) 'Whole-system approaches to improving the health and wellbeing of healthcare workers: A systematic review', PloS one, 12(12), pp. e0188418. doi: 10.1371/journal.pone.0188418.

Braquehais, M. D., Vargas-Cáceres, S., Gómez-Durán, E., Nieva, G., Valero, S., Casas, M., & Bruguera, E. (2020) ‘The impact of the COVID-19 pandemic on the mental health of healthcare professionals’. QJM: monthly journal of the Association of Physicians, hcaa207. Advance online publication. https://doi.org/10.1093/qjmed/hcaa207

Bratman, G. N., Anderson, C. B., Berman, M. G., Cochran, B., De Vries, S., Flanders, J. ... & Daily, G. C. (2019) ‘Nature and mental health: An ecosystem service perspective’. Science advances, 5(7), eaax0903. https://DOI:10.1126/sciadv.aax0903

Braun, V., & Clarke, V. (2019) ‘To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales’, Qualitative Research in Sport, Exercise and Health, DOI:10.1080/2159676X.2019.1704846

Braun, V., & Clarke, V. (2021) ‘Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches’. Counselling and Psychotherapy Research, 21(1), 37-47. https://doi.org/10.1002/capr.12360

Braun, V., & Clarke, V. (2021a) ‘Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches’. Counselling and psychotherapy research, 21(1), 37-47. https://doi.org/https://doi.org/10.1002/capr.12360

Braun, V., & Clarke, V. (2021b) ‘One size fits all? What counts as quality practice in (reflexive) thematic analysis?’ Qualitative research in psychology, 18(3), 328-352. https://doi.org/https://doi.org/10.1080/14780887.2020.1769238

Braun, V., & Clarke, V. (2022) ‘Conceptual and design thinking for thematic analysis. Qualitative Psychology, 9(1), 3. https://doi.org/https://doi.org/10.1037/qup0000196

Braun, V., & Clarke, V. (2022b) ‘Thematic analysis: A practical guide’. Sage.

Braun, V., & Clarke, V., (2019) ‘Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 11, pp. 589 - 597. https://doi.org/10.1080/2159676X.2019.1628806.

British Medical Association (2022) ‘BMA Covid Review 2. The impact of the pandemic on medical profession’. Available at: https://www.bma.org.uk/media/5620/20220141-bma-covid-review-report-2-the-impact-of-the-pandemic-on-the-medical-profession-final.pdf

(Accessed: 03 March 2024).

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002) ‘Using meta ethnography to synthesise qualitative research: a worked example’. Journal of health services research & policy, 7(4), 209–215. https://doi.org/10.1258/135581902320432732

Bruce-Barrett, C., Matlow, A., Rafman, S., & Samson, L. (2007) ‘Pandemic Influenza Planning for Children and Youth: Who's Looking Out for Our Kids?’ Healthcare Management Forum, 20(1), 20–24. https://doi.org/10.1016/s0840-4704(10)60254-2

Buljac-Samardzic, M., Doekhie, K. and Wijngaarden, J. (2020) 'Interventions to improve team effectiveness within health care: A systematic review of the past decade', Human resources for health, 18(1), pp. 2. doi: 10.1186/s12960-019-0411-3.

Busch, IM., Moretti, F., Mazzi, M., Wu, AW., & Rimondini, M. (2021) ‘What We Have Learned from Two Decades of Epidemics and Pandemics: A Systematic Review and Meta-Analysis of the Psychological Burden of Frontline Healthcare Workers’, Psychotherapy and psychosomatics, vol. 90, no. 3, pp. 178–190, viewed 11 June 2022, <https://search.ebscohost.com/login.aspx?direct=true&db=mnh&AN=33524983&site=ehost-live>.

Butler, A., Hall, H. and Copnell, B. (2016) ‘A guide to writing a qualitative systematic review protocol to enhance evidence-based practice in nursing and health care’, Worldviews on Evidence-Based Nursing, 13(3), pp. 241–249. doi: 10.1111/wvn.12134.

Census. (2021) ‘Coronavirus and key workers in the UK’. Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/coronavirusandkeyworkersintheuk/2020-05-15#health-and-social-care-was-the-most-common-key-worker-occupation-group (Accessed: 02 July 2024).

Centers for Disease Control and Prevention, (2022) ‘The National Institute for Occupational Safety and Health: Health Worker Mental Health’. Available at: https://www.cdc.gov/niosh/newsroom/feature/health-worker-mental-health.html (Accessed: 02 December 2022)

Çetinkaya, F., Dur, N., Akbulut, Z.F., & Eryalcin, O. (2019) ‘Evaluation of the Violence Experienced by Nurses of Different Generations and their Strategies for Coping with the Stress Resulting from Violence.’ Available at: https://internationaljournalofcaringsciences.org/docs/48_centicaya_original_11_3.pdf (Accessed 02 August 2024).

Chan, E. Y. Y., Gobat, N., Kim, J. H., Newnham, E. A., Huang, Z., Hung, H., Dubois, C., Hung, K. K. C., Wong, E. L. Y., & Wong, S. Y. S.. (2020) ‘Informal home care providers: the forgotten health-care workers during the COVID-19 pandemic’. The Lancet, 395(10242), 1957–1959. https://doi.org/10.1016/s0140-6736(20)31254-x

Chen, K., Lou, V. W., Tan, K. C., Wai, M. Y., & Chan, L. L. (2021) ‘Burnout and intention to leave among care workers in residential care homes in Hong Kong: Technology acceptance as a moderator’. Health & social care in the community, 29(6), 1833–1843. https://doi.org/10.1111/hsc.13294

Chersich, M. F., Gray, G., Fairlie, L., Eichbaum, Q., Mayhew, S., Allwood, B., ... & Rees, H. (2020) ‘COVID-19 in Africa: care and protection for frontline healthcare workers’. Globalization and health, 16, 1-6. Doi: https://doi.org/10.1186/s12992-020-00574-3

Chew, Q. H., Chia, F.-A., Ng, W. K., Lee, W. C. I., Tan, P. L. L., Wong, C. S., Puah, S. H., Shelat, V. G., Seah, E.-J., Huey, C. W. T., Phua, E. J., & Sim, K. (2020) ‘Perceived stress, stigma, traumatic stress levels and coping responses amongst residents in training across multiple specialties during COVID-19 pandemic—A longitudinal study’. International Journal of Environmental Research and Public Health, 17(18), 6572. https://doi.org/10.3390/ijerph17186572

Chiang, Y. M., & Chang, Y. (2012) ‘Stress, depression, and intention to leave among nurses in different medical units: implications for healthcare management/nursing practice’. Health policy (Amsterdam, Netherlands), 108(2-3), 149–157. https://doi.org/10.1016/j.healthpol.2012.08.027

Chinn, D., & Homeyard, C., (2017) ‘Easy read and accessible information for people with intellectual disabilities: Is it worth it? A meta-narrative literature review’. *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, 20, pp. 1189 - 1200. https://doi.org/10.1111/hex.12520.

Chung, B.P.M., Wong, T.K.S., Suen, E.S.B. and Chung, J.W.Y. (2005) 'SARS: caring for patients in Hong Kong', Journal of Clinical Nursing, 14(4), pp. 510-517.

Cocchiara, R. A., Peruzzo, M., Mannocci, A., Ottolenghi, L., Villari, P., Polimeni, A., Guerra, F., & La Torre, G. (2019) ‘The Use of Yoga to Manage Stress and Burnout in Healthcare Workers: A Systematic Review’. Journal of clinical medicine, 8(3), 284. https://doi.org/10.3390/jcm8030284

Constantinou, C. S., M. Georgiou, and M. Perdikogianni. (2017) ‘A Comparative Method for Themes Saturation (Comets) in Qualitative Research.’ Qualitative Research 17 (5): 571–588. doi:10.1177/1468794116686650.

Cooke, A., Smith, D., & Booth, A. (2012) ‘Beyond PICO: The SPIDER Tool for Qualitative Evidence Synthesis’. Qualitative Health Research, 22(10), 1435-1443. https://doi.org/10.1177/1049732312452938

Costello, H., Walsh, S., Cooper, C. and Livingston, G. (2019) 'A systematic review and meta-analysis of the prevalence and associations of stress and burnout among staff in long-term care facilities for people with dementia', International psychogeriatrics, 31(8), pp. 1203-1216. doi: 10.1017/S1041610218001606.

Cox, D. T., Shanahan, D. F., Hudson, H. L., Plummer, K. E., Siriwardena, G. M., Fuller, R. A., & Gaston, K. J. (2017) ‘Doses of neighbourhood nature: the benefits for mental health of living with nature’. BioScience, 67(2), 147-155. https://doi.org/10.1093/biosci/biw173

CQC (2022a) ‘About us’. Available at: https://www.cqc.org.uk/about-us (Accessed: 14 December 2022).

CQC (2022b) ‘Requirements relating to registered managers. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 7’. Available at: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-7-requirements-relating-registered-managers (Accessed: 14 December 2022).

Creswell, J. W. (2014) ‘Research Design: Qualitative, Quantitative and Mixed Methods Approaches’ (4th ed.). Thousand Oaks, CA: Sage.

Critical Appraisal Skills Programme (2023) ‘CASP Qualitative Studies Checklist’. [online] Available at: https://casp-uk.net/casp-tools-checklists/ (Accessed: 18 March 2024).

Cuthbertson, L., Robb, Y., & Blair, S. (2020) ‘Theory and application of research principles and philosophical underpinning for a study utilising interpretative phenomenological analysis’. Radiography, 26(2),e94-e102. https://doi.org/https://doi.org/10.1016/j.radi.2019.11.092

Czuba, K. J., Kayes, N. M., & McPherson, K. M. (2019) ‘Support workers' experiences of work stress in long-term care settings: A qualitative study’ Available at: https://search.ebscohost.com/login.aspx?direct=true&db=edb&AN=140354724&site=eds-live (Accessed: 02 December 2022).

DeJean, D., Giacomini, M., Vanstone, M., & Brundisini, F. (2013) ‘Patient experiences of depression and anxiety with chronic disease: a systematic review and qualitative meta-synthesis’. Ontario health technology assessment series, 13(16), 1–33.

Delgado, C., Roche, M., Fethney, J., & Foster, K. (2020) ‘Workplace resilience and emotional labour of Australian mental health nurses: Results of a national survey’.. *International journal of mental health nursing*. https://doi.org/10.1111/inm.12598.

Delgado, C., Upton, D., Ranse, K., Furness, T., & Foster, K. (2017) ‘Nurses’ resilience and the emotional labour of nursing work: An integrative review of empirical literature’. International journal of nursing studies, 70, 71-88.

Depraetere, J., Vandeviver, C., Keygnaert, I., & Beken, T. V.. (2021) ‘The critical interpretive synthesis: an assessment of reporting practices’. International Journal of Social Research Methodology, 24(6), 669–689. https://doi.org/10.1080/13645579.2020.1799637

Dimmock, J., Krause, A. E., Rebar, A., & Jackson, B. (2022) ‘Relationships between social interactions, basic psychological needs, and wellbeing during the COVID-19 pandemic'. Psychology & Health, 37(4), 457–469. https://doi.org/10.1080/08870446.2021.1921178

Dimond, B. (2005) 'Exploring the legal status of healthcare documentation in the UK'.. *British journal of nursing*, 14 9, pp. 517-8 . https://doi.org/10.12968/BJON.2005.14.9.18078.

Douglas-Moore, JL., Lewis, R., & Patrick, JRJ. (2014) 'The importance of clinical documentation'. The Bulleting of the Royal College of Surgeons in England, Vol. 96, No1 doi: https://doi.org/10.1308/rcsbull.2014.96.1.18

Downe S., Walsh D., Simpson L., Steen M., (2009) 'Template for metasynthesis', Available from sdowne@uclan.ac.uk

Drew K., Morris R., Tod, D., & Eubank, M., (2019) 'A meta-study of qualitative research on the junior-to-senior transition in sport'. Psychology of Sport and Exercise, 45, Art. No.: 101556. https://doi.org/10.1016/j.psychsport.2019.101556

Duffield, C., Roche, M., Homer, C., Buchan, J., & Dimitrelis, S. (2014) 'A comparative review of nurse turnover rates and costs across countries'.. *Journal of advanced nursing*, 70 12, pp. 2703-12 . https://doi.org/10.1111/jan.12483.

Dutta, A., Sharma, A., Torres-Castro, R., Pachori, H., & Mishra, S. (2021) 'Mental health outcomes among health-care workers dealing with COVID-19/severe acute respiratory syndrome coronavirus 2 pandemic: A systematic review and meta-analysis'. Indian journal of psychiatry, 63(4), 335–347. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_1029_20

Eisinger, R., & Fauci, A. (2018) 'Ending the HIV/AIDS Pandemic. *Emerging Infectious Diseases'*, 24, pp. 413 - 416. https://doi.org/10.3201/eid2403.171797.

Elfering, A., Grebner, S., Leitner, M., Hirschmüller, A., Kubosch, E.J. and Baur, H. (2016) 'Quantitative work demands, emotional demands, and cognitive stress symptoms in surgery nurses Informa UK Limited'.

Entwistle, V., Carter, S., Cribb, A., & McCaffery, K. (2010) 'Supporting Patient Autonomy: The Importance of Clinician-patient Relationships'. *Journal of General Internal Medicine*, 25, pp. 741-745. https://doi.org/10.1007/s11606-010-1292-2.

Etzion, D., Eden, D. and Lapidot, Y. (1998) 'Relief From Job Stressors and Burnout', Journal of applied psychology, 83(4), pp. 577-585. doi: 10.1037/0021-9010.83.4.577.

Feeley, C., Thomson, G. and Downe, S. (2019) 'Caring for women making unconventional birth choices: A meta-ethnography exploring the views, attitudes, and experiences of midwives', Midwifery, 72, pp. 50–59. doi: 10.1016/j.midw.2019.02.009.

Felice, C., Tanna, G., Zanus, G., & Grossi, U. (2020) ‘Impact of COVID-19 Outbreak on Healthcare Workers in Italy: Results from a National E-Survey. *Journal of Community Health*, 45, pp. 675 - 683. https://doi.org/10.1007/s10900-020-00845-5.

Fernández-Basanta, S., Lagoa-Millarengo, M., & Movilla-Fernández, M.-J. (2021) ‘Encountering Parents Who Are Hesitant or Reluctant to Vaccinate Their Children: A Meta-Ethnography’. International Journal of Environmental Research and Public Health, 18(14). https://doi.org/10.3390/ijerph18147584

Fossey, E., Harvey, C., Mcdermott, F., & Davidson, L. (2002) ‘Understanding and Evaluating Qualitative Research’. Australian & New Zealand Journal of Psychiatry, 36(6), 717-732. https://doi.org/10.1046/j.1440-1614.2002.01100.x

Frąckowiak-Sochańska, M. (2020) ‘Open Access Repository: Mental health in the pandemic times’, Society register, doi: 10.14746/sr.2020.4.3.03

France, E. F., Uny, I., Ring, N., Turley, R. L., Maxwell, M., Duncan, E. A. S., Jepson, R. G., Roberts, R. J., & Noyes, J,. (2019) ‘A methodological systematic review of meta-ethnography conduct to articulate the complex analytical phases’. BMC Medical Research Methodology, 19(1). https://doi.org/10.1186/s12874-019-0670-7

Franza, F., Basta, R., Pellegrino, F., Solomita, B., & Fasano, V., (2020) ‘The Role of Fatigue of Compassion, Burnout and Hopelessness in Healthcare: Experience in the Time of COVID-19 Outbreak’ *Psychiatria Danubina*, 32 Suppl 1, pp. 10-14 .

Gardner, M.J., McKinstry, C. and Perrin, B. (2022) ‘Effectiveness of allied health clinical supervision following the implementation of an organisational framework’, BMC health services research, 22(1), p. 261. doi:10.1186/s12913-022-07636-9.

Garside, R. (2014) ‘Should we appraise the quality of qualitative research reports for systematic reviews, and if so, how?’ *Innovation: The European Journal of Social Science Research*, 27, pp. 67 - 79. https://doi.org/10.1080/13511610.2013.777270.

Gee, S. and Skovdal, M. (2017). 'The role of risk perception in willingness to respond to the 2014–2016 West African Ebola outbreak: a qualitative study of international health care workers', Global health research and policy, 2(1), pp. 21. doi: 10.1186/s41256-017-0042-y.

Gellis, Z. D. (2002) ‘Coping with Occupational Stress in Healthcare: A Comparison of Social Workers and Nurses’, *Administration in Social Work*, 26(3), pp. 37–52. doi: 10.1300/J147v26n03_03.

George-Levi, Sivan & Laslo-Roth, Roni & Bareket-Bojmel, Liad & Margalit, Malka. (2021) ‘Perceptions of family support and college support: the mediating roles of hope and peer support’. Journal of Further and Higher Education. 46. 1-14. 10.1080/0309877X.2021.1906850.

Georgellis, Y., Lange, T. and Tabvuma, V. (2012) 'The impact of life events on job satisfaction', Journal of vocational behavior, 80(2), pp. 464-473. doi: 10.1016/j.jvb.2011.12.005.

Giusti EM, Pedroli E, D'Aniello GE, Stramba Badiale C, Pietrabissa G, Manna C, Stramba Badiale M, Riva G, Castelnuovo G and Molinari E. (2020) ‘The Psychological Impact of the COVID-19 Outbreak on Health Professionals: A Cross-Sectional Study’. Front. Psychol. 11:1684. doi: 10.3389/fpsyg.2020.01684

Glaser, B. G., & Strauss, A., L. (1967) ‚The Discovery of Grounded Theory: Strategies for Qualitative Research’. Chicago: Aldine. p.61

GOV. (2021) ‘Making a support bubble with another household’. Available at: https://www.gov.uk/guidance/making-a-support-bubble-with-another-household#what-a-support-bubble-is (Accessed: 05 July 2024).

Government Digital Service (2022) ‘2 Years of COVID-19 on GOV.UK’. Available at: https://gds.blog.gov.uk/2022/07/25/2-years-of-covid-19-on-gov-uk/ (Accessed: 02 August 2024).

Grant, A., Berg, J., & Cable, D. (2014) ‘JOB TITLES AS IDENTITY BADGES: HOW SELF-REFLECTIVE TITLES CAN REDUCE EMOTIONAL EXHAUSTION’. *Academy of Management Journal*, 57, pp. 1201-1225. https://doi.org/10.5465/AMJ.2012.0338.

Greenberg, N., Docherty, M., Gnanapragasam, S., & Wessely, S.. (2020) ‘Managing mental health challenges faced by healthcare workers during covid-19 pandemic’. BMJ, m1211. https://doi.org/10.1136/bmj.m121q

Guest, G., A. Bunce, and L. Johnson. (2006) ‘How Many Interviews are Enough? an Experiment with Data Saturation and Variability.’ Field Methods 18 (1): 59–82. doi:10.1177/1525822X05279903.

Hadjiantonis, G., Paromita, P., Mundnich, K., Nadarajan, A., Booth, B.M., Narayanan, S. and Chaspari, T. (2020) ‘Dynamical systems modeling of day-to-day signal-based patterns of emotional self-regulation and stress spillover in highly demanding health professions’. 42nd Annual International Conference of the IEEE Engineering in Medicine & Biology Society (EMBC), pp. 284-287, doi: 10.1109/EMBC44109.2020.9175604.

Hakanen, J.J. and Bakker, A.B. (2017) 'Born and Bred to Burn out: A Life-Course View and Reflections on Job Burnout', Journal of occupational health psychology, 22(3), pp. 354-364. doi: 10.1037/ocp0000053.

Hansen, M. M., Jones, R., & Tocchini, K. (2017) ‘Shinrin-yoku (forest bathing) and nature therapy: A state-of-the-art review’. International journal of environmental research and public health, 14(8), 851. https://doi.org/10.3390/ijerph14080851

Hao F. Xiao Q. & Chon K. (2020) ‘Covid-19 and china’s hotel industry: impacts a disaster management framework and post-pandemic agenda’. International Journal of Hospitality Management. https://doi.org/10.1016/j.ijhm.2020.102636

Hawkley, L.C. and Cacioppo, J.T. (2010) ‘Loneliness Matters: A Theoretical and Empirical Review of Consequences and Mechanisms’ Oxford University Press (OUP).

Health and Social Care Act. (2008) ‘(Regulated Activities) Regulations 2014: Regulation 18. Care Quality Commission. Available at: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-staffing (Accessed: : 22 August 2022)

Hennink, M. M., Hutter, I., & Bailey, A. (2020) ‘Qualitative research methods’ (Second ed.). Sage.

Herber, O. R., & Johnston, B. M. (2013) ‘The role of healthcare support workers in providing palliative and end-of-life care in the community: a systematic literature review’. Health & social care in the community, 21(3), 225-235. https://doi.org/https://doi.org/10.1111/j.1365-2524.2012.01092.x

Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015) ‘Loneliness and social isolation as risk factors for mortality: a meta-analytic review’. Perspectives on psychological science : a journal of the Association for Psychological Science, 10(2), 227–237. https://doi.org/10.1177/1745691614568352

Husserl, E. (1983) ‘Ideas pertaining to a pure phenomenology and to a phenomenological philosophy’. First book. Martinus Nijhoff Publishers.

Institute for Government. (2021) ‘Lifting lockdown in 2021. The next phase of the government’s coronavirus strategy’. Available at: https://www.instituteforgovernment.org.uk/sites/default/files/publications/lifting-lockdown-2021_0.pdf (Accessed: 05 July 2024).

Iserson, K.V. (2020) 'Healthcare Ethics During a Pandemic', The western journal of emergency medicine, 21(3), pp. 477-483. doi: 10.5811/westjem.2020.4.47549.

Ivbijaro, G., Brooks, C., Kolkiewicz, L., Sunkel, C. and Long, A. (2020) 'Psychological impact and psychosocial consequences of the COVID 19 pandemic Resilience, mental well-being, and the coronavirus pandemic', Indian Journal of Psychiatry, 62, pp. S395-S403. doi: 10.4103/psychiatry.IndianJPsychiatry_1031_20.

Jelliman, P., & Porcellato, L. (2017) ‘HIV is Now a Manageable Long-Term Condition, But What Makes it Unique? A Qualitative Study Exploring Views About Distinguishing Features from Multi-Professional HIV Specialists in North West England’. *Journal of the Association of Nurses in AIDS Care*, 28, pp. 165–178. https://doi.org/10.1016/j.jana.2016.09.008.

Jimenez-Picon, N., Romero-Martin, M., Ponce-Blandon, J., Ramirez-Baena, L., Palomo-Lara, J., & Gomez-Salgado, J. (2021) ‘The Relationship between Mindfulness and Emotional

Intelligence as a Protective Factor for Healthcare Professionals': Systematic Review. *International Journal of Environmental Research and Public Health*, 18. https://doi.org/10.3390/ijerph18105491.

Kasdovasilis, P., Alikari, V., Zyga, S., Guppy, A., & Theofilou, P. (2019) 'Film clips smoking behavior and nicotine craving: The interrelationship between stress, smoking cues and craving'. Psychiatrike , 30(3), 226–234. https://doi.org/10.22365/jpsych.2019.303.226

Kasdovasilis, P., Cook, N., & Montasem, A., (2022) 'UK healthcare support workers and the COVID-19 pandemic: an explorative analysis of lived experiences during the COVID-19 pandemic'. Home Health Care Services Quarterly 1–26.. doi:10.1080/01621424.2022.2123757

Kasdovasilis, P., Cook, N., Montasem, A., & Davis, G. (2022) 'Healthcare support workers' lived experiences and adaptation strategies within the care sector during the COVID-19 pandemic. A meta-ethnography review'. Home health care services quarterly, 1–24. Advance online publication. https://doi.org/10.1080/01621424.2022.2105771

Katana, M., Röcke, C., Spain, S., M., Allemand, M. (2019) 'Emotion Regulation, Subjective Well-Being, and Perceived Stress in Daily Life of Geriatric Nurses'. Frontiers in Psychology, 10:1097.DOI: https://doi.org/10.3389/fpsyg.2019.01097

Kearney M. H. (1998) 'Ready-to-wear: discovering grounded formal theory'. Research in nursing & health, 21(2), 179–186. https://doi.org/10.1002/(sici)1098-240x(199804)21:2<179::aid-nur8>3.0.co;2-g

Kerr, J. L., Dattilo, J., & O'Sullivan, D. (2012) 'Use of recreation activities as positive coping with chronic stress and mental health outcomes associated with unemployment of people with disabilities.' Work (Reading, Mass.), 43(3), 279–292. https://doi.org/10.3233/WOR-2012-1390

Kim, B.J. and Lee, S. (2021) 'A Cross-Sectional Study on the Impacts of Perceived Job Value, Job Maintenance, and Social Support on Burnout Among Long-Term Care Staff in Hawaii', International journal of environmental research and public health, 18(2). doi: 10.3390/ijerph18020476.

Kisely, S., Warren, N., Mcmahon, L., Dalais, C., Henry, I., Siskind, D. (2020) 'Occurrence, prevention, and management of the psychological effects of emerging virus outbreaks on healthcare workers: rapid review and meta-analysis'. BMJ m1642. doi:10.1136/bmj.m1642

Koh, Y., Hegney, D., G., and Drury, V. (2011). 'Comprehensive systematic review of healthcare workers' perceptions of risk and use of coping strategies towards emerging respiratory infectious diseases', International Journal of Evidence-Based Healthcare, 9(4), pp. 403–419. doi: 10.1111/j.1744-1609.2011.00242.x.

Kunert, K., King, M. L., & Kolkhorst, F. W. (2007) 'Fatigue and sleep quality in nurses: Tiredness can negatively affect hospital nurses' quality of life and patient care'. Journal of Psychosocial Nursing and Mental Health Services, 45(8), 31–37.

Labrague, L., (2020) ‘Psychological resilience, coping behaviours and social support among health care workers during the COVID-19 pandemic: A systematic review of quantitative studies’. *Journal of Nursing Management*, 29, 1893 - 1905. https://doi.org/10.1111/jonm.13336.

Larkin, M., & Thompson, A., R. (2011) ‘Qualitative Research Methods in Mental Health and Psychotherapy’. A Guide for Student and Practitioners. Doi: 10.1002/9781119973249.ch8

Laslo-Roth, R., George-Levi, S., & Margalit, M. (2021) ‘Hope during the COVID-19 outbreak: coping with the psychological impact of quarantine’. *Counselling Psychology Quarterly*, 34, pp. 771 - 785. https://doi.org/10.1080/09515070.2021.1881762.

Lateef, F. (2020) 'Face to face with coronavirus disease 19: Maintaining motivation, psychological safety, and wellness', Journal of emergencies, trauma and shock, 13(2), pp. 116-123. doi: 10.4103/JETS.JETS_27_20.

Lee, S.M., Kang, W.S., Cho, A., Kim, T. and Park, J.K. (2018) 'Psychological impact of the 2015 MERS outbreak on hospital workers and quarantined hemodialysis patients', Comprehensive psychiatry, 87, pp. 123-127. doi: 10.1016/j.comppsych.2018.10.003.

Lehmann, M., Bruenahl, C., Löwe, B., Addo, M., Schmiedel, S., Lohse, A., & Schramm, C., (2015) ,’Ebola and Psychological Stress of Health Care Professionals’. *Emerging Infectious Diseases*, 21, pp. 913 - 914. https://doi.org/10.3201/eid2105.141988.

Leng, T., White, C., Hilton, J., Kucharski, A., Pellis, L., Stage, H., Davies, N., Keeling, M., & Flasche, S. (2020) ‘The effectiveness of social bubbles as part of a Covid-19 lockdown exit strategy, a modelling study’.. *Wellcome open research*, 5, pp. 213 . https://doi.org/10.12688/WELLCOMEOPENRES.16164.2.

Lewis, R. and Kelly, S., (2018) ‘Changing hearts and minds: examining student nurses’ experiences and perceptions of a general practice placement through a ‘community of practice’lens. BMC medical education, 18, pp.1-10.

Li, Y., Scherer, N., Felix, L., & Kuper, H. (2021) ‘Prevalence of depression, anxiety and post-traumatic stress disorder in health care workers during the COVID-19 pandemic: A systematic review and meta-analysis’. PloS one, 16(3), e0246454. https://doi.org/10.1371/journal.pone.0246454

Lincoln, Y. S., and E. G. Guba. (1985) ‘Naturalistic Inquiry’. Newbury Park, CA: Sage

Lindberg, C., Fagerström, C., Sivberg, B., & Willman, A., 2014. Concept analysis: patient autonomy in a caring context.. *Journal of advanced nursing*, 70 10, pp. 2208-21 . https://doi.org/10.1111/jan.12412.

Liu, Q., Luo, D., Haase, J.E., Guo, Q., Wang, X.Q., Liu, S., Xia, L., Liu, Z., Yang, J. and Yang, B.X. (2020) 'The experiences of health-care providers during the COVID-19 crisis in China: a qualitative study', The Lancet. Global health, 8(6), pp. e790-e798. doi: 10.1016/S2214-109X(20)30204-7.

Lucas, S.,A. (2020) ‘The perception of Direct Care Staff and Administrators with Experiencing Compassion Fatigue and Compassion Satisfaction in an Urban Health Care Facility’. Available at: https://www.proquest.com/openview/93bf112f61cbefeb1ad4f465c063eff0/1?pq-origsite=gscholar&cbl=18750&diss=y (Accessed 02 August 2024).

Mache, S., Servaty, R. and Harth, V. (2020) 'Flexible work arrangements in open workspaces and relations to occupational stress, need for recovery and psychological detachment from work', Journal of occupational medicine and toxicology (London, England), 15(1), pp. 1-5. doi: 10.1186/s12995-020-00258-z.

Madhav, N., Oppenheim, B., Gallivan, M., Prime Mulembakani, Rubin, E. and Wolfe, N. (2017) ‘Pandemics: Risks, Impacts, and Mitigation’. Nih.gov. [online] doi:10.1596/978-1-4648-0527-1/pt5.ch17.

Magnavita, N., Chirico, F., Garbarino, S., Bragazzi, N. L., Santacroce, E., & Zaffina, S. (2021) ‘SARS/MERS/SARS-CoV-2 Outbreaks and Burnout Syndrome among Healthcare Workers. An Umbrella Systematic Review’. International journal of environmental research and public health, 18(8), 4361. https://doi.org/10.3390/ijerph18084361

Maiorano T, Vagni M, Giostra V, Pajardi D. (2020) ‘COVID-19: Risk Factors and Protective Role of Resilience and Coping Strategies for Emergency Stress and Secondary Trauma in Medical Staff and Emergency Workers—An Online-Based Inquiry’. Sustainability. 12(21):9004. https://doi.org/10.3390/su12219004

Mak, I. W., Chu, C. M., Pan, P. C., Yiu, M. G., & Chan, V. L. (2009) ‘Long-term psychiatric morbidities among SARS survivors’. General hospital psychiatry, 31(4), 318–326. https://doi.org/10.1016/j.genhosppsych.2009.03.001oi:10.1016

Malpass, A., Shaw, A., Sharp, D., Walter, F., Feder, G., Ridd, M., & Kessler, D. (2009) "Medication career" or "moral career"? The two sides of managing antidepressants: a meta-ethnography of patients' experience of antidepressants.. *Social science & medicine*, 68 1, pp. 154-68 . https://doi.org/10.1016/j.socscimed.2008.09.068.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016) ‘Sample Size in Qualitative Interview Studies: Guided by Information Power’. Qualitative health research, 26(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Manstead A. S. R. (2018) ‘The psychology of social class: how socioeconomic status impacts thought feelings and behaviour’. British Journal of Social Psychology 267–291. https://doi.org/10.1111/bjso.12251

Mapp, T. (2008) ‘Understanding phenomenology: The lived experience’. British Journal of Midwifery, 16(5), 308–311. https://doi.org/10.12968/bjom.2008.16.5.29192

Mariani R, Renzi A, Di Trani M, Trabucchi G, Danskin K and Tambelli R. (2020) 'The Impact of Coping Strategies and Perceived Family Support on Depressive and Anxious Symptomatology During the Coronavirus Pandemic (COVID-19) Lockdown'. Front. Psychiatry 11:587724. doi: 10.3389/fpsyt.2020.587724

Mark, G. and Smith, A.P. (2012) 'Occupational stress, job characteristics, coping, and the mental health of nurses', British journal of health psychology, 17(3), pp. 505-521. doi: 10.1111/j.2044-8287.2011.02051.x.

Martin, P., Tian, E., Kumar, S., & Lizarondo, L. (2022) 'A rapid review of the impact of COVID-19 on clinical supervision practices of healthcare workers and students in healthcare settings'. *Journal of Advanced Nursing*. https://doi.org/10.1111/jan.15360.

Maunder, R., Hunter, J., Vincent, L., Bennett, J., Peladeau, N., Leszcz, M., Sadavoy, J., Verhaeghe, L., Steinberg, R., & Mazzulli, T. (2003) 'The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital' *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, 168 10, pp. 1245-51 .

Merten, S., Hilber, A., Biaggi, C., Sécula, F., Bosch-Capblanch, X., Namgyal, P., Hombach, J., & Quach, C. (2015) 'Gender Determinants of Vaccination Status in Children: Evidence from a Meta-Ethnographic Systematic Review'. *PLoS ONE*, 10. https://doi.org/10.1371/journal.pone.0135222.

Methley, A., Campbell, S., Chew-Graham, C., Mcnally, R., & Cheraghi-Sohi, S. (2014) 'PICO, PICOS and SPIDER: a comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews'. *BMC Health Services Research*, 14. https://doi.org/10.1186/s12913-014-0579-0.

Moghaddam-Tabrizi, F., & Sodeify, R. (2021) 'Lived Experiences of Nurses in the Care of Patients with COVID-19: A Study of Hermeneutic Phenomenology. Iranian journal of nursing and midwifery research, 26(6), 537–543. https://doi.org/10.4103/ijnmr.IJNMR_319_20

Mohanty, A., Kabi, A., & Mohanty, A. P. (2019) 'Health problems in healthcare workers: A review'. Journal of family medicine and primary care, 8(8), 2568–2572. https://doi.org/10.4103/jfmpc.jfmpc_431_19

Mohd Arifin, S. R. (2018) 'Ethical considerations in qualitative study'. INTERNATIONAL JOURNAL OF CARE SCHOLARS, 1(2), 30–33. https://doi.org/10.31436/ijcs.v1i2.82

Moore J. W. (2016) 'What Is the Sense of Agency and Why Does it Matter?'. *Frontiers in psychology*, *7*, 1272. https://doi.org/10.3389/fpsyg.2016.01272

Moradi, Y., Mollazadeh, F., Karimi, P., Hosseingholipour, K. and Baghaei, R. (2020) 'Psychological disturbances of survivors throughout COVID-19 crisis: a qualitative study', BMC Psychiatry, 20(1), pp. 1-8. doi: 10.1186/s12888-020-03009-w.

Morris, T. (2019) ‘Experiential learning – a systematic review and revision of Kolb’s model. *Interactive Learning Environments*, 28, 1064 - 1077. https://doi.org/10.1080/10494820.2019.1570279.

Murrell, P., & Claxton, C. (1987) ‘Experiential Learning Theory as a Guide for Effective Teaching’. *Counselor Education and Supervision*, 27, 4-14. https://doi.org/10.1002/J.1556-6978.1987.TB00735.X.

Musto, L., Schreiber, R., & Rodney, P. (2021) ‘Risking vulnerability: Enacting moral agency in the is/ought gap in mental health care’.. *Journal of advanced nursing*. https://doi.org/10.1111/jan.14776.

Neubauer, B., Witkop, C., & Varpio, L. (2019) ‘How phenomenology can help us learn from the experiences of others’. *Perspectives on Medical Education*, 8, pp. 90 - 97. https://doi.org/10.1007/s40037-019-0509-2.

NHS (2021) ‘Working in the NHS. Available at: https://www.jobs.nhs.uk/about_nhs.html (Accessed: 15 December 2021)

NHS (2022) ‘Coronavirus (COVID-19) symptoms in adults’. Available at: https://www.nhs.uk/conditions/coronavirus-covid-19/symptoms/main-symptoms/ (Accessed: 02 December 2022).

NHS (2024) ‘Healthcare Support Workers’. Available at: https://www.healthcareers.nhs.uk/explore-roles/healthcare-support-worker/roles-healthcare-support-worker/healthcare-support-worker (Accessed: 01 July 2024)

NHS Workforce Statistics (2024) ‘NHS Workforce Statistics-April 2024 (Including selected provisional statistics for May 2024)’. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics (Accessed: 02 August 2024)

Nicholson, E., Murphy, T., Larkin, P., Normand, C., & Guerin, S.. (2016) ‘Protocol for a thematic synthesis to identify key themes and messages from a palliative care research network’. BMC Research Notes, 9(1). https://doi.org/10.1186/s13104-016-2282-1

Nightingale, S., Spiby, H., Sheen, K., & Slade, P. (2018) ‘The impact of emotional intelligence in health care professionals on caring behaviour towards patients in clinical and long-term care settings: Findings from an integrative review’ *International journal of nursing studies*, 80, 106-117. https://doi.org/10.1016/j.ijnurstu.2018.01.006.

Nizza, I. E., Farr, J., & Smith, J. A. (2021) ‘Achieving excellence in interpretative phenomenological analysis (IPA): Four markers of high quality’. Qualitative research in psychology, 18(3), 369-386. https://doi.org/https://doi.org/10.1016/j.radi.2019.11.092

Noblit, G., Hare, R. (1988) ‘Meta-Ethnography: Synthesising Qualitative Studies’. Sage, London.

Norris, F.H., Sonis, J., Triffleman, E., King, D.W. and King, L.A. (2006) 'Disaster research methods: Past progress and future directions', Journal of traumatic stress, 19(2), pp. 173-184. doi: 10.1002/jts.20109.

Ntoumanis, N., Ng, J., Prestwich, A., Quested, E., Hancox, J., Thøgersen-Ntoumani, C., Deci, E., Ryan, R., Lonsdale, C., & Williams, G. (2020) 'A meta-analysis of self-determination theory-informed intervention studies in the health domain: effects on motivation, health behavior, physical, and psychological health'. *Health Psychology Review*, 15, pp. 214 - 244. https://doi.org/10.1080/17437199.2020.1718529.

Nyashanu, M., Pfende, F., & Ekpenyong, M. (2020a) 'Exploring the challenges faced by frontline workers in health and social care amid the COVID-19 pandemic: Experiences of frontline workers in the english midlands region, UK'. Journal of Interprofessional Care, 34(5), 655-661. doi:10.1080/13561820.2020.1792425

Nyashanu, M., Pfende, F., & Ekpenyong, M. S. (2020b) 'Triggers of mental health problems among frontline healthcare workers during the covid-19 pandemic in private care homes and domiciliary care agencies: Lived experiences of care workers in the midlands region, uk'. Health & Social Care in the Community, doi:10.1111/hsc.13204

NHS Digital (2020) 'NHS workforce statistics- December 2020 (Including selected provisional statistics for January 2021)', Available at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/december-2020 (Accessed: 27 March 2021

Obilor, E., I. (2023) 'Convenience and Purposive Sampling Techniques: Are they the same?' International Journal of innovative Social & Science Education Research 11 (1):1-7, Jan 2023 ISSN: 2360-8978

Palinkas, L., Horwitz, S., Green, C., Wisdom, J., Duan, N., & Hoagwood, K. (2015) 'Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research'. *Administration and Policy in Mental Health and Mental Health Services Research*, 42, pp. 533-544. https://doi.org/10.1007/s10488-013-0528-y.

Parliament (2021) 'Government guidance during the pandemic. Restrictions on visiting care homes during the pandemic'. Section 18. Available at: https://publications.parliament.uk/pa/jt5801/jtselect/jtrights/1375/137505.htm (Accessed: 05 July 2024).

Paterson, B.L. (2001) 'The Shifting Perspectives Model of Chronic Illness'. Journal of Nursing Scholarship, 33: 21-26. https://doi.org/10.1111/j.1547-5069.2001.00021.x

Patton, M.Q. (2002) 'Qualitative research and evaluation methods'. 3rd Sage Publications; Thousand Oaks, CA, p46.

PayScale (2021) ‘Average Registered Nurse Salary in United Kingdom’ Available at: https://www.payscale.com/research/UK/Job=Registered_Nurse_(RN)/Salary (Accessed: : 26 March 2021)

PayScale (2024) ‘Average Personal Support Worker (PSW) Hourly Pay in United Kingdom’ Available at: https://www.payscale.com/research/UK/Job=Personal_Support_Worker_(PSW)/Hourly_Rate (Accessed: 05 March 2024).

Peat, G., Rodriguez, A., & Smith, J. (2019) ‘Interpretive phenomenological analysis applied to healthcare research’. *Evidence-based nursing*, *22*(1), 7–9. https://doi.org/10.1136/ebnurs-2018-103017

Pietilä, A. M., Nurmi, S. M., Halkoaho, A., & Kyngäs, H. (2020) ‘Qualitative Research: Ethical Considerations. The Application of Content Analysis in Nursing Science Research. Springer, Cham. https://doi.org/10.1007/978-3-030-30199-6_6

Plessas, A., Paisi, M., Baines, R., Wheat, H., Delgado, M. B., Mills, I., & Witton, R. (2021) ‘Frontline experiences and perceptions of urgent dental care centre staff in england during the COVID-19 pandemic: A qualitative study’. British Dental Journal, doi:10.1038/s41415-021-3375-3

Portoghese, I., Galletta, M., Burdorf, A., Cocco, P., D'Aloja, E., & Campagna, M. (2017) ‘Role Stress and Emotional Exhaustion Among Health Care Workers: The Buffering Effect of Supportive Coworker Climate in a Multilevel Perspective’. Journal of occupational and environmental medicine, 59(10), e187–e193. https://doi.org/10.1097/JOM.0000000000001122

Portoghese, I., Galletta, M., Coppola, R. C., Finco, G., & Campagna, M. (2014) ‘Burnout and workload among health care workers: the moderating role of job control’. Safety and health at work, 5(3), 152-157.

Raven, J., Wurie, H. and Witter, S. (2018) 'Health workers’ experiences of coping with the Ebola epidemic in Sierra Leone’s health system: a qualitative study', BMC health services research, 18(1), pp. 251. doi: 10.1186/s12913-018-3072-3.

Ridge, L. J., Stimpfel, A. W., Dickson, V. V., Klar, R. T., & Squires, A. P. (2021) ‘How clinicians manage routinely low supplies of personal protective equipment’. American journal of infection control, 49(12), 1488–1492. https://doi.org/10.1016/j.ajic.2021.08.012

Riesenberg, L. A., & Justice, E. M. (2014) ‘Conducting a successful systematic review of the literature’, part 1. Nursing, 44(4), 13–17. https://doi.org/10.1097/01.NURSE.0000444728.68018.ac

Ritchie, J., Lewis, J., McNaughton Nicholls, C., & Ormston, R. (2014) ‘Qualitative research practice: A guide for social science students and researchers (Second edition)’. SAGE Publications.

Rossiter, K. and Godderis, R. (2020) 'Essentially invisible: risk and personal support workers in the time of COVID-19', Sociology of health & illness, 42(8), pp. e25-e31. doi: 10.1111/1467-9566.13203.

Royal College of Nursing (2007) ‘The Regulation of Healthcare Support Workers. Available at: file:///C:/Users/Pavlos/Downloads/1107.pdf (Accessed: 14 December 2022).

Ryan, R. M., & Deci, E. L. (2017) ‘Self-determination theory: Basic psychological needs in motivation, development, and wellness’. The Guilford Press. https://doi.org/10.1521/978.14625/28806

Sattar, R., Lawton, R., Panagioti, M., & Johnson, J. (2021) ‘Meta-ethnography in healthcare research: a guide to using a meta-ethnographic approach for literature synthesis’. BMC Health Services Research, 21(1). https://doi.org/10.1186/s12913-020-06049-w

Scells, H., Zuccon, G., Koopman, B., Deacon, A., Azzopardi, L., & Geva, S. (2017). ‘Integrating the Framing of Clinical Questions via PICO into the Retrieval of Medical Literature for Systematic Reviews’. *Proceedings of the 2017 ACM on Conference on Information and Knowledge Management*. https://doi.org/10.1145/3132847.3133080.

Schoeni, R. F., Wiemers, E. E., Seltzer, J. A., & Langa, K. M. (2021) ‘Association between risk factors for complications from COVID-19, perceived chances of infection and complications, and protective behavior in the US’. JAMA network open, 4(3), e213984-e213984.

Schultze, U., & Avital, M. (2011) ‘Designing interviews to generate rich data for information systems research’. Inf. Organ., 21, 1-16.

Schwinger, M., Trautner, M., Kärchner, H., & Otterpohl, N. (2020) ‘Psychological Impact of Corona Lockdown in Germany: Changes in Need Satisfaction, Well-Being, Anxiety, and Depression’. International journal of environmental research and public health, 17(23), 9083. https://doi.org/10.3390/ijerph17239083

Selman, L. E., Chao, D., Sowden, R., Marshall, S., Chamberlain, C., & Koffman, J. (2020) ‘Bereavement support on the frontline of COVID-19: Recommendations for hospital clinicians. Journal of Pain and Symptom Management’, 60(2), e81–e86. https://doi.org/10.1016/j.jpainsymman.2020.04.024

Selye, H. (1980) ‘Stress, Aging and Retirement’. The Journal of Mind and Behavior, 1(1), 93–110. Available at: http://www.jstor.org/stable/43852812 (Accessed: 27 December 2023)

Shanafelt, T. D., Boone, S., Tan, L., Dyrbye, L. N., Sotile, W., Satele, D., ... & Oreskovich, M. R. (2012) ‘Burnout and satisfaction with work-life balance among US physicians relative to the general US population’. Archives of internal medicine, 172(18), 1377-1385.

Shanafelt, T., Ripp, J., & Trockel, M. (2020) ‘Understanding and addressing sources of anxiety among health care professionals during the COVID-19 pandemic’. Jama, 323(21), 2133-2134.

Sharma, G. (2017) ‘Pros and cons of different sampling techniques’. International Journal of Applied Research 3 (7): ISSN: 794-752

Sharov, K.S. (2020) ‘Adaptation to SARS-CoV-2 under stress: Role of distorted information’. European Journal of Clinical Investigation 50.. doi:10.1111/eci.13294

Shepherd, D.A. and Haynie, J.M. (2011) 'Venture failure, stigma, and impression management: A self-verification, self-determination view', Strategic entrepreneurship journal, 5(2), pp. 178-197. doi: 10.1002/sej.113.

Sim, J., B. Saunders, J. Waterfield, and T. Kingstone. (2018) ‘Can Sample Size in Qualitative Research Be Determined Apriori?’ International Journal of Social Research Methodology 21 (5): 619–634. doi:10.1080/13645579.2018.1454643.

Skills for care (2024) ‘Career progression’. Available at: https://www.skillsforcare.org.uk/Careers-in-care/Career-progression/Career-progression.aspx (Accessed: 01 July 2024).

Smith, J. A. (2011) ‘Evaluating the contribution of interpretative phenomenological analysis. Health psychology review, 5(1), 9-27. https://doi.org/https://doi.org/10.1080/17437199.2010.510659

Smith, J. A., Flowers, P., & Larkin, M. (2009) ‘Interpretative Phenomenological Analysis: Theory, Method and Research’. In Interpretative Phenomenological Analysis: Theory, Method and Research SAGE Publications.

Sonnentag, S. and Bayer, U. (2005) 'Switching Off Mentally', Journal of occupational health psychology’, 10(4), pp. 393-414. doi: 10.1037/1076-8998.10.4.393

Soundy, A. and Heneghan, N. R. (2022) ‘Meta-ethnography’, *International Review of Sport and Exercise Psychology*, 15(1), pp. 266–286. doi: 10.1080/1750984X.2021.1966822.

Spiers, J., & Riley, R. (2019) ‘Analysing one dataset with two qualitative methods: The distress of general practitioners, a thematic and interpretative phenomenological analysis’. Qualitative research in psychology, 16(2), 276-290. https://doi.org/https://doi.org/10.1080/14780887.2018.1543099

Steed, L.B., Swider, B.W., Keem, S., Liu, J.T. (2021) ‘Leaving Work at Work: A Meta-Analysis on Employee Recovery From Work’. Journal of Management 47, 867–897.. doi:10.1177/0149206319864153

Sterling, M. R., Tseng, E., Poon, A., Cho, J., Avgar, A. C., Kern, L. M., Ankuda, C. K., & Dell, N. (2020) ‘Experiences of Home Health Care Workers in New York City During the Coronavirus Disease 2019 Pandemic’. JAMA Internal Medicine, 180(11), 1453. https://doi.org/10.1001/jamainternmed.2020.3930

Stroumpouki, T., Perrett, S., Kasdovasilis, P., Papatheodorou, P., Paparizos, V., & Stavropoulou, A. (2020) "A journey towards acceptance": The process of adapting to life with HIV in Greece. A Qualitative study. Applied nursing research : ANR, 53, 151249. https://doi.org/10.1016/j.apnr.2020.151249

Taha, S., Matheson, K., Cronin, T., & Anisman, H. (2014) ‘Intolerance of uncertainty, appraisals, coping, and anxiety: the case of the 2009 H1N1 pandemic’. British journal of health psychology, 19(3), 592–605. https://doi.org/10.1111/bjhp.12058

The King’s Fund (2018) ‘Staffing shortfall of almost 250.000 by 2030 is major risk to NHS long-term plan, experts warn’. Available at: https://www.kingsfund.org.uk/press/press-releases/staffing-shortfall-major-risk-nhs-long-term-plan (Accessed: : 29 December 2020).

The King’s Fund (2024a) ‘The NHS budget and how it has changed. Available at: https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-budget-nutshell (Accessed: 13 July 2024).

The King’s Fund (2024b) ‘Social care in a nutshell’. Available at: https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/social-care-nutshell (Accessed: 13 July 2024).

Tomasso, L. P., Yin, J., Cedeño Laurent, J. G., Chen, J. T., Catalano, P. J., & Spengler, J. D. (2021) ‘The relationship between nature deprivation and individual wellbeing across urban gradients under COVID-19’. International journal of environmental research and public health, 18(4), 1511.

Tongco, M. D. C. (2007) ‘Purposive Sampling as a Tool for Informant Selection’. Ethnobotany Research and Applications, 5, 147–158. Retrieved from https://ethnobotanyjournal.org/index.php/era/article/view/126 (Accessed: 19 March 2024).

Torres Munguia, J., A., Bandaru, F.C., Diaz Pavez, L.R. et al. (2022) ‘A global dataset of pandemic- and epidemic- prone disease outbreaks’. Sci Data 9, 683. https://doi.org/10.1038/s41597-022-01797-2

Toye, F., Seers, K., Hannink, E., et al. (2017) ‘A mega-ethnography of eleven qualitative evidence syntheses exploring the experience of living with chronic non-malignant pain’. BMC Med Res Methodol, 17, 116. https://doi.org/10.1186/s12874-017-0392-7

Trogolo, M. A., Moretti, L. S., & Medrano, L. A. (2022) ‘A nationwide cross-sectional study of workers' mental health during the COVID-19 pandemic: Impact of changes in working conditions, financial hardships, psychological detachment from work and work-family interface’. BMC psychology, 10(1), 73. https://doi.org/10.1186/s40359-022-00783-y

Tsoy, D., Tirasawasdichai, T., & Kurpayanidi, K. I. (2021) ‘Role of social media in shaping public risk perception during COVID-19 pandemic: A theoretical review. International Journal of Management Science and Business Administration, 7(2), 35-41.

https://DOI:10.18775/ijmsba.1849-5664-5419.2014.72.1005

UK Parliament (2021) ‘Coronavirus: A history of English lockdown laws’. House of Commons Library. Available at: https://commonslibrary.parliament.uk/research-briefings/cbp-9068/ (Accessed: 05 July 2024)

University of Central Lancashire (2024) ‘DProf Clinical Studies’. Available at: https://www.uclan.ac.uk/postgraduate-research/courses/clinical-studies-dprof (Accessed: 23 July 2024).

Vadean, F., & Saloniki, E. C. (2023) ‘Job Quality and Job Separation of Direct Care Workers in England’. *Innovation in aging*, *7*(2), igad009. https://doi.org/10.1093/geroni/igad009

Vagni, M., Maiorano, T., Giostra, V., & Pajardi, D. (2020) ‘Coping With COVID-19: Emergency Stress, Secondary Trauma and Self-Efficacy in Healthcare and Emergency Workers in Italy’. Frontiers in psychology, 11, 566912. https://doi.org/10.3389/fpsyg.2020.566912

Van Manen, M. (2017) ‘Phenomenology in its original sense. Qualitative Health Research’, 27(6), 810-825. https://doi.org/10.1177/1049732317699381

Vandevala, T., Pavey, L., Chelidoni, O., Chang, N., Creagh-Brown, B. and Cox, A. (2017) ‘Psychological rumination and recovery from work in intensive care professionals: associations with stress, burnout, depression and health Springer Science and Business Media’ LLC.

Vasileiou, K., J. Barnett, S. Thorpe, and Young, T. (2018) ‘Characterising and Justifying Sample Size Sufficiency in Interview-based Studies: Systematic Analysis of Qualitative Health Research over a 15-year Period’. BMC Medical Research Methodology 18: 148. doi:10.1186/s12874-018-0594-7.

Vujcic, M., Tomicevic-Dubljevic, J., Grbic, M., Lecic-Tosevski, D., Vukovic, O., & Toskovic, O. (2017) ‘Nature based solution for improving mental health and well-being in urban areas’. Environmental Research, 158, 385-392.

Walsh, D., & Downe, S. (2004) ‘Midwives’ contribution to normal childbirth care: Cross-sectional study in public hospitals in catalonia’ Springer Science and Business Media LLC. doi:10.1186/isrctn14062994

Walsh, D., Downe, S. (2006) ‘Appraising the quality of qualitative research’. Midwifery 22, 108–119.

Walt, J., (2020) ‘The possible impact of Reformed theology on education as a science, with special reference to the situation in South Africa’ (1940–)., 54, pp. 10. https://doi.org/10.4102/ids.v54i2.2551.

Wang, Y., McKee, M., Torbica, A. and Stuckler, D. (2019) 'Systematic Literature Review on the Spread of Health-related Misinformation on Social Media', Social science & medicine (1982), 240, pp. 112552. doi: 10.1016/j.socscimed.2019.112552.

Wendelboe-Nelson, C., Kelly, S., Kennedy, M., & Cherrie, J. (2019) ‘A Scoping Review Mapping Research on Green Space and Associated Mental Health Benefits’. International Journal of Environmental Research and Public Health, 16(12), 2081. https://doi.org/10.3390/ijerph16122081

Wendsche, J. and Lohmann-Haislah, A. (2016) 'A meta-analysis on antecedents and outcomes of detachment from work', Frontiers in psychology, 7, pp. 2072. doi: 10.3389/fpsyg.2016.02072.

White, E.M., Wetle, T.F., Reddy, A. and Baier, R.R. (2021) 'Front-line Nursing Home Staff Experiences During the COVID-19 Pandemic', Journal of the American Medical Directors Association, 22(1), pp. 199-203. doi: 10.1016/j.jamda.2020.11.022.

White, M. P., Alcock, I., Grellier, J., Wheeler, B. W., Hartig, T., Warber, S. L., Bone, A., Depledge, M. H., & Fleming, L. E. (2019) ‘Spending at least 120 minutes a week in nature is associated with good health and wellbeing’. Scientific Reports, 9(1). https://doi.org/10.1038/s41598-019-44097-3

Workforce intelligence (2024) ‘The state of the adult social care sector and workforce in England’ Published October 2023 (data correct as at 2022/23). Available at: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx (Accessed: 08 August 2024).

World Health Organisation (2017) ‘Managing epidemics. Key facts about major deadly diseases’. Available at: https://www.who.int/emergencies/diseases/managing-epidemics-interactive.pdf (Accessed: 20 October 2020).

World Health Organisation (2020) ‘Coronavirus disease (COVID-19)’. Available at: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/coronavirus-disease-covid-19 (Accessed: 20 October 2020).

World Health Organisation (2022) ‘Health workers and administrators’. Retrieved from https://www.who.int/teams/risk-communication/health-workers-and-administrators (Accessed: 21 August 2022).

Xiao, Y., & Watson, M. (2019) ‘Guidance on Conducting a Systematic Literature Review’. Journal of Planning Education and Research, 39(1), 93-112. https://doi.org/10.1177/0739456X17723971

Xiong, J., Lipsitz, O., Nasri, F., Lui, L. M. W., Gill, H., Phan, L., Chen-Li, D., Iacobucci, M., Ho, R., Majeed, A., & McIntyre, R. S. (2020) ‘Impact of COVID-19 pandemic on mental health in the general population: A systematic review. Journal of affective disorders', 277, 55–64. https://doi.org/10.1016/j.jad.2020.08.001

Yardley, L. (2000) 'Dilemmas in qualitative health research'. Psychology & Health, 15(2), 215-228. https://doi.org/10.1080/08870440008400302

7. APPENDIX

Appendix 1. Detailed template for meta synthesis of qualitative studies

Author (year) and country	**Aims clear ?**	**Participants appropriate for question ?**	**Design appropriate for aims and theoretical perspective ?**	**Methods appropriate for design?**	**Sample size & sampling justified?**	**Does the data analysis fit with the chosen methodology ?**	**Reflexivity present?**	**Study ethical ?**	**Do the data presented justify the findings?**	**Is the context described sufficiently ?**	**Is there sufficient evidence of rigour ?**	Overall rating
Bandini et al (2021) USA	Y	Y (potential underrep.)	UC - theoretical perspective not stated. However, the design would appear to be appropriate	Y	UC Sampling yes but sample size not addressed	Y	N however, RAND corp. nonprofit, nonpartisan and was assessment of inter-rater reliability	Y. Got approval and no obvious issues noted	Y Y, However no indication of how many pps views are presented – no pp IDs	Y	N Some described but could be more detail about how coding changed, a diagram showing how codes relate to themes etc. Limited description of divergent views	B

Kupa & Geyer (2020) S Africa	Y	Y	Y	Y	UC. Sampling justified and some issues noted by authors but not sample size. Pp profile in line with population	Y	N although respondent vlidation was stated as being used	Y	Y, However no indication of how many pps views are presented – no pp IDs	Y	UC. Some elements well described but others very vague (p.5)	B
Nyashanu et al (2020a; exploring the challenges…) UK	Y	Y (assumed) but lack of context does make interpretation difficult	UC - theoretical perspective not stated. However, the design would appear to be appropriate	UC. Not described in detail. What questions were asked?	UC. Sampling justified but nothing on sample size.	Y, although not described in detail	N	Y	Y	N. Not clear what the duties of the workers are or the areas in which they work	N No detail about coder agreement , how coding was done other measures to ensure	C
Nyashanu et al (2020b; triggers of mental health…) UK	Y	Y	UC - theoretical perspective not stated. However, the design would appear to be appropriate	UC. What Qs were asked?	UC. Sampling justified but nothing on sample size.	Y	N	Y	Y	N. Not clear what the duties of the workers are or the areas in which they work	Y as part of the silences framework	C
Sterlin et al (2020) US	Y	Y	UC - theoretical perspective not stated. However, the design would	Y. Match average care worker as described in intro	Y Sampling justified, data saturation addressed	Y	N but multiple coders throughout	Y	Y, However no indication of how many pps views are	Y	Y Detailed description of steps of grounded theory, data saturation	B

			appear to be appropriate						presented – no pp IDs		

Grading System

A: *No, or few flaws. The study credibility, transferability, dependability and confirmability is high.*

B: *Some flaws, unlikely to affect the credibility, transferability, dependability and/or confirmability of the study.*

C: *Some flaws that may affect the credibility, transferability, dependability and/or confirmability of the study.*

D: *Significant flaws that are very likely to affect the credibility, transferability, dependability and/or confirmability of the study.*

Appendix 1.1. The Joanna Briggs Institute (JBI) QARI Extraction Tool for Qualitative Research

Reviewer	Pavlos Kasdovasilis		Date	06/2021
Author	Bandini, J., Rollison, J., Feistel, K., Whitaker, L., Bialas, A., Etchegaray, J.		Year	2021
Journal	NEW SOLUTIONS: A Journal of Environmental and Occupational Health Policy		Record Number	1

1#	Methodology (including philosophical perspective)	Not stated. Assumption of interpretivism (seeks to understand) with phenomenological focus.
2#	Method (including recruitment strategy)	Qualitative. Agency aides for journaling and interviews using limited snowball sampling method
3#	Phenomena of interest (study purpose and aim)	To (1) Examine experiences of agency employed home care aides during COVID-19 & to (2) identify ways to mitigate concerns
4#	Setting (clinical, community)	Community settings (service user's houses)
5#	Geographical (region, country)	Wester New Yok (WNY) & Southeast Michigan (SEMI)
6#	Cultural	
7#	Participants (whole study & eligible participants)	16 home care aides
8#	Data analysis	Thematic Analysis
9#	Author's conclusions	This study highlights important challenges faced by home care aides during the COVID-19 pandemic notably around workplace safety and the impact of COVID- 19 on job responsibilities, which created elevated levels of stress related to the uncertainty and fear of the virus. These findings point to areas for future research to support policies to improve safety of aides during a public health crisis and beyond.
10#	Comments	Very good study, information can be clearly found around experiences. Extraction of both participant quotes and authors meanings

Findings	Illustration from publication (page number)	Evidence		
		Unequivocal	Credible	Unsupported
Aide workplace safety concerns	23		X	
Putting oneself at risk in the client's home	23		X	
Access to PPE	24	X		
Transportation challenges	24		X	
Impact of COVID-19 on aide job responsibilities	25		X	
Changes to caseload	24		X	
Transformation in client interactions	24-25		X	
New challenges for everyday tasks	25	X		
Agency perspectives to improve workplace safety concerns	25-26	X		

Extractions of findings complete. Yes No

Reviewer	Pavlos Kasdovasilis	Date	06/2021
Author	Madeline R. Sterling; Emily Tseng; Anthony Poon, BS; Jacklyn Cho; Ariel C. Avgar; Lisa M. Kern; Claire K. Ankuda; Nicola Dell	Year	2020
Journal	JAMA internal Medicine	Record Number	2

1#	Methodology (including philosophical perspective)	Not stated. Assumption of interpretivism (seeks to understand) with phenomenological focus.
2#	Method (including recruitment strategy)	Qualitative. Audio-recorded semi structure interviews. Workers employed by a home care agency in NYC and speak English. Education Fund staff conducted a general outreach who had in person training courses at the Education Fund headquarters. The lead investigator then approached these individuals via email or phone with a script. Approval from Corden University. $25 gift cards.
3#	Phenomena of interest (study purpose and aim)	To understand the experiences of home health care workers during the COVID-19 pandemic in New York City
4#	Setting (clinical, community)	Community (service users homes)
5#	Geographical (region, country)	New York, USA
6#	Cultural	Mean age 47.6, 32 women, 21 Black participants, 6 Hispanic participants
7#	Participants (whole study & eligible participants)	33 home health care workers
8#	Data analysis	Grounded theory
9#	Author's conclusions	Home health care workers have been on the front lines, working to ensure the health of older adults and those with chronic conditions or disabilities during the COVID-19 pandemic. In doing so, these workers are at considerable risk for contracting COVID-19 themselves. The risk of contracting COVID-19 has been exacerbated by inconsistent delivery of information on what home care workers should do to protect themselves and their clients, inadequate PPE, and a heavy reliance on public transportation. Already a vulnerable workforce, home health care workers face additional risks to their physical, mental, and financial well-being during the COVID-19 pandemic. Interventions and policies are urgently needed to protect this workforce and the vital role that they play.
10#	Comments	Good content but felt really brief overall. Extraction of both participant quotes and authors meanings

Findings	Illustration from publication (page number)	Evidence		
		Unequivocal	Credible	Unsupported
On the front line of COVID-19 medical management, but invisible	1455	X		
Providing day to day care for patients with chronic conditions	1456	X		
Monitoring patients for COVID-19 symptoms	1456	X		
Taking precautions to prevent COVID-19 in the home	1456		X	
Feeling invisible	1456	X		
Heightened Risk for COVID-19 Transmission to Patients and Themselves	1456			
Risk of transmitting COVID-19 to patients	1456	X		
Risk of contracting COVID-19 themselves	1456		X	
Reliance on public transportation, which increases exposure risk	1456		X	

Numerous home care workers per patient, increases risk of spread	1456	X		
Varying Levels of Support From Agencies, Including Information and Personal Protective Equipment	1456			
Differing amounts of COVID-19 information	1456		X	
Limited personal protective equipment	1457		X	
Lacking COVID-19–specific training	1457		X	
Reliance on Alternative Sources for Support	1457	X		
Information sources included news media, social media, and others	1457	X		
Non agency sources of personal protective equipment	1457		X	
Peer support	1457		X	
Forced to Make Tough Trade-offs Between Their Own Health and Finances	1457		X	
Working vs risk of exposure	1457			X
Working vs risk of losing wages and benefits	1457	X		
Risk of transmission vs duty to provide care	1457	X		

Extractions of findings complete. Yes No

Reviewer	Pavlos Kasdovasilis	Date	06/2021
Author	Mathew Nyashanu , Farai Pfende & Mandu Ekpenyong	Year	2020
Journal	Journal of interprofessional Care	Record Number	3

1#	Methodology (including philosophical perspective)	Not stated. Assumption of interpretivism (seeks to understand) with phenomenological focus.
2#	Method (including recruitment strategy)	Qualitative semi structured interviews
3#	Phenomena of interest (study purpose and aim)	To explore the challenges faced by different frontline workers in health and social care during the COVID-19 pandemic
4#	Setting (clinical, community)	Community settings, organisations(unspecified)
5#	Geographical (region, country)	English Midlands region UK
6#	Cultural	Not-specified
7#	Participants (whole study & eligible participants)	Organisations 30 approached 20 participated. 15 support workers, 15 nurses, 15 managers
8#	Data analysis	Thematic analysis, use of NVIVO
9#	Author's conclusions	The results of this study regarding the impact of COVID-19 suggest that health and social care organizations are not adequately equipped to deal with extreme pandemics like COVID- 19. Therefore, with a view to strengthening future pandemic preparedness, a coordinated approach between government and health and social care organizations in order to manage and contain such pandemics is needed. Furthermore, greater efficiency in testing and isolation of affected individuals by COVID-19 would appear key in managing and preventing the spread of the pandemic.
10#	Comments	Very accurate study. Very rich data. However, not all data was relevant as they had managers and nurses included into the study. However, they had clear quotes from support workers therefore it was easier to extract data that was only relevant. Extraction of both participant quotes and authors meanings

Findings	Illustration from publication (page number)	Evidence		
		Unequivocal	Credible	Unsupported
Lack of pandemic preparedness	656			X (no SP quote)
Lack of pandemic preparedness	654	X		
Shortage of Personal Protective Equipment (PPE)	654	X		
Anxiety and fear amongst professionals	654	X		
Challenges in enforcing social distancing	654	X		
Challenges in fulfilling social shielding responsibility	654			X (no SP quote)
Anxiety and fear amongst residents and service users	654		X	
Delay in testing	658	X		
Evolving PPE guidance	658	X		
Shortage of staff	658	X		

Extractions of findings complete. Yes No

Reviewer	Pavlos Kasdovasilis	Date	06/2021
Author	Mathew Nyashanu, Farai Pfende, Mandu S. Ekpenyong	Year	2020
Journal	Health and Social Care in the Community	Record Number	4

1#	Methodology (including philosophical perspective)	Not stated. Clear interpretivism (seeks to understand) *"The utilisation of EQA was meant to better understand the topic as opposed to offering a final solution to the matter under investigation".*
2#	Method (including recruitment strategy)	Qualitative. Explorative qualitative approach (EQA)
3#	Phenomena of interest (study purpose and aim)	Given that most COVID-19 cases were now being looked after in care homes and domiciliary care settings, this study explored triggers of mental health problems among frontline healthcare professionals. The study chose to look at private care homes and domiciliary care agencies because of the severe impact the sector was experiencing compared to the entities run by the National Health Services (NHS).
4#	Setting (clinical, community)	Community
5#	Geographical (region, country)	Midland's region, UK
6#	Cultural	Not stated
7#	Participants (whole study & eligible participants)	40 research participants
8#	Data analysis	Thematic approach underpinned by aspects of interpretive phenomenological analysis (IPA) guided by the f our phases of data analysis in the Silences Framework
9#	Author's conclusions	Support is needed for frontline workers in private care homes and domiciliary care to reduce and prevent the impact of mental health problems in workplaces. More importantly, central government needs comprehensive policies that cater for PPE supply and other forms of support for professionals working in private healthcare organisations.
10#	Comments	Very accurate study. Very rich data. Extraction of both participant quotes and authors meanings

Findings	Illustration from publication (page number)	Evidence		
		Unequivocal	Credible	Unsupported
Fear of infection and infecting others	3	X		
Lack of recognition/disparity between NHS and private healthcare conditions	3			X (no SP quote)
Lack of guidance	4		X	
Unsafe hospital discharges	4	X		
Loss of professionals and residents through deaths	4			X (no SP quote)
Unreliable testing and delayed results	4			X (no SP quote)
Staff shortages	4	X		

Extractions of findings complete. Yes No

Appendix 2. Conceptual Maps

THEMES	Bandini et al., 2021	Kupa & Geyer, 2020	Nyashanu et al., 2020a	Nyashanu et al., 2020b	Sterling et al., 2020
JOB ROLE	**x**	**x**	**x**		**x**
WHAT IT MEANS TO BE AN ESSENTIAL WORKER DURING AN INFECTIOUS DISEASE	**x**	**x**	**x**	**x**	**x**
MARGINALISED PROFESSION WHEN EMPHASIS IS GIVEN PRIMARILY TO DOCTORS AND NURSES	**x**	**x**	**x**		
FEAR OF INFECTION OF THE DISEASE TO BOTH SERVICE USERS AND THEMSELVES	**x**		**x**	**x**	**x**
FEELINGS OF SAFETY AND CONCERNS FROM PPE	**x**	**x**	**x**		
TRANSPORTATION CHALLENGES	**x**	**x**			
LEVEL OF SUPPORT AND GUIDANCE FROM COMPANY AND OTHER BODIES	**x**	**x**	**x**	**x**	
A HIGHER CALLING		**x**			**x**
ADAPTATION STRATEGIES	**x**	**x**	**x**		**x**

Appendix 3. UCLAN HEALTH Research Ethics Committee

University of Central Lancashire
UCLan

University of Central Lancashire
Preston PR1 2HE
01772 201201
uclan.ac.uk

25th June 2021

Gershan Davis / Pavlos Kasdovasilis
School of Medicine
University of Central Lancashire

Dear Gershan

Re: Health Ethics Review Panel Application
Unique Reference Number: HEALTH 0194

The Health Ethics Review Panel has granted approval of your proposal application 'UK healthcare support workers and the COVID-19 pandemic: An explorative analysis of adaptation and development of an intervention protocol to support coping mechanisms'. Approval is granted up to the end of project date*.
It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by the Ethics Review Panel
- you notify EthicsInfo@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to the Ethics Review Panel
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purpose e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Pro forma).

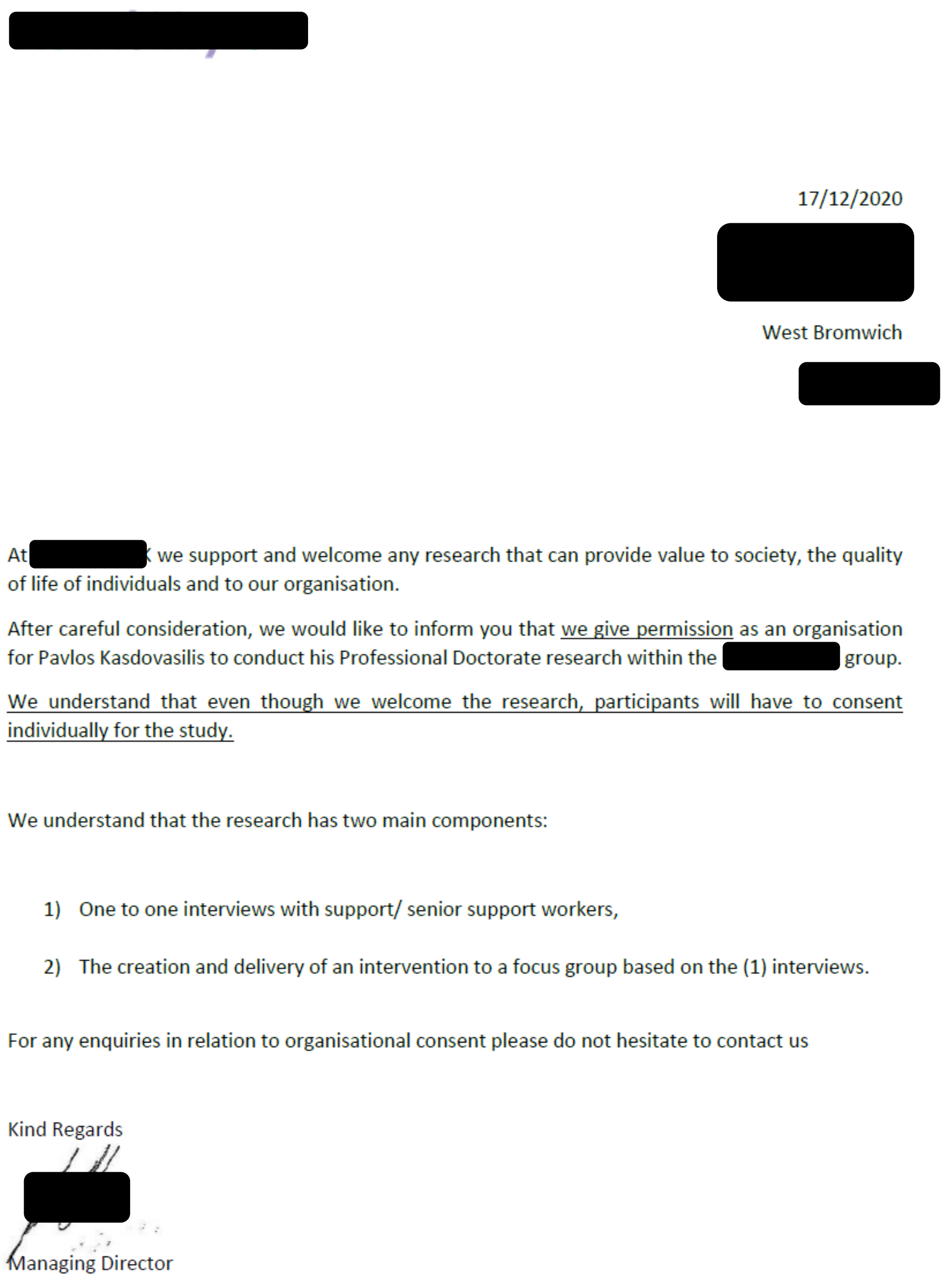
Yours sincerely

Julie Cook
Deputy Vice-Chair
Health Ethics Review Panel

* for research degree students this will be the final lapse date

NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals gained.

Appendix 4. Organisational consent



[redacted]

17/12/2020

[redacted]

West Bromwich

[redacted]

At [redacted] we support and welcome any research that can provide value to society, the quality of life of individuals and to our organisation.

After careful consideration, we would like to inform you that <u>we give permission</u> as an organisation for Pavlos Kasdovasilis to conduct his Professional Doctorate research within the [redacted] group.

<u>We understand that even though we welcome the research, participants will have to consent individually for the study.</u>

We understand that the research has two main components:

1) One to one interviews with support/ senior support workers,
2) The creation and delivery of an intervention to a focus group based on the (1) interviews.

For any enquiries in relation to organisational consent please do not hesitate to contact us

Kind Regards

[redacted]

Managing Director

Appendix 5. Emails to OPS, HoQ and Staff

Dear everyone,

My name is Pavlos Kasdovasilis and I am currently a Professional Doctorate student in Clinical Studies (Department of Medicine) at the University of Central Lancashire. At the same time I work for [redacted] as the Service Development and Research Manager (Head Office branch).

The reason I am contacting you is because I am conducting a research that aims at exploring the lived experiences of healthcare support workers within a care organisation during the pandemic and the interrelationship of those experiences between home and work. Overall, it aims at exploring the ‘how to’ of health care support workers during the pandemic.

If you would like additional information please contact me directly at pkasdovasilis@uclan.ac.uk
If you are available and wish to participate please contact me directly or express your interest to your manager in order to arrange an interview.

Furthermore, I would be more than happy to attend any team meetings in order to explain to you the project in more details and to give you the chance to ask me any questions that you may have in relation to it.

The interviews will be conducted 1:1 via Microsoft Teams and will be confidential. No data or any other information from the interviews will be shared with [redacted]. The interviews will last approximately 45 minutes.

Kind Regards,
Pavlos Kasdovasilis MBPsS
DProf student in Clinical Studies, Department of Medicine.

Appendix 6. Information Sheet

06/04/2021

Information Sheet

UK Healthcare support workers and the COVID-19 pandemic: An explorative analysis of adaptation and development of an intervention protocol to support coping mechanisms

You are invited to take part in a research study. Before you decide whether to take part please take some time to understand why the research is being done and what it involves. If you have any further queries, please do not hesitate to contact me [Pavlos Kasdovasilis] at pkasdovasilis@uclan.ac.uk or the supervisory team [Gershan Davis] at gdavis1@uclan.ac.uk, [Alexander Montasem] at amontasem@uclan.ac.uk and [Michael Farrell] at mfarrell4@uclan.ac.uk.

What is the purpose of this research?

The research aims is to identify what coping mechanisms health-care support workers used during the COVID-19 pandemic in both their personal and professional lives. At the same time, it will explore the experiences and the strategies as it interacts with personal life and work. Overall, it aims at exploring the 'how to' of health care support workers during the pandemic. The interview is conducted by a Professional Doctorate student from the University of Central Lancashire, Department of Medicine and you were approached because you work as a support worker.

Why have I been asked to take part?

You have been invited to take part in this study because you currently work at [redacted]. Additionally, your experiences are an invaluable part of the research project which will help us understand better the emotional quality of life during the pandemic.

What do I have to do?

You will be asked to participate in a 1:1 online discussion in order to have a conversation about your experience. The interview is expected to last at least 45 minutes. The interviewer will ask you a series of questions related to your experience and emotional wellbeing.

Two different recordings will be required when you agree to participate 1) for consent and 2) for the interview. During the interview you are encouraged to discuss and express any thoughts and feelings you have about the topic.

Benefit of Research?

- Understand the feelings and the journey of staff members as well as inform the community of their experiences.
- Provide feedback to the organisation of what works and what does not work well so that they potentially change their policies.
- Support in creating an intervention that would help the mental wellbeing of staff members working as healthcare support workers.

How will my data be used?

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit".

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The University privacy notice for research participants can be found on the attached link https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php

Further information on how your data will be used can be found in the table below.

How will my data be collected?	The data will be collected via Microsoft Teams Recording
How will my data be stored?	The data will be stored on the University online secure servers until transcribed. Once transcribed the data will be uploaded to NVivo software of analysis which will be accessible via the university credentials.
How long will my data be stored for?	The data will be stored until it is transcribed, and anonymised data will be stored securely for 5 years.
What measures are in place to protect the security and confidentiality of my data?	The data will be Accessed: via Teams and will be secured via username and password.
Will my data be anonymised?	The data will be anonymised during transcribing. Once transcribed the data will not be able to be traced back to the participant. During anonymisation random initials will be allocated for each participants. This will take place within 5 days of the day of the interview.
How will my data be used?	Your experiences will provide us with the information we need in order to complete this research by analysing your adaptation journey during the COVID-19
Who will have access to my data?	The data will be Accessed: only by the **interviewer**: [Pavlos Kasdovasilis, p.kasdovasilis@uclan.ac.uk] and the **supervisory team**: [Gershan Davis, gdavis1@uclan.ac.uk], [Alexander Montasem, amontasem@uclan.ac.uk] and [Michael Farrell, mfarrell4@uclan.ac.uk]. No other organisation apart from the University of Lancashire will have access to the data.
Will my data be archived for use in other research projects in the future?	*No*
How will my data be destroyed?	*The data will be deleted once the*

	transcribing is complete, but the researcher will keep anonymised transcripts

Are there any risks in taking part?
It is possible that some of the topics discussed during the interview may cause distress (although every effort has been made to minimise the chances of this happening). If this should happen I will pause the interview. If you wish we may then continue, but we can end the interview at any time, but you can talk with your manager for support if needed.

What will happen if I want to stop taking part?
You may withdraw from the study at any time without giving a reason, by informing the researcher on the contact details above. However, once the data has been anonymised (5 days after the interview has taken place), it will not be possible to identify you for withdrawal at this stage.

What will happen to the results of the research study?
It is intended to publish the findings from this study to relevant academic journals and conferences.

What if I'm unhappy or there is a problem?

If you are unhappy, or if there is a problem, please feel free to contact any of the individuals mentioned above. If you remain unhappy, or have a complaint which you feel you cannot come to us with, then please contact the Ethics, Integrity and Governance Unit at OfficerForEthics@uclan.ac.uk

Appendix 7. Verbal consent form

<u>(information sheet prior to this document)</u>

Please note that If at any point you wish to withdraw you can inform the interviewer. Do you have any questions?

I am now going to read the consent form. If you have any questions while I am reading it please do let me know, can I start recoding?

Participant consent form

Version number & date: V1.0 06/04/2021
Title of the research project: UK Healthcare support workers and the COVID-19 pandemic: An explorative analysis of adaptation and development of an intervention protocol to support coping mechanisms

Name of researcher(s): Pavlos Kasdovasilis

1. I confirm that I have read and have understood the information sheet dated [**xx/xx/2021**] for the above study, or it has been read to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that taking part in the study involves [**describing my lived experiences that helped me (or not) adapt during COVID-19 to both work and private life; and that this discussion is going to be recorded**].

3. I understand that my participation is voluntary and that I am free to stop taking part and can withdraw from the study at any time without giving any reason and without my rights being affected. In addition, I understand that I am free to decline to answer any particular question or questions.
4. I understand that I can ask for access to the information I provide and I can request the destruction of that information if I wish at any time prior to [**anonymisation**]. I understand that following [**anonymisation, 5 days after the interview**] I will no longer be able to request access to or withdrawal of the information I provide.
5. I understand that the information I provide will be held securely and in line with data protection requirements at the University of Central Lancashire.
6. I understand that signed consent forms and [**video recordings**] will be retained in [**Microsoft Teams University server**] until [**the data has been transcribed**].
7. I agree to take part in the above study.

My name is Pavlos Kasdovasilis today's date is …………. 2021 and can you please state your full name for this e-consent document please?

Appendix 8. Debrief sheet

23/06/2021

Debrief Sheet

UK Healthcare support workers and the COVID-19 pandemic: An explorative analysis of adaptation and development of an intervention protocol to support coping mechanisms

Thank you for participating in this project and sharing your experiences during the COVID-19 pandemic.

What is the purpose of this research?
The research aims is to identify what coping mechanisms health-care support workers used during the COVID-19 pandemic in both their personal and professional lives. At the same time, it will explore the experiences and the strategies as it interacts with personal life and work. Overall, it aims at exploring the 'how to' of healthcare support workers during the pandemic. The interview is conducted by a Professional Doctorate student from the University of Central Lancashire, Department of Medicine and you were approached because you work as a support worker.

What will happen if I want to stop taking part?
You may withdraw from the study at any time without giving a reason, by informing the researchers on the contact details below. However, once the data has been anonymised (a week after the interview has taken place), it will not be possible to identify you for withdrawal at this stage.

Principal Investigator: Professional Doctorate candidate in Clinical Studies, Department of Medicine, **Pavlos Kasdovasilis [pkasdovasilis@uclan.ac.uk]**

Supervising team : Professor of Medicine, **Gershan Davis [gdavis1@uclan.ac.uk]**

Senior Lecturer in Behavioural & Social Sciences, **Alexander Montasem [amontasem@uclan.ac.uk]**

How will my data be used?
The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit".
Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The University privacy notice for research participants can be found on the attached link https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php
Please refer back to the Participant Information Sheet for full information.

What if I’m unhappy or there is a problem?

If you are unhappy, or if there is a problem, please feel free to contact any of the individuals mentioned above. If you remain unhappy, or have a complaint which you feel you cannot come to us with, then please contact the Ethics, Integrity and Governance Unit at OfficerForEthics@uclan.ac.uk

Further support and advice

The researcher has tried to be compassionate, non-judgmental and provide a safe and supportive environment. However the researcher not able to give any professional advice or treatment in relation to underlying conditions related to either physical or mental health.
For any medical concerns, issues or advice please contact your GP or mental health team.
If you have any concerns in relation to the run of the service that affects you please contact the Care Quality Commission (CQC) or your local authority (which will be either your local council or NHS).
Below is a list of national services that will enable you to access further support and guidance.

Organisations offering support:

Mind:	https://www.mind.org.uk/	(General Mental Health)
Befriends Worldwide:	https://www.befrienders.org/	(Worldwide directory of emotional support)
CALM:	https://www.thecalmzone.net/	(Listening services, talk, web chat)
Mind Recovery Net:	https://mindrecoverynet.org.uk/	(List of recovery colleges)
The Mix:	https://www.themix.org.uk/	(Support and advice for under 25s)
NICE:	https://www.nice.org.uk/	(General information)
NHS111:	https://111.nhs.uk/	(NHS helpline for non-emergencies)

Appendix 9. Procedure from initial organisational consent to post interview

1	Managing Director approval	Approval
2	Emailed Operations Managers (OM) & Head of Quality (HoQ)	Advertising
3	Service managers were contacted by OM & (HoQ)	Advertising
4	Service managers printed information sheet and put in staff office	Advertising
5	Staff contacted me by email to express interest	Interest
6	I emailed to book an appointment	Appointment booking
7	Microsoft Teams meeting (video & audio); prior to interview information sheet and verbal consent	Pre-interview
8	Recorded interview took place via Microsoft Teams	Interview
9	Send debrief form after interview ended via email	After interview

Appendix 10. Demographics of participants according to age, role and years in care

	Name	Age	Role	Years in care
01	AB	50	Support Worker	34
02	BC	42	Senior Care Worker	7
03	CD	40	Senior Care Worker	15
04	DE	37	Senior Care Worker	10
05	EF	28	Support Worker	4
06	FG	30	Senior Care Worker	4
07	GH	22	Support Worker	4
08	IJ	34	Support Worker	3
09	JK	52	Support Worker	20
10	KL	27	Support Worker	9
11	LM	26	Senior Care Worker	1
12	NM	34	Support Worker	9
13	NO	35	Senior Care Worker	18
14	OP	33	Support Worker	1
15	PQ	39	Support Worker	23

Appendix 11. Participant coding raw data

Name	Files	References
Lived Experiences of adaptation of support workers during COVID-19 Pandemic	15	276
THEME Take message from COVID-19 Pandemic	12	33
SUBTHEME Inadequate government response	5	10
quicker response from government	1	1
Keep the public informed	1	1
Infodemic	2	2
Government failed	1	1
Government at fault for the lose of life	1	2
Data changing so quickly	1	1
Better preparation for next time	1	1
Better government guidance	1	1
SUBTHEME Different handling from the working organisation	7	13
Professional development during COVID	1	1
Potential solution to a future problem	2	5
pandemic preparedness	1	1
Mental health support	1	1
Care based on the COVID client	1	1
Business as usual	1	1
Building proper models of working	1	1
Bad handling from management	1	2
SUBTHEME Changed perception	6	10
Underestimating COVID	1	1
Take from the pandemic	1	1
Raise awareness	1	1
Pandemic worked good	1	1
Message to the people	3	5
Different awareness due to COVID	1	1
THEME Expressing interest about support workers health	8	15

SUBTHEME Support from others	1	2
Understanding from healthcare professionals and other	1	1
Losing my dignity from government to prove I am ill	1	1
SUBTHEME Support from managers	5	6
supportive manager	1	1
Supportive management due to health issues	1	1
Support from manager was really good	1	1
Manager very supportive	1	1
Good support from management	1	1
a bit disappointed from higher management	1	1
SUBTHEME Support from company	4	4
More support would be useful	1	1
Difficulties of current support	1	1
Company was not supportive on a caring level	1	1
a bit more concerns about us from the company or others for how we are emotionally	1	1
SUBTHEME Support from colleagues	3	3
supporting colleagues as coping	1	1
Supporting colleague more than self	1	1
Support for staff members	1	1
THEME Emotions and behaviours arising from the COVID-19 Pandemic	14	37
SUBTHEME Work as a medium for stability when everything else is changing	3	3
Workload during pandemic did not change	1	1
Work as usual	1	1
The only normal thing during COVID was work	1	1
SUBTHEME Self realisation and awareness	7	10
Start socialising the moment I could	1	1

Reality of nothing to talk about since no news.	1	1
Realisation	2	2
Men don't cry	1	1
happy that until know did not get COVID	1	1
Currently	1	1
COVID improved my life	1	1
Coughed guild	1	1
(forced) acceptance	1	1
SUBTHEME Difficulty adjusting in the beginning	5	8
First realisation	1	1
First lockdown	1	1
First emotional effect	1	1
effect from COVID	2	3
beginning of the pandemic the expectations were hight	1	1
Adapting lifestyle during pandemic	1	1
SUBTHEME Caring	9	10
Work whilst keeping your loved us safe	1	1
Unaware that you put others first	1	1
Stepping up to the occasion	1	1
similarities between work and home	1	1
Responsibility	1	1
Mindful of talking about work since other people did not go to work	1	1
keeping everyone happy at work	1	1
Helping people is part of who I am	1	1
Doing the right thing	1	1
Care is for people who care	1	1
SUBTHEME Anxiety	4	6
Anxiety, Loneliness since only work allowed for an escape	1	1
Anxiety because colleagues were working elsewhere as well, fear of infection	1	1
always worrying due to work	1	1
always worrying	1	1

afraid been alone and not having many things to do	1	1
A lot of anxiety	1	1
THEME Coping mechanisms	15	65
SUBTHEME Work related coping	4	11
Work as coping so that not to think	1	1
Taking time off work	1	1
Resilience and perseverance	1	1
Reflecting	1	1
Professional boundaries	1	4
maintaining hygiene standards	1	1
keeping the workplace safe	1	1
Keeping busy to forget about COVID and negativity	1	1
SUBTHEME Non-traditional coping mechanisms	5	12
Wishing coping mechanism	1	2
Small treats	1	1
My-time	1	1
life is very simple	1	1
Learning a new self	1	1
isolation is over so it's easier to cope	1	1
forced coping mechanisms	1	1
Excitement died out	1	2
Driving as a procedure of shutting switch off from work	1	1
Control as a form of keep going	1	1
SUBTHEME General activities	7	12
What helps with COVID	1	1
Using meditation as coping mechanism	1	1
Social media for connection	2	2
reading as coping	1	1
Online platform as coping	1	1
movies and game as coping	1	1
Gaming as a coping mechanism	1	2
drawing as coping	1	1
developing skills during pandemic	1	1

Crocheting as mindfulness	1	1
SUBTHEME Family	4	7
Preferred to have family around	1	1
living at close proximity to family which is helpful	1	1
Kids as coping	1	1
Family to help keep headspace busy	1	1
Family as coping	1	2
activities with family	1	1
SUBTHEME Faith and hope	6	9
never giving up	1	1
Hope to get out of lockdown	1	1
Hop that things will get better	1	1
Faith as a coping mechanism	3	6
SUBTHEME Exercise	4	4
Gym as coping	1	1
Going to walks since nothing else to do	1	1
exercise as coping	1	1
COVID helped engaged in walking	1	1
coping mechanism	4	10
THEME Challenging experiences	15	126
SUBTHEME Professional challenges	15	40
OTHER	11	20
work problems	1	2
Unhappy with employers	1	1
underrepresented staff focus on NHS	1	1
traveling between jobs (as support worker) can be dangerous	1	1
The need to work in order to pay the bills	1	1
scared about the job	1	1
Problem because he can't read the face due to face masks	1	1
pressure at work	1	1
Lack of PPE	1	1
Difficulties from service user's families	1	1
Biggest professional challenge	6	9

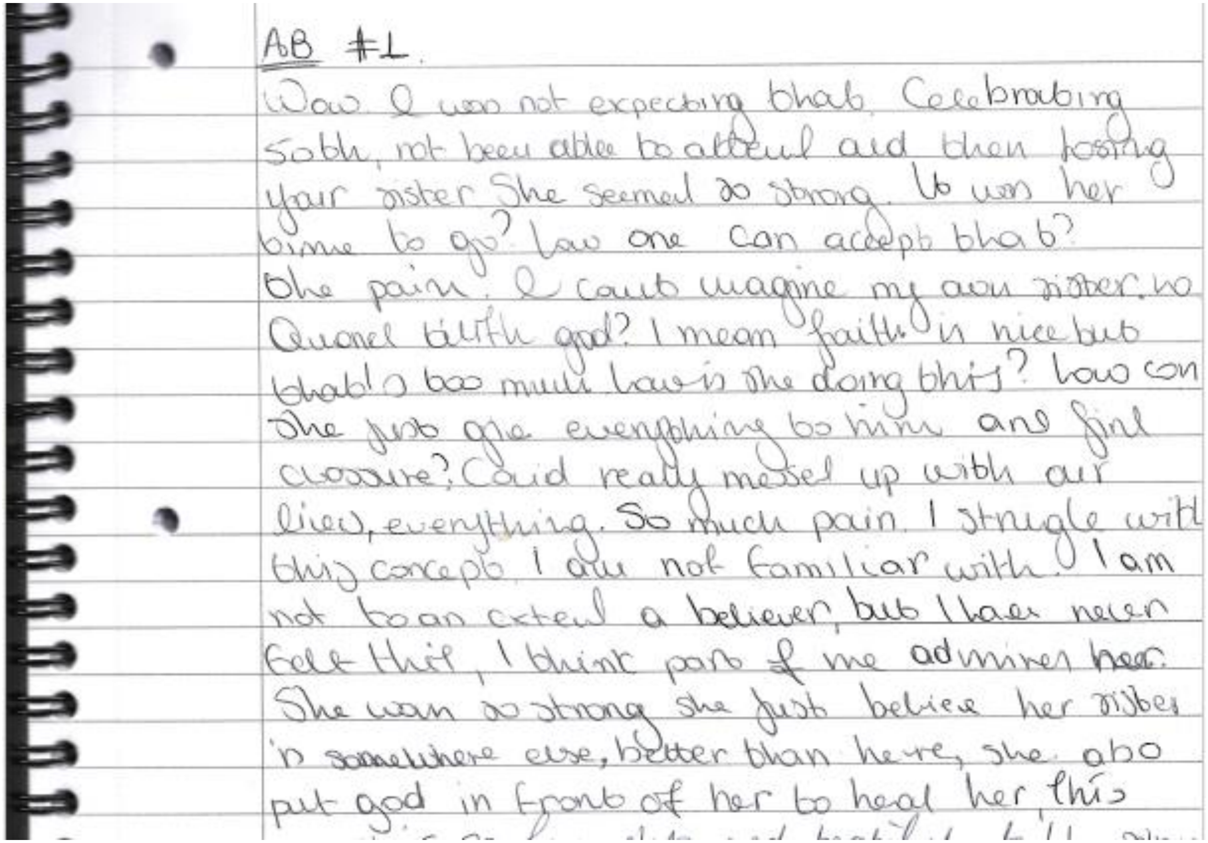
LACK OF SUPPORT STAFF	6	8
understaffed	1	1
The working hours because very exhausting	1	1
Impact to work	1	1
Giving good care#	1	1
Difficulties at work	2	2
Concerns related to work	1	2
COVID 19 AT WORK	5	6
Service users putting us at risk	1	1
Outbreak at one of the services	1	1
Moving in with service users to protect everyone	1	1
keeping the service user and self safe	1	1
Did not know what to do if they have a service user with COVID	1	1
Colleagues getting diagnosed with COVID	1	1
CARING FOR COLLEAGUES AND SERVICE USERS	6	6
the risk of been a support worker	1	1
permanently working	1	1
Overworking	1	1
Kept working to support colleagues	2	2
Difficult for the clients	1	1
SUBTHEME Personal challenges	14	44
LOSS OF LIFE	4	6
Personal impact of COVID	2	3
Losing a colleague	1	1
Impact of COVID	2	2
ISOLATION	7	7
missing normal days, but everyone is feeling the same	1	1
Living with COVID forever like the flu	1	1
Introvert still miss interaction	1	1
Impact of COVID on vacations	1	1
Fear of extended lockdown	1	1

Difficulty in the beginning	1	1
difficulties of COVID	1	1
HEALTH ISSUES	5	16
weight and mental health	1	1
Mental health currently with COVID	1	1
Mental health after getting COVID	1	1
Losing hope - no solution on sight	1	1
Living with long COVID	2	5
living with covid	1	1
Desperation and self harm	1	1
Desperation	1	1
COVID affected my quickness	1	1
Contracting long COVID	1	1
biggest challenge	1	1
A lot of health issues within the family whilst keeping the job and protecting everyone	1	1
FAMILY	9	15
Very conscious about seeing my nephew	1	1
Son's life affected due to covid	1	1
Really hard with kids	1	1
Not knowing how to react around family and friends because of the sector working in	1	1
Not been able to visit family during COVID	2	2
More difficulties in personal life than professional	1	2
keeping things to myself to protect others	1	1
Family and COVID	1	1
Desperation for help	1	1
Could not see family	1	1
Communicating with wife to explain	1	1
Burden	1	1
Biggest personal challenge	1	1

SUBTHEME Interlapping challenges	13	42
worrying that you will take it home	1	1
work life balance has taken a hit	1	1
Wanting to help in the time of need and crisis, resulted in arguments at home	1	1
Stress of the unknown	1	1
Stigma	1	1
Submit to fate	1	1
self sacrifice	1	3
Seeing is believing	1	1
Pushing for results at the expense of self	1	1
Not know what do make out of this disease	1	1
Not going out with clients caused agitation	1	1
not following plans, dreams due to COVID marathon race	1	1
Not everyone uses their mask	1	1
Not able to switch off	1	1
Normal people don't trust people like us	1	1
No work benefits to support difficult situations	1	1
No clear guidance from employers	1	1
nightmare	1	1
New situation	1	1
never switching off	1	3
My life is ruined because I’ve tried to help people	1	2
More stress, same activities	1	2
maintaining work life balance	1	1
living separate lives due to COVID and protecting family	1	1
Kept working even when ill	1	1
Into the unknown , mass hysteria	1	1
How to maintain employment but keep myself safe	1	1
Getting the results that I am positive	1	1
Getting infected with COVID	1	1

Fighting COVID both at work and at home	1	1
fear of infection	1	1
Fear of getting covid whilst providing care and whilst protecting colleagues	1	1
Doing your part	1	1
Constantly reassuring other but not self	1	1
Constant pressure	1	1
Biggest professional and personal challenge	1	1

Appendix 12. Diary [example 1]



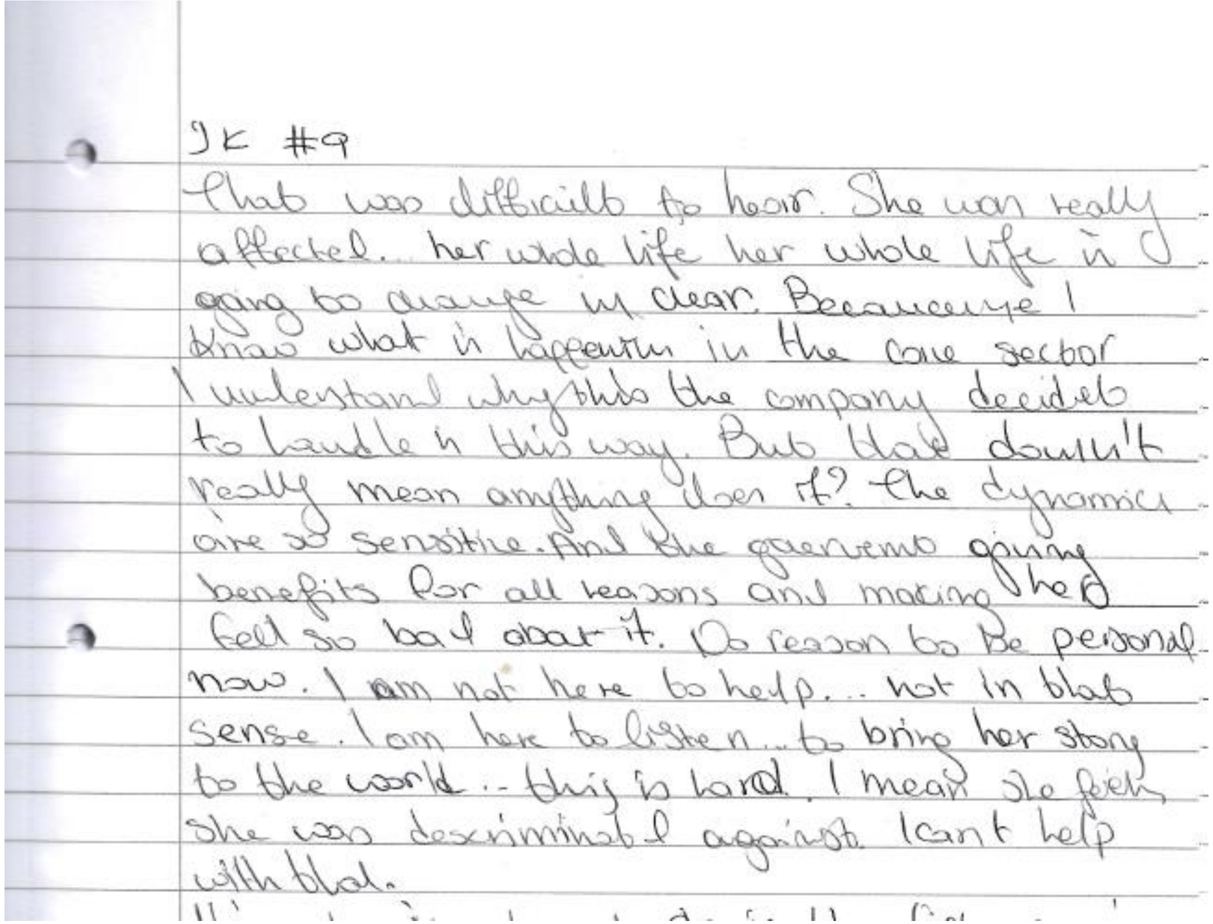
AB #1.

Wow. I was not expecting that. Celebrating
50th, not been able to attend and then losing
your sister She seemed so strong. It was her
time to go? How one can accept that?
The pain. I can't imagine my own sister. No
Quarrel with god? I mean faith is nice but
that's too much. How is she doing this? How can
She just give everything to him and find
closure? Could really messed up with our
lives, everything. So much pain. I struggle with
this concept I am not familiar with. I am
not to an extent a believer, but I have never
felt this, I think part of me admires her.
She was so strong she just believe her sister
is somewhere else, better than here, she also
put god in front of her to heal her, this

Wow I was not expecting that. Celebrating 50th, not been able to attend and then losing your sister. She seemed so strong. It was her time to go? How one can accept that? The	From my non-understanding to processing her beliefs as they are so much different from my own. I need time to process this.
	Trying to imagine my own sister and only the

pain. I can't imagine my own sister. No. Quarrel with god? I mean faith is nice but that too much. How is she doing this? How can she just give everything to Him and find closure. COVID messed up with our lives, everything. So much pain. I struggle with this concept I am not familiar with. I am not to an extend a believe, but I have never felt this, I think part of me admires her. She was so strong and she just believe her sister is somewhere else better than here, she also put god in front of her to heal her […]	thought terrifies me. I wouldn't quarrel with god, but emotions would be way darker. Need to distance myself, time to remove the thoughts that came to my mind due to this interview. Pure admiration from my side towards her.

Appendix 12. Diary [example 2]



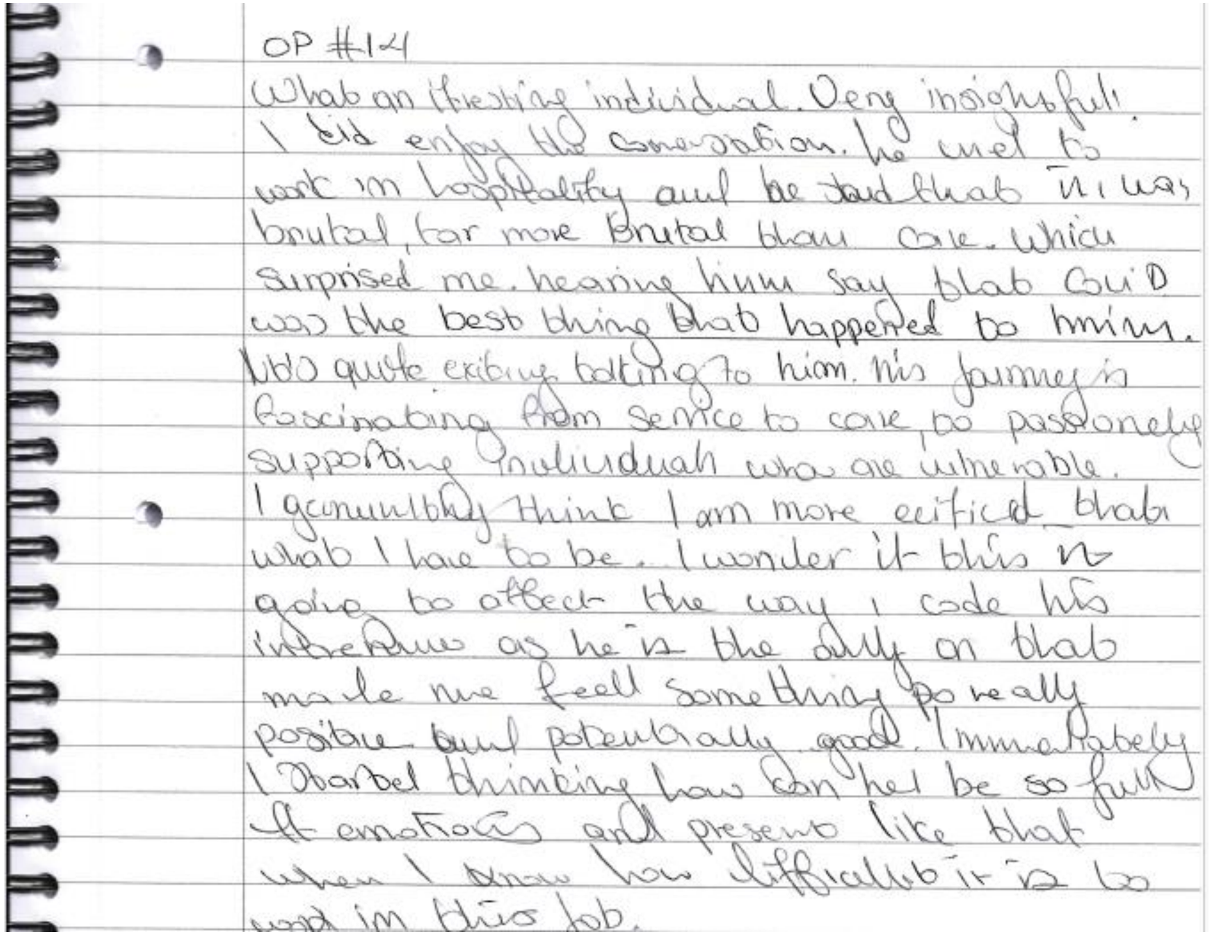
JK #9

That was difficult to hear. She was really
affected... her whole life her whole life is
going to change is clear. Because I
know what is happening in the care sector
I understand why this the company decided
to handle in this way. But that doesn't
really mean anything does it? The dynamics
are so sensitive. And the government giving
benefits for all reasons and making her
feel so bad about it. No reason to be personal
now. I am not here to help... not in that
sense. I am here to listen... to bring her story
to the world... this is hard. I mean she feels
she was discriminated against. I can't help
with that.

That was difficult to hear. She was really	Personal view. Come back to this interview

affected…her whole life is going to change and that […] is clear. Because I know what is happening in the care sector I understand why the company decided to handle it this way. But that doesn't really mean anything really. does it? The dynamics are so…sensitive. And the government giving benefits for all reasons and making her feel so bad about it. No reason to be personal now. I am not here to help… not in that sense. I am here to listen…to bring her story to the world…this is hard.	at the end. Knowing is actually good at this moment. Potential understanding of government may lead to less importance of her emotions? My overall emotions for this interview. Need time to reset

Appendix 12. Diary [example 3]



OP #14

What an interesting individual. Very insightful.
I did enjoy the conversation. He used to
work in hospitality and he said that it was
brutal, far more brutal than care. Which
surprised me. Hearing him say that CoViD
was the best thing that happened to him.
Was quite exciting talking to him. His journey is
fascinating from service to care, to passionately
supporting individuals who are vulnerable.
I genuinely think I am more critical than
what I have to be. I wonder if this is
going to affect the way I code his
interview as he is the only one that
made me feel something so really
positive and potentially good. Immediately
I started thinking how can he be so full
of emotions and present like that
when I know how difficult it is to
work in this job.

What an interesting individual. Very insightful. I did enjoy the conversation. He	Personal view-very positive. Still a strong emotion rather than neutral.

used to work in hospitality and he said it was brutal, far more brutal than care. Which surprised me hearing him say that COVID was the best thing that happened to him. It's quite exciting talking to him, his journey is fascinating from service to care to passionately support individuals who are vulnerable. I genuinely think I am more excited than I have to be. I wonder if this is going to affect the way I code his interview as he is the only one that made me feel something really positive but potentially good. Immediately I started thinking how can he be so full of emotions and present like that when I know how difficult is it work in this job.	Researcher's "hat", new concept. I can see that my thinking process have changed slightly on how to process information for the Prof Doc rather than only for business.

Appendix 13. Sample [1] of Thematic Analysis VS Interpretative Phenomenological Analysis

	IJ	**RTA**		**IPA**	
1	*I love going to the parks and stuff like that*	He loves parks for air, freedom?	Supporting pillars and connection	Second use of “love”, strong, primal emotion, connection to nature?	Support and intimacy
2	*I love spending time with my family.*	Family as a catalyst		Family construct, sphere – protect?	
3	*I love going to the zoo so I used to do a lot of things with my family and like more timeline 'cause it's me and my family like most of the time*	Zoo as something that the family enjoys, but it gives him time to spend time with family so a binding factor		Zoo as family time, intimate connection, potential peace. Family is the support mechanisms	
4	*They [the kid and wife] help me.*	Honesty on how he feels, supporting pillars	Pure support – knows why	Acknowledging the support. Simple yet powerful.	Strong support
5	*They support me*	Support		Powerful statement, raw, unrefined. Truth.	
6	*I got a very good partner*	Partner in life, appreciation	Support from partner & children	Giving credit to support. Partner is the cornerstone	Support from partner & children
7	*She supported me well mentally and physically*	Holistic support from partner, spoke with fondness		Partner is pillar. Steady, knows where he stands, facts presenting.	
8	*She’s always there and I've got kids as well*	She is having his back, able to ‘fight’ as she is there and having the kids adds up to the emotion of support		Knows that support, knows where he stand within this. Dynamic, feels centered.	

Appendix 13. Sample [2] of Thematic Analysis VS Interpretative Phenomenological Analysis

	DE	**RTA**		**IPA**	
1	*I ended [working] two or three waking nights*	Overworked? Ended up how? And why?		Forced? Ended up does not have a good meaning	
2	*I chose to do them because the manager that oversees that service has got children*	Caring nature; care for manager's children	Caring trait prevalent	Protector, caring, going above and beyond. Reasoning that if manager got COVID and then the children got COVID from manager then DE would feel negative emotions	Caring as a significantly important behaviour, integral part of who they are
3	*I was like well I've got no dependence*	Reasoning for care		Putting oneself at the forefront as they have to think only about themselves. This comes from a caring place rather than an ego place	
4	*so I would rather go in and risk getting it [COVID-19]*	standing up to a bigger task. Conscious of outcomes; risk assessing	Potential sacrifice	Assessed that DE can handle a potential COVID diagnosis due to being adult?	Ready to sacrifice part of self because of how much DE cares
5	*And of course this was way before vaccines that I would [say and think like this*	Using self as a shield to protect vulnerable population		No vaccine, yet willing to shield vulnerable individuals. Not only they support vulnerable adults on a day-to-day basis but that extends to the children as well. Caring nature.	

Appendix 13. Sample [3] of Thematic Analysis VS Interpretative Phenomenological Analysis

	KL	RTA		IPA	
1	*in the 10 days I stayed and I felt really, really supported*	Good support	Supported by manager	Very positive with the managerial support she received	Supported by manager
2	*But I probably would have liked to have maybe heard from some higher senior management*	Appreciated from manager but not at a higher level	Sadness with grievance	Appreciation only at a service level. Something is missing because the upper management team did not communicate their gratitude	Something was missing
3	*other than being mentioned in a newsletter by just not even by name, was the only kind of recognition I've that I've I felt I got for*	Recognition was non-existent		Not recognised. A simplistic mention of what she has done	
4	*moving in for 10 days, which obviously is quite a quite a big thing to do*	Acknowledging that the support she provided was important	Self-awareness	Recognising the gravity of her support. Self-aware	Self-awareness
5	*It is away from your own home, you know, and not being able to actually leave a property for ten whole days*	Explaining why she was not happy signifying the importance of her contribution		Specific about the situation, giving context almost like apologetically hinting the fact she was not appreciate d enough for her actions	

Appendix 14. Enhanced Supervision Protocol

Enhanced Supervision Protocol

Introduction

This supervision protocol should be used in complement to your organisations original policies and procedures. This protocol is not to be used as a standalone tool but rather as a complementary one. The basis of this protocol is to offer the supervisor a guided tool to navigate supervision during the times of a pandemic exploring the 4 areas of importance.

For the supervisor
I understand that:

- I will guide the supervisee according to the template and within reason
- I will maintain confidentiality according to my organisations policies and procedures
- I will offer advice/ guidance/ pathways of recovery after I make sure the plan of change advised is realistic OR in case I cannot, I will seek appropriate support from management / quality department / experts in order to advise the supervisee accordingly
- Prompts are for supporting you guide the conversation acting as a sample question. You DO NOT have to follow them. They are for indication only.

For the supervisee
I understand that:

- These sessions are confidential according to the organisation policies and procedures
- The supervisor may seek additional support from management / quality department / experts in order to build a guidance to advise me appropriately
- These records may be Accessed: for audit purposes from internal (e.g., Quality Department) or external parties (e.g., CQC, NHS trust, Local Council) depending on the area of work

Signed: [Supervisor]…………………………………… **Date:**………………………………

Signed: [Supervisee]…………………………………… **Date:**……………………………..

Enhanced Supervision Protocol

Introduction

This supervision protocol should be used in complement to your organisations original policies and procedures. This protocol is not to be used as a standalone tool but rather as a complementary one. The basis of this protocol is to offer the supervisor a guided tool to navigate supervision during

AREAS TO DISCUSS DURING SUPERVISION:

☐ Current Feelings ☐ Professional Challenges ☐ Personal Challenges
☐ Coping Strategies ☐ Pathway of Support / Change

Current Feelings:
prompts:

1. How are you feeling at the moment?
2. How is everything?
3. Forgetting everything for a moment, how are you feeling?

Professional Challenges
prompts:

1. What is your biggest concern within the service?
2. What do you think of the overall run of the service at the moment?
3. Do you have any concerns around how the care is provided?

Personal Challenges
prompts:

1. How is life treating you?
2. Is everything O.K. at the personal front?
3. How is your personal life? Any big stressors on that front?

Coping Strategies **Prompts:** 1. What helps you get going generally? 2. What keeps you motivated? 3. When you feel low, what bring you back to keep providing care?
Pathway of Support/ Change **Prompts:** 1. What can I do to make your work life easier during this time? 2. Do you know what you need to help you keep you motivated? 3. Any improvements we can introduce?

Notes :………
……
……
……
……
……
……
……
……
……
……
……
……
……

Appendix 15. Supervisee interviews and proposed approach from supervisor

Supervisee	1
Problem category	Personal Challenges
Domain	Missing socialising
Supervisee quotes	“I think probably speaking off from work and the worry. 'cause like I said, you know I couldn't go to the gym, I couldn't see my friends. I couldn't see family so that was quite difficult, quite isolating”. KL
Supervisor	How do you think we can help you so that you will not feel so isolated? Have you thought of using social media to connect with others? Would you find e-coffee days with colleagues helpful?
Supervisee	2
Problem category	Professional challenges
Domain	Long hours
Supervisee quotes	“Staff calling in sick and working 80 hours a week. Cause some staff obviously at the beginning, panic sort of went into self-isolation. Then we like we were working like 14 hour shifts. Pretty much moving in with our guys [service users] just to keep them safe”. NO
Supervisor	We will aim to discuss with local authority to inform them that we can't deliver on all core hours contracted. Would you be able to cope until then? We do appreciate all the support. As you understand this is an extremely difficult situation, what would you need to be able to cope? Do you think the quality of care you give is impacted?
Supervisee	3
Problem category	Support
Domain	Check on us!
Supervisee quotes	*“Advice that we usually get is you should go and speak to this person or that and they're mainly not available when you are”. BC*
Supervisor	Would allocating different times throughout the week be helpful?
Supervisee	4
Problem category	Coping mechanisms
Domain	Faith and hope
Supervisee quotes	“Erm, I would say my faith. Honestly, I would say my faith. Uhm, because as a Christian I have to just believe that, you know, its god’s will. […] I quarrel with God. I you know, I got angry and everything but after a while I started to calm down, and you know, just look at the bigger picture”. AB
Supervisor	Would you like us to allocate time in the staff office for prayer?

Appendix 16. Health Ethics – Amendment

University of Central Lancashire
Preston PR1 2HE
01772 201201
uclan.ac.uk

22nd September 2023

Neil Cook / Pavlos Kasdovasilis
School of Medicine and Dentistry
University of Central Lancashire

Dear Pavlos and Neil

Re: Health Ethics Review Panel Application
Unique Reference Number: HEALTH 0194 Amendment

The Health Ethics Review Panel has approved your proposed amendment to your application ‘UK healthcare support workers and the COVID-19 pandemic: An explorative analysis of adaptation and development of an intervention protocol to support coping mechanisms’.

Yours sincerely,

Simon Alford
Deputy Vice-Chair
Health Ethics Review Panel

Appendix 17. Questionnaire for protocol

1828
University of
Central Lancashire
UCLan

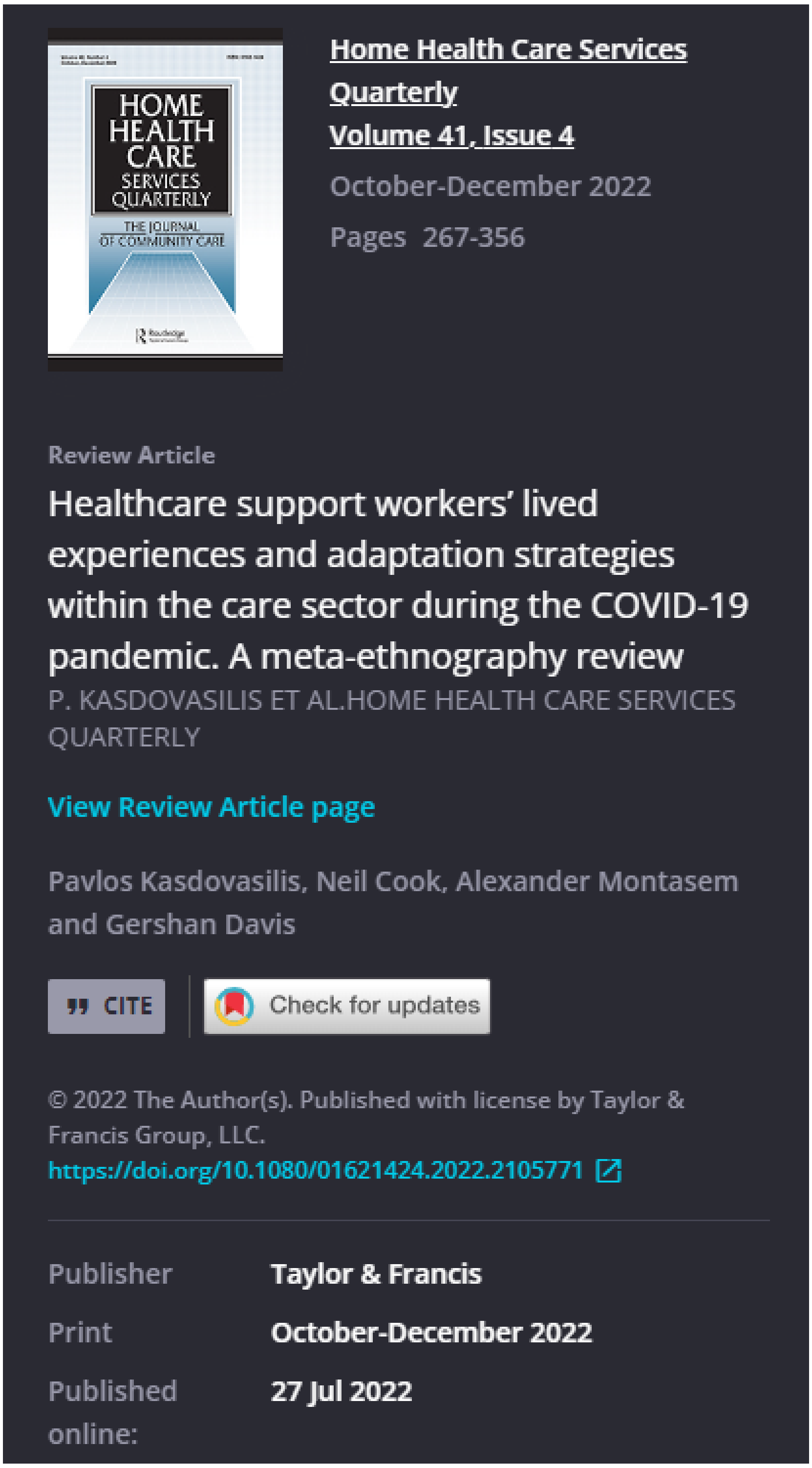
Thank you for agreeing to evaluate our protocol. This protocol was designed after carefully considering existing data, industry knowledge and current supervision practises. We would like to understand the potential usefulness of the protocol and get your feedback on potential improvements.

Please tick the box that is more appropriate for your answer.

[please note this protocol is intended to be used during a pandemic and at this stage it is just a recommendation for social care providers]

	QUESTIONS	1	2	3	4	5
1	I have received training on how to perform supervision (either from current employer or in the past)	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**
2	The current protocol is providing a helpful structure on the topics I need to discuss.	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**
3	Following the pathway presented is easier for me to discuss what I need to discuss. (Please consider this only based on the structure of the protocol since you have not used it)	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**
4	Overall, I find the protocol useful in times of a pandemic since it gives me the relevant pathway.	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**
5	I feel I can focus on the content of the conversation since the protocol provides me the structure	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**
6	Any additional feedback (feedback on usability, how well (or not) it can be integrated into current practice, whether it highlights new issues that would not otherwise be asked in the supervision etc)					

Appendix 18. Meta Ethnography Publication



Home Health Care Services Quarterly
Volume 41, Issue 4
October-December 2022
Pages 267-356

Review Article

Healthcare support workers' lived experiences and adaptation strategies within the care sector during the COVID-19 pandemic. A meta-ethnography review

P. KASDOVASILIS ET AL.HOME HEALTH CARE SERVICES QUARTERLY

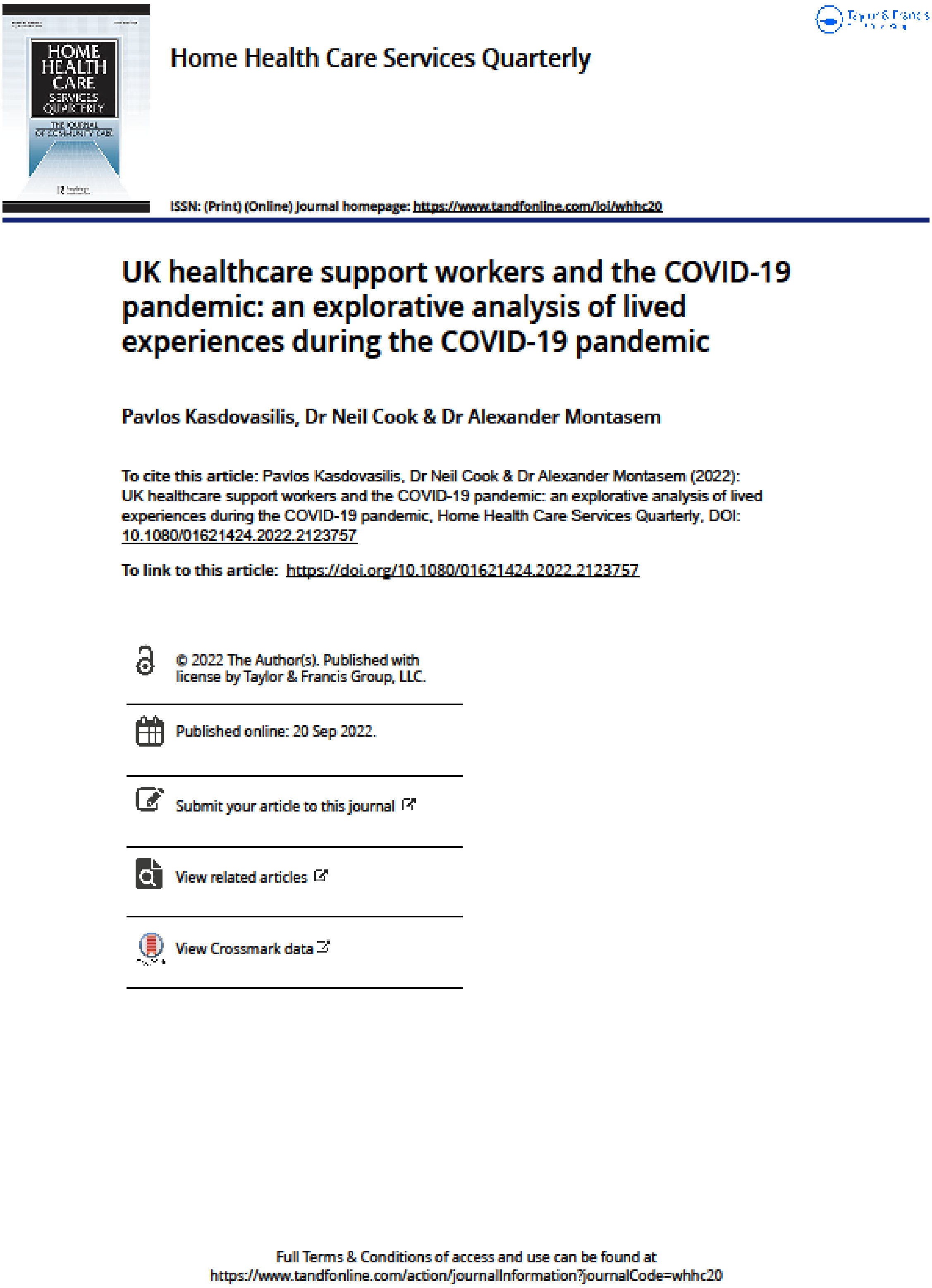
View Review Article page

Pavlos Kasdovasilis, Neil Cook, Alexander Montasem and Gershan Davis

https://doi.org/10.1080/01621424.2022.2105771

Publisher	**Taylor & Francis**
Print	**October-December 2022**
Published online:	**27 Jul 2022**

Appendix 19. Qualitative Study Publication



Home Health Care Services Quarterly

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/whhc20

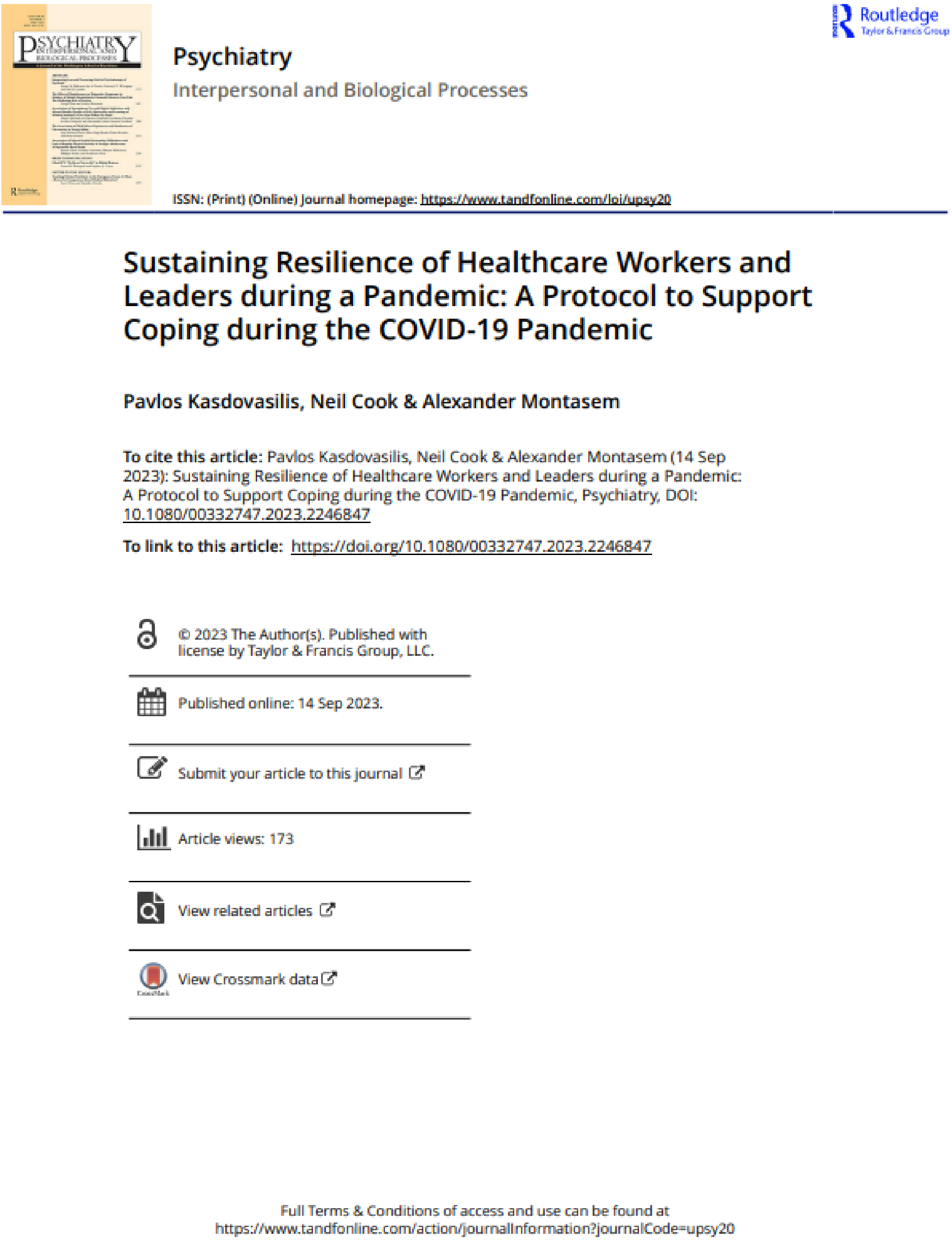
UK healthcare support workers and the COVID-19 pandemic: an explorative analysis of lived experiences during the COVID-19 pandemic

Pavlos Kasdovasilis, Dr Neil Cook & Dr Alexander Montasem

To cite this article: Pavlos Kasdovasilis, Dr Neil Cook & Dr Alexander Montasem (2022): UK healthcare support workers and the COVID-19 pandemic: an explorative analysis of lived experiences during the COVID-19 pandemic, Home Health Care Services Quarterly, DOI: 10.1080/01621424.2022.2123757

To link to this article: https://doi.org/10.1080/01621424.2022.2123757

Appendix 20. Theoretical Protocol Publication



Routledge
Taylor & Francis Group

Psychiatry
Interpersonal and Biological Processes

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/upsy20

Sustaining Resilience of Healthcare Workers and Leaders during a Pandemic: A Protocol to Support Coping during the COVID-19 Pandemic

Pavlos Kasdovasilis, Neil Cook & Alexander Montasem

To cite this article: Pavlos Kasdovasilis, Neil Cook & Alexander Montasem (14 Sep 2023): Sustaining Resilience of Healthcare Workers and Leaders during a Pandemic: A Protocol to Support Coping during the COVID-19 Pandemic, Psychiatry, DOI: 10.1080/00332747.2023.2246847

To link to this article: https://doi.org/10.1080/00332747.2023.2246847