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Human resource management in homecare in England: managing people for safe care during crisis

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Abstract

Background Human resource management (HRM) of healthcare organisations plays an important role in improving the continuity of care, managing staff, and ensuring patient safety. During COVID-19, there were several HR-related issues, creating a significant challenging situation for health and social care institutions. This study explored the HRM issues that are associated with the patient safety in homecare, and how homecare providers have responded to these HR-related challenges during the COVID-19 pandemic. The aim of this is to explore the role of HRM practices in helping care organisations operate efficiently and supporting their workforce to adapt to future disruptive changes and crises.

Methods Qualitative strategies include narrative inquiry involving gathering information in the form of storytelling by the research participants. Between February 2021 and December 2021, data were collected through semi-structured interviews of 31 participants, including homecare staff (homecare transition practitioners, homecare social workers, and carers), family members, and service users in England.

Results The research identified key HRM challenges during the pandemic, including staff shortages, high turnover, ineffective communication, occupational stress for front-line carers, and lack of training, all adversely affecting the safety of homecare patients. In response, homecare providers employed strategies like opportunistic recruitment, digital technology for training and communication, and flexible work arrangements to mitigate these issues.

Conclusions Several implications are proposed, with the over-riding aim of ensuring effective management of HRM practices in responding to address key areas: staffing, performance management, and training. Homecare providers should utilise short-term adaptive recruitment strategies, while also focusing on long-term workforce development and resilience to effectively respond to current and future care needs. Prioritising staff well-being for retention and care quality are crucial. Homecare providers are encouraged to offer flexible work arrangements and digital communication methods, all while being mindful of preventing technostress and digital exhaustion among their staff. They also need to bridge training gaps and employ effective delivery methods to equip healthcare workers with essential skills, thereby enhancing resilience and adaptability in homecare.

Keywords HR practices, Homecare, Social care, COVID-19, Safety, Care quality

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Introduction

In the healthcare sector, ample evidence supports the implementation of human resource management (HRM) practices to promote organisational performance outcomes [1–5]. However, much of this research has focused on acute hospitals, with other care settings, particularly social care, receiving far less attention. Since COVID-19, the scarcity of research on HRM and its related challenges in the social care sector has also become more evident, despite the sector being severely affected by the pandemic [6, 7]. Social care has borne the brunt of many policy and organisational changes aimed at managing the crisis, with staff, patients, and access to resources significantly impacted as priority was given to acute care [8]. What is particularly striking is the lack of research on homecare services. Therefore, there is an urgent need for research focused on homecare and address the HRM challenges within this sector.

In England, homecare encompasses a variety of care and support services designed to assist individuals in living independently within their own homes [9]. Homecare can be provided through hourly visits, where caregivers offer care for set periods, or live-in arrangements, where a caregiver resides full-time to provide around-the-clock support [10]. The great majority of homecare service in England are delivered by independent providers, including commercial (for-profit) and charity sectors; meanwhile, a small amount is provided by local councils or the National Health Service's Clinical Commissioning Groups [10]. The number of individuals receiving homecare in the country is increasing, driven by the aging population and heightened demand since the COVID-19 pandemic [11, 12]. As a result, the number of homecare providers has significantly increased in recent years. Approximately 9,528 homecare services were reported in 2018-19, marking a 23% increase over the six-year period from 2014 to 2019 [13]. By June 2024, this number had grown to over 12,000 registered homecare providers in England [14].

HRM plays an important role in ensuring high-quality care and improving patient safety in homecare [15, 16], yet HRM challenges continue to be significant barriers to achieving these outcomes [17, 18]. The pandemic has also brought long-present challenges in HRM in homecare to the fore, while adding a host of new ones. Therefore, our study aims to explore the emerging HRM issues that are associated with the patient safety in homecare in England during COVID-19 and examine how organisations adapted their HRM strategies to ensure patient safety. Identifying these challenges and adaptations is crucial for understanding how HRM practices can safeguard patient safety and care quality during crises, providing insights to inform policy and help organisations prepare for future disruptions.

Background

HRM challenges during the COVID-19 pandemic

The effective management of HRM practices plays a key role in an organisation's efforts to operate businesses and help their workforce adapt to disruptive changes and crisis [19, 20]. Despite this significance, many organisations have struggled to efficiently implement HRM practices in response to major disruptions, exemplified by the COVID-19 pandemic [21]. Recent research has highlighted a range of HRM challenges during this period including staff turnover and job loss [22, 23], concerns over employee wellbeing [24–26], difficulties in training delivery and addressing skills gaps [27, 28], as well as a decline in employee performance and productivity [29]. HR practitioners, therefore, have been under considerable pressure to adapt and transform HRM processes in response to the difficulties intensified by the COVID-19 crisis [30, 31].

COVID-19 has also brought further HRM challenges which organisations have been struggling to overcome. One of the most noticeable difficulties involves shifting to remote work environment or altering workplace conditions during the time of crisis [24, 32]. Managers and HR practitioners had to find new ways to ensure their staff having suitable equipment and digital skills to work from home, support employees' wellbeing, keeping them motivated, and maintain social connections and communication [25, 33]. Nevertheless, for other industries such as manufacturing, construction, or healthcare support, remote working is not a viable option [33]. As a result, health and social care organisations face significant obstacles in alternating and adapting new work arrangements.

Impact of HRM on healthcare organisational performance

Within the health and social care, the effective management of HRM practices and initiatives is critically important for individual and organisational performance [34, 35]. Key components of performance outcomes in healthcare organisations typically include financial results and costs, individual job performance, and quality of care (e.g., adherence to evidence-based practices, positive patient outcomes and experiences) [36]. In recent years, an important trend we observed in research within healthcare and organisational studies is the increasing emphasis on the quality-of-care services and patient safety. This focus has only been an important priority for organisations since the early 2000s [37], following a significant number of preventable incidents resulting from unsafe care practices, as reported by the U.S. Institute of Medicine (IOM) and the World Health Organization (WHO) [38, 39]. Since then, improving care quality and patient safety emerged as a key objective in healthcare organisational performance. Consequently, the important

link between HRM and quality and safety of care has gained increased attention in the fields of organisational science and healthcare [40–42].

In the context of acute care settings, there has been an abundance of evidence supporting the use of HRM practices in hospitals to promote healthcare organisation's performance outcomes, particularly in areas like quality of care and patient safety [1–5]. These studies demonstrated common findings that HRM is one of the crucial determinants to achieve successful healthcare quality programs through appropriate staffing levels, retaining highly skilled employees, ensuring high job satisfaction, empowering staff in the workplace, supporting employee well-being, establishing effective team structures, and fostering strong communication and leadership. Nevertheless, a significant amount of research has tended to focus on acute hospitals, whereas other care settings such as domiciliary care or homecare have been overlooked [15]. Critics have also pointed out that much research in HRM and patient safety has been specifically and predominantly directed at registered nurses in hospital settings and does not pay sufficient attention to other healthcare professions [36]. Therefore, research into HRM practices, patient safety, and care quality in homecare is critical to fill the gaps in the literature.

In homecare, a limited number of studies have highlighted the important role of HRM in ensuring high-quality care and improving patient safety [15, 16]. Prior to the COVID-19 crisis, reports and studies on patient safety in homecare found HRM challenges as major barriers to care quality and patient safety [13, 15, 17, 18]. The pandemic has also brought long-present challenges in HRM in homecare to the fore, while adding a host of new ones. Therefore, this study aims to explores emerging HRM issues related to patient safety in homecare during COVID-19 in England and examines how homecare organisations adapted their HRM strategies to ensure patient safety amidst the challenges of the pandemic.

The role of HRM in responding to COVID-19 in health and social care sector

The COVID-19 pandemic has exacerbated HRM issues in health and social care sector, placing considerable pressure on care providers. During this period, the major HRM challenges in healthcare were related to staff turnover and retention [43, 44], training and skill gaps [27], communication [45], managing staff and supporting their well-being [46, 47]. Nevertheless, despite the health and social care sector being heavily impacted by COVID-19, there have been limited studies exploring the role of HRM and HRM-related issues in health organisations. Furthermore, most of these studies have merely reported the HRM challenges encountered during the crisis, without investigating further about how these challenges can act as barriers to care quality and impact patient safety. Other research has also been calling for further qualitative studies looking into the impacts of HRM challenges to patient's experience [48]. Therefore, we aim to fill in this literature gap by investigating how HRM challenges influence homecare patient safety and discovering the responses of homecare providers during the pandemic.

HRM within healthcare organisations is crucial in effectively responding to the pandemic [49]. Health and social care providers have developed a number of HRM innovations, focusing on new ways of managing, ways of working, and work roles [35]. One of the most salient approaches has been using digital technology to transition to virtual forms of recruitment, selection, training, and online meetings [28, 50, 51]. COVID-19 might have brought the opportunities for changing work arrangements and skill upgrades with respect to the use of technology [50]; however, the digital transition approach has been seen to create difficulties concerning technology-related stress and exhaustion, as employees can be constantly expected to be available and respond to emails or online meetings [52]. Workload and working hours can be increased, resulting in stress and burnout among staff [45]; therefore, organisations must take into consideration of how their employees experience and feel about the virtual tools in times of the pandemic [24].

Besides using digital technology, care providers have responded to the HRM challenges through a mix of adaptation measures. For example, to increase care staff capacity, organisations recruited and redirected staff from other areas, including hiring and training unemployed individuals, encouraging retired carers to return to work, and recruiting the military, medical students and civilian nurses [27]. Nonetheless, there might be a potential limitation of adopting non-standard employment, which is that the staff might not be familiar with the new roles due to their lack of experience in incident response [53]. Furthermore, relocating staff to work during COVID-19 might pose potential risks, cause distress and conflicts, and raise other ethical concerns for professionals [54–56]. As a result, healthcare providers must be able to justify the process of staff reallocation and carefully prepare guidelines for non-standard employees [53, 55]. Once again, it is noteworthy that most studies investigating HRM issues in healthcare organisations during COVID-19 have been conducted primarily in acute care hospitals and very little research is focusing on homecare, revealing a significant gap in the literature. Additionally, a majority of these research have only explored the issues in HRM but did not investigate further the impact of these issues on care quality and patient safety. Such an extensive list of emerging HRM-related issues caused by the pandemic requires further discussion regarding their

influence on the quality-of-care service and patient experience, especially in homecare settings.

Methodology

The research took an inductive approach using the qualitative strategy of narrative inquiry which involved gathering information in the form of storytelling by the research participants [57]. The narrative research is suitable for exploring a phenomenon which detailed stories help understand and for grasping how people create meaning from their experience [57, 58]. In this case, the narrative research strategy helps explore the HRM challenges in homecare during the COVID-19 pandemic, their impact on care quality, and the HRM approaches employed by homecare providers to address these challenges. This strategy also allows for reviewing the participants' stories to validate the meaning and interpretation of the research topics in homecare from different perspectives.

Therefore, this research employs semi-structured interviews, as they provide the flexibility needed to explore a wide range of issues related to HRM challenges in homecare, while allowing participants to share their experiences in their own words. Semi-structured interviews enable participants to go beyond a strict set of predefined questions, offering richer, more nuanced insights into how they experienced and addressed the challenges posed by the COVID-19 pandemic [59]. This approach is particularly well-suited to narrative inquiry, as it encourages storytelling and deeper reflection, helping to capture diverse perspectives on HRM practices and their impact on care quality [60].

Data collection methods

Data were collected by the first author between February 2021 and December 2021 through semi-structured individual interviews. A total of 31 participants were selected, including homecare staff (homecare transition practitioners, social workers, and carers), family members, and service users (Table 1). The participants come from various regions across England. This selection was made to capture a diverse range of perspectives from across the country, reflecting the shared challenges and approaches

Table 1 List of interview participants

Interviews (I)	Roles	Regions	Types of care provided / received
I.01	Homecare Transition Practitioner	Yorkshire & the Humber	Hospital-to-home transition
I.02	Homecare Transition Practitioner	Yorkshire & the Humber	Hospital-to-home transition
I.03	Homecare worker (Carer)	London	Basic supportive care
I.04	Homecare worker (Carer)	South West	Basic supportive care
I.05	Homecare worker (Carer)	Yorkshire & the Humber	Basic supportive care
I.06	Homecare worker (Carer)	East Midlands	Basic supportive care
I.07	Homecare worker (Carer)	London	Basic supportive care
I.08	Homecare worker (Carer)	North West	Basic supportive care
I.09	Homecare worker (Carer)	East Midlands	Basic supportive care
I.10	Homecare worker (Carer)	Yorkshire & the Humber	Basic supportive care
I.11	Homecare worker (Carer)	West Midlands	Basic supportive care
I.12	Homecare worker (Social worker)	East Midlands	Care services coordination
I.13	Family member	West Midlands	Supportive care, assistance
I.14	Service user	London	Basic supportive care
I.15	Homecare worker (Carer)	West Midlands	Basic supportive care
I.16	Service user	East Midlands	Basic supportive care
I.17	Homecare worker (Carer)	South West	Basic supportive care
I.18	Homecare worker (Carer)	East of England	Basic supportive care
I.19	Homecare worker (Carer)	East of England	Basic supportive care
I.20	Homecare worker (Carer)	Yorkshire & the Humber	Basic supportive care
I.21	Homecare worker (Carer)	Yorkshire & the Humber	Basic supportive care
I.22	Homecare worker (Carer)	Yorkshire & the Humber	Basic supportive care
I.23	Homecare worker (Carer)	East Midlands	Basic supportive care
I.24	Homecare worker (Carer)	North East	Basic supportive care
I.25	Homecare worker (Carer)	North East	Basic supportive care
I.26	Homecare worker (Carer)	London	Basic supportive care
I.27	Service user	Yorkshire & the Humber	Basic supportive care
I.28	Homecare worker (Social worker)	East Midlands	Care services coordination
I.29	Homecare worker (Carer)	London	Basic supportive care
I.30	Family member	East Midlands	Supportive care, assistance
I.31	Service user	London	Basic supportive care

to HRM in homecare services during the COVID-19 pandemic. All research participants are involved with the same type of provider, which is private, for-profit organisations that deliver personal care and support to individuals in their own homes through hourly visits.

None of the participants declined to participate or withdrew from the study. In this paper, homecare staff are also referred to as care workers, support workers, carers, and caregivers. Participants were recruited through opportunistic and snowball sampling methods, with informed consent obtained from each participant. Due to COVID-19 restrictions on face-to-face meetings, the interviews were conducted online or by phone. Each interview lasted between 45 and 60 min, was audio-recorded, and then transcribed. Field notes were taken during and after each interview. Full transcripts were developed immediately after each interview and were then returned to the participants to ensure that their statements were accurately captured and to allow for any corrections or comments. No repeat interviews were conducted, and data saturation was reached when no new themes or insights emerged. The first author designed and structured the interview questions based on key themes identified in the literature review (e.g., staffing challenges, training and development difficulties, staff performance and well-being, changes in work conditions, communication, leadership, impact on patient safety and quality, etc.), which served as the foundational framework for the semi-structured interviews. Three sets of questions were prepared: one for homecare workers, one for service users, and one for family members (Supplementary File 1).

Data analysis

In this research, thematic analysis was used by the first author for analysing the data. The researcher first read through the transcriptions, then sorted related ideas and patterns into various key categories using a list of codes, which were reviewed and arranged into organising themes [61]. The interviews were transcribed and identifying information was pseudonymised in this process. The analysis was performed in English and the software NVivo 11 was used to organise, manage, and analyse data. The thematic analysis began after the first interview, with repeated reading of the first transcripts to identify key themes related to the review of the literature. Then, the data was coded and there were three forms of coding: open coding, axial coding, and selective coding.

The analysis began with open coding, where the first author conducted a first read-through of the collected data and condensed them into initial categories [62]. The researcher remained open to creating new themes and revising initial codes throughout the analysis. During this stage, open codes were developed both from the interview data and insights from the literature review (Supplementary File 2). In the axial coding stage, these open codes were organised into themes and sub-themes, with four initial themes identified: staffing, communication, carers' occupational stress, and lack of training. During selective coding, all data and codes were reviewed by the first author to examine selectively relevant themes and select data that supported the central conceptual themes [62]. After that, all three authors reviewed the codes and discussed them together to ensure coherence, refine the themes, and validate the overall analysis. Theme 2 (communication) and theme 3 (carers' occupational stress) were amalgamated to present a bigger picture of the challenges in managing staff, resulting in three final themes that were refined into a cohesive narrative that addresses the research questions. These final themes are detailed in the next section.

Findings

The findings revealed three dominant themes highlighting the HRM challenges that can negatively affect the safety of service users in homecare and how homecare providers responded to these challenges (Fig. 1).

Making do: staffing home care in crisis

Shortage of staff has been a significant challenge to homecare providers during the time of crisis. Data from the research participants reveal that homecare workplaces experienced high turnover and staff shortages during the pandemic due to staff burn-out, fear of virus, lack of support from the care providers, and staff isolating with confirmed COVID-19 or with suspected infection. For example, one homecare social worker said:

> *There's obviously a certain number of people working in homecare would have had COVID as well, but at that time, it obviously posed challenges to them. [...] They would need to self-isolate and wouldn't be able to go into people's homes (I.12, Social worker).*

Since COVID-19, homecare providers have experienced additional staffing hurdles related to recruitment and retention of staff. In recent years, a significant number of social care staff have been leaving the sector, presenting significant challenges for providers in recruiting care workers, directly affecting care service. For example, research respondents reported that because there was not enough staff, service users might have to receive less care than normal:

> *There was one time when many clients needed services, and we faced a challenge because many team members, especially the older ones, were not available or had resigned. This created a shortage of staff*

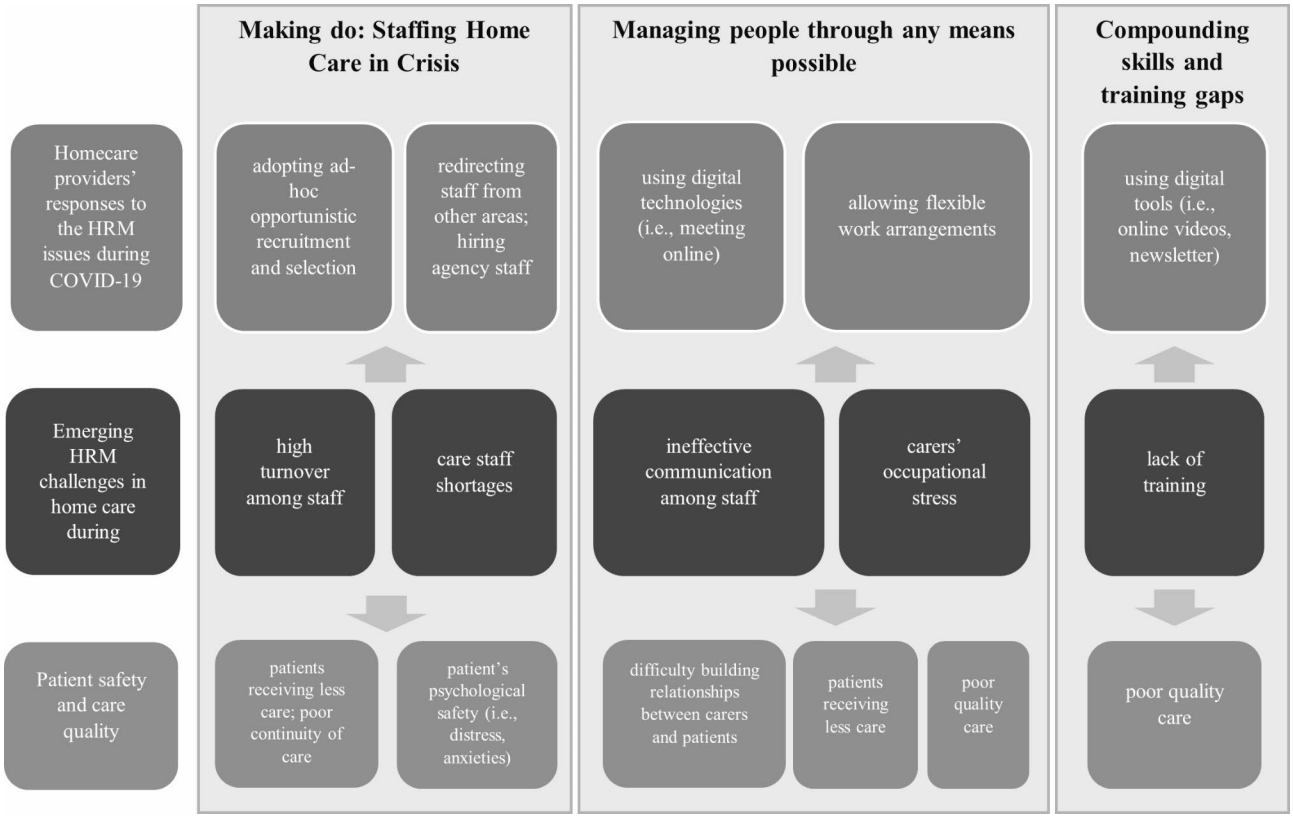


Fig. 1 HRM challenges impacting homecare patient safety, and responses from homecare providers during the COVID-19 pandemic in England

for client care, making service delivery more difficult (I.03, Carer).

Before the pandemic, my doctor used to visit five days a week. During the pandemic, this was reduced to three days a week, and currently, we are considering reducing it further to two days a week (I.27, Service user).

In addition, if an excessive number of staff members fall ill and are unable to work, the amount of care and support provided to certain individuals would be reduced. The service users will receive fewer hours of care than are currently funded for them due to the shortage of available staff to deliver the required services:

In the event that too many staff became ill with COVID and there wasn't anyone there to support, certain individuals will be given less care, less hours than what they are being funded (I.20, Carer).

Furthermore, high turnover can lead to the inconsistency in the care workforce. It can potentially impact the performance of the team and patient's psychological safety by causing distress for patients who do not like to have many different caregivers coming to their homes:

The inconsistency with staff members can cause a lot of distress and anxiety for the individual. Some individuals like to know when people are coming home, and if the individual doesn't know who's coming on, getting someone that they don't like or not very keen on for that day, it can cause a lot of anxieties for the individual (I.06, Carer).

Although shortage of staff is not a new phenomenon in healthcare sector, COVID-19 has put a lot more pressure and extra constraint on healthcare organisations to change their HR strategies. All homecare managers in this study reported that their organisations had to adopt an ad-hoc, opportunistic and 'all hands-on deck' approach in the recruitment and selection processes during the time of crisis. For example, all interviews must be conducted online, work experience criteria were reduced, fewer reference checks, and fewer shadowing shifts for new employees to lessen in-person interaction. Respondents also expressed difficulty in recruiting and retaining support workers due to high turnover rates, inconsistent care provision, and low wages in the healthcare and social care sectors:

One challenge I had was to interview and select twenty-two applicants for the support worker positions (I.19, Carer).

The turnover in the sector can sometimes mean that people won't have a consistent person coming into their homes, so this challenge for the home carers and the providers themselves will be relatively short periods of time to work with people from the amount that they're paid as well, so I think it can be a challenge of recruiting people into the sector, then retaining them (I.12, Social worker).

In addition, to address staffing challenges, homecare providers had to relocate staff from different areas to undertake care duties or recruit more temporary care staff. For example, some participants, including managers and homecare transition practitioners, were asked to perform care duties at service users' homes, which were not part of their responsibilities before COVID-19. Additionally, care providers had to recruit more temporary carers and agency staff to cope with staff shortages:

I remember applying for the job and then getting a call from a woman at the agency. She seemed eager for me to start working immediately. […]. We had a Zoom interview. I met with the woman from the agency and, I believe, her boss. The manager of the agency was also there. They seemed to like me and offered me the job (I.23, Carer).

Managing people through any means possible

The second theme focused on how homecare providers had to find as many different ways as possible to manage their care staff. Given the extreme pressures of the pandemic, homecare organisations could be seen to adopt a highly ad-hoc approach to HRM in order to deal with the rapidly growing problems with which they were presented. This could be seen across a number of issues. For instance, communication was highly disrupted as many carers expressed that they struggled to communicate effectively with their managers. Some said there were slow email replies or no responses from phone calls; others reported they did not have as many supervision meetings as before:

I have occasions where you're required an immediate response from your line managers, especially nowadays where it's working from home, and it can be quite difficult sometimes to get in contact with them. I've had incidents that required on call but there's been no answer from on calls (I.06, Carer).

In homecare, individuals often work alone, so not being able to reach a manager can be problematic for the service users. […] During summer, I faced a delay in response when inquiring about shifts, which was a bit frustrating, especially when I was readily available. Prompt communication is key in this field, and such lapses, even if rare, can be inconvenient (I.17, Carer).

Usually, I have one supervision meeting per month but now I only meet my line manager online once in every three or even four months because she's always busy since COVID (I.29, Carer).

The challenges in communication such as delayed responses can create obstacles for homecare workers in delivering timely and appropriate services to service users. Caregivers described difficulties in communicating with their managers can hinder their ability to perform duties effectively and may impact the safety and well-being of service users:

Communication with the head office can be challenging due to delayed responses or being passed between departments. […] Delayed responses can hinder my ability to do my job effectively, which might indirectly impact service user safety (I.10, Carer).

From the interviews, carers also indicated that they experienced occupational stress attributed by poor communication and management. For example, two homecare transition practitioners in this study expressed their frustrations when their transition tasks were suspended, and they were required to take on-call shifts and deliver care to service users, which are not their duties before COVID-19. One of them, who decided to leave the role soon after due to this reason, said:

I feel overwhelmed with workload, especially when asked to perform tasks not part of my job (I.02, Homecare Transition Practitioner).

These are significant issues which can negatively impact the care quality. One carer expressed that *"fatigue can hinder your ability to perform well"* and emphasised the

importance of maintaining sound well-being to deliver high-quality service (I.03, Carer).

In response to these challenges in staff management, homecare providers and managers had to find ways of improvising approaches to communication, safety, and managing performance. Organisations have altered their management of staff by adopting technologies to organise meetings online, enabling remote work for admin staff, and allowing flexible work arrangements:

> *All meetings with my staff are now on Teams. Often, we had to video call after midnight after the individual went to bed (I.07, Carer).*

> *Communication is mainly through WhatsApp. They inform me about available shifts, and sometimes they call if there's an urgent need (I.18, Carer).*

> *Before COVID, staff members had to attend in person for handovers, but now I can only email or text my colleagues because we are not allowed to meet in person (I.11, Carer).*

The data suggested that homecare staff have had to adapt their lives around the pandemic and co-ordinate work through any means possible, which detrimentally affected their mental health. For instance, some carers said they were under pressure and stressed when being expected to answer calls or emails instantly, even during late hours or during their days off. Participants also found it difficult to provide or receive emotional support and build relationships with their colleagues or service users virtually, especially during the challenging time of COVID-19. A transition practitioner said:

> *The pandemic restricted the amount of time or visit that I could go see the individuals that required support in person, and it was all restricted to online, slash zoom calls and that had an impact on the rapport built with the individual. I feel like it didn't build up the same level of trust (I.01, Homecare transition practitioner).*

Compounding skills and training gaps

The crisis both presented large challenges with maintaining training and development activities, while also present a large number of new training needs. A significant challenge emerged from data is the lack of training provided by care providers during the COVID-19 pandemic. A support worker described she only received one brief training session online about how to use personal protective equipment (PPE). Another care worker expressed how his care agency only sent out government guidelines, newsletters, and online resources through emails but offered no specific training:

> *They were sending out weekly newsletters informing staff about mental health or looking after yourself, then some updates on the government guidelines, and other things, and they're kind of expected us to read through and learn it by ourselves (I.26, Carer).*

Some homecare team leaders and managers suggested that care providers did not know much about the virus and therefore, were slow to respond. Additionally, providers faced significant difficulties in interpreting and keeping up with the rapidly changing sector-specific guidance. The frequent updates and sheer volume of information posed substantial challenges, which make it hard for homecare providers to stay current and compliant with the latest guidelines:

> *I think there's been a lot for providers to interpret. My observation is that the guidance has changed fairly quickly […] I think no matter what sector we've worked in, the sheer amount of guidance that has come through has been absolutely challenging to keep up with (I.12, Social worker).*

This lack of clarity about PPE requirements could increase infection risks among homecare service users, seriously affecting their safety. Furthermore, without appropriate training, homecare staff might find it difficult handling challenging situations, which could potentially lead to errors and cause harm to service users. For instance, a member of care staff expressed that they were not guided by her employer on how to handle the situation when the service users feeling stressed and wanting to go out during the national lockdown, raising concerns about emotional, social, and functional safety:

> *There is the challenge of helping them understand why they can't, for instance, going to the cinema, or go to a recreational activity within the community. If they feel like they cannot go out or they cannot go to shop or cinema, it could affect their emotional health or mental health (I.22, Carer).*

> *[…] the service user can get quite frightened, can get quite scared when something that's not been explained to them (I.21, Carer).*

In response to skills and training gaps, a few homecare organisations have tried and adopted digital tools to provide some trainings for their care workers during COVID-19. For example, one care support worker mentioned that they had to watch online videos about COVID-19, while a homecare manager reported using Zoom for training. However, some carers said they found it difficult to use digital tools and some methods of online training were not very engaging. Overall, there were still significant issues in compounding skills and training gaps when homecare providers struggled to find ways to train their staff. A lack of clarity about guidance also raised serious concerns about homecare patient safety.

Discussion

Our study explored the emerging HRM challenges that are associated with homecare patient safety in England and how homecare providers have responded to these challenges during the COVID-19 pandemic. The aim of this is to explore the role of HRM practices in helping care organisations operate efficiently and supporting their workforce to adapt to future disruptive changes and crises. There were three key themes identified: staffing homecare in crisis, managing staff through any means possible, and compounding skills and training gaps. Each theme has presented a number of HRM issues during the pandemic: staff shortages, high turnover, ineffective communication, employee occupational stress, and the lack of training. These issues are significant barriers to homecare patient safety as highlighted by previous research and reports [13, 15, 17, 18].

In the first theme, the data revealed that homecare organisations had to take on ad-hoc opportunistic recruitment and selection, redirect staff from other areas to take care duties, and hire temporary agency staff, in response to staff shortages and high turnover. During the pandemic, many care providers experienced challenges in recruiting, retaining, and maintaining staff morale [43, 44, 48]. Data from this study showed similar findings of homecare providers struggling to retain and recruit care employees. A number of reasons for this issue include staff burn-out, fear of virus, lack of support from the care providers, and staff isolating with confirmed COVID-19 or with suspected infection. Without sufficient number of care workers, service users receive less care than normal because the providers facing challenges in maintaining continuity of care. Some service users also feel stressed and anxious when they keep receiving care from different people due to high turnover of staff. These findings reflect the importance of HR practices in recruitment and retention to ensure safety and well-being of service users [5, 23, 34].

Responding to staff shortages and high turnover, homecare providers have adopted ad-hoc opportunistic recruitment and selection (e.g., online interviews, fewer reference checks, fewer shadowing shifts for new employees), mass recruitment, hiring temporary agency carers, and redirecting staff from other areas. Previous studies have shown that other organisations including healthcare providers had similar approaches [25, 28, 50, 51, 56]. However, these measures have also created new challenges to HR managers in terms of dealing with inexperience non-standard care staff [53], and ensuring there are no potential risks and ethical concerns to those who are relocated to work during COVID-19 [55]. In this research, two transition practitioners described their frustration in the way their managers required them to deliver care at people's homes, which was not part of their duties before the pandemic. Although task allocation can be a quick solution for capacity problem, it can raise conflicts and cause distress for care workers [56]. Previous research has also discovered the negative feelings of health professionals who were reallocated to COVID-19 unit at hospitals [54].

The second theme of this paper has shown how homecare providers had to manage their staff through any means possible by using digital technologies or adopting flexible work arrangements. Data from this study revealed the majority of carers experienced a lack of responses from their managers during the time of crisis. Leadership communication has strong influence on staff work performance [36, 42, 45] and the lack of communication can be a major of stress and contribute to employee burnout [25]. Indeed, COVID-19 has made a serious impact on healthcare professionals' health and wellbeing as they are at high risk of stress, burnout, fear, and anxiety [43, 46, 47]. In this research, data have shown the feeling of burnout or stress can adversely impact the performance and commitment of staff to their jobs, which leads to service users receiving less care or poor-quality care. These findings are consistent with previous research of how communication issues and occupational stress during COVID-19 can negatively affect the performance of carers, potentially leading to poor quality care services [27, 44].

This study has shown homecare providers had to find new ways to improve communication and manage their performance. However, there was a lack of wellbeing support from homecare team leaders to their staff, whereas in hospital settings, there have been evidence of how effective leadership and communication can improve performance of health professionals during the time of COVID-19 [49]. To maintain communication and managing staff performance, homecare organisations' approaches have included using digital technologies to organise meetings online, enabling remote work for admin staff, and allowing flexible work arrangements such as online handovers or late-night video calls for

night shift care workers. These adaptation measures corroborate findings from previous research on organisations adopting digital tools and remote work to maintain communication with their staff [28, 50, 51]. Nevertheless, even with digital tools, some respondents in this study still expressed their struggles in communicating with their managers. This finding is in accordance with previous research showing difficulties in communication among healthcare workers during the pandemic despite the implementation of digital technology [45]. Interestingly, this paper also found an opposite result of some other participants describing their feeling of pressure while being constantly expected to answer calls or emails. This emerging issue was similarly discussed in prior research on technostress and digital exhaustion [24, 52].

Regarding the third theme of compounding skills and training gaps, the research found that all homecare providers used digital tools as an effort to provide training for staff; however, it was challenging for them to effectively identify the training needs, develop the training programs, and implement appropriate training methods. During the time of crisis, training on knowledge related to COVID-19 and contagion control methods are essentials to the safety of staff and patients [49]. Nevertheless, most participants reported there was a lack of training on knowledge related to COVID-19. It was explained by the uncertain situation of COVID-19 and the inconsistency in official national guidance in preventing transmission and protecting workers from the virus. Although previous studies have reported challenges in training delivery and skills gaps during COVID-19 [27, 28], training arrangements have been highly focused and prioritised in hospital settings [49]. Scholars even consider COVID-19 pandemic as an opportunity for organisation to eventually upgrade skills and competencies [50]. However, in homecare sector, lack of training still is a major HR challenge. Without proper training, homecare support staff might not know how to handle PPE requirements, or they might struggle in dealing with challenging circumstances, all of which could potentially cause harm to service users physically and mentally. In line with these findings, prior studies provided evidence of how lack of training and unskilled care staff can negatively impact the safety of patients [63]. The COVID-19 has further exacerbated this HR challenge, adversely impacting the quality of care [27, 44]. Consequently, it is imperative for homecare providers to develop relevant training strategies, ensuring their staff receive adequate knowledge and skills to perform their roles effectively and deliver high-quality care.

The only adaptation approach which all homecare providers in this study took was to use online training tools such as videos, newsletters, and virtual training courses. Nonetheless, some care workers expressed the methods of passive online training were not very engaging. This research also found very little evidence of homecare managers providing training on the use of digital tools. As a result, homecare providers must not overlook this type of challenge among employees so that they can also train them on the utilisation of technology to facilitate their work and communication [28]. Although using digital technology is a popular measure among organisations during the time of pandemic [50, 51], this study has shown that homecare organisations still face major HRM challenges related to identifying the needs for technological training, the development of training program, and the utilisation of proper training methods. Therefore, homecare managers need to explore innovative training methods and programmes, ensuring that staff members are equipped with all the essential knowledge to effectively prepare for future crises.

Conclusions, implications, and future research

This research found several HRM challenges that emerged during the COVID-19 pandemic and could harmfully influence the safety of patients in homecare in England: staff shortages, high turnover, ineffective communication, occupational stress, and the lack of training. These issues could lead to patients' inability to access care, patients receiving less care or getting poor quality care, also cause potential risks and harm to service users. This study also provided evidence of how homecare organisations have responded to the difficulties through huge individual and collective efforts, from increasing care staff capacity by adopting ad-hoc opportunistic recruitment and selection, and redirecting staff from other areas, to embracing digital technologies and allowing flexible work arrangements. Nevertheless, some of the HRM issues including staff shortages and training gaps persist without definite solutions, and COVID-19 even brought further challenges in how to deal with non-standard employment, redirect and reallocate staff appropriately, and maintain effective communication while making sure there are no technostress or digital exhaustion among staff. Therefore, homecare organisations in England are still facing many major HRM challenges, and at the same time have to ensure to protect the wellbeing of both carers and service users.

A number of implications are proposed, with the overriding aim of ensuring effective management of HRM practices in responding to address key areas: staffing, performance management, and training. In response to staff shortages and high turnover, while short-term adaptive recruitment strategies (ad-hoc opportunistic recruitment and selection, redirecting existing staff to different roles) can be effective, it is important for homecare providers to consider the second-order side effects of the responses [47], and ensure that staff are adequately prepared before

assigning them to care roles. Providing relevant training to temporary support workers and agency staff is key to maintain the quality and continuity of care [64]. For a long-term approach, we encourage homecare providers to focus on long-term workforce planning, investing in skill development, and creating a stable, competent workforce that is not only aligned with evolving care needs but also equipped and resilient in responding to future crises [20].

In terms of management challenges, flexible working arrangements and digital methods can are important to maintain communication and performance. However, staff well-being and mental health should be prioritised to enhance retention and care quality [33]. Homecare providers should provide comprehensive support and protect the wellbeing of their staff [20], improve communication and demonstrate strong leadership [28, 36], and be mindful of avoiding technostress and digital exhaustion while adopting digital technologies for communication and training. Maximising the benefits of flexible work requires aligning it with employee autonomy and establishing a trust-based employment environment [65].

Addressing training gaps, we recommend that homecare providers identify training needs, develop relevant training programs, and use proper methods for training delivery [66]. This approach not only address current challenges but also prepares healthcare workers for future crises, ensuring they are equipped with the necessary skills and knowledge to respond effectively to similar situations [28]. The proactive training and development are crucial for resilience and adaptability in homecare during unforeseen events.

Our research has provided critical insights into the understudied area of HRM in homecare during times of crisis, offering both theoretical and practical contributions. For academics, this study expands the current literature by addressing the HRM challenges specific to homecare during the COVID-19 pandemic and contributing to a better understanding of how HRM can support patient safety in this sector. The study used a strong theoretical approach to explain the purposes of the research and the importance of the research questions. Another strength of this paper is using the data source triangulation that involves interviews with diverse participant groups, including homecare workers, service users, and family members. This strategy helps enhance the depth and reliability of the findings.

For practitioners, the findings offer recommendations on adapting HRM strategies to manage crises effectively, improve workforce resilience, and enhance care quality and patient safety. By focusing on a sector that has been severely impacted but relatively overlooked, our study provides actionable insights that can help shape future HRM practices and policies in homecare. However, this research was limited due to small sample. Also, while writing this paper, the pandemic is still present and therefore, it is not possible to capture accurately the long-term challenges. Future research could include larger sample sizes, along with involving mixed methods and directing toward longitudinal analysis to explore further HRM issues and providing implications for the effectiveness of HRM in homecare settings.

Abbreviations

COVID-19	Coronavirus Disease 2019
HRM	Human Resource Management
HR	Human Resource
PPE	Personal Protective Equipment

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

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Authors' contributions
TL was responsible for the conceptualisation and design of the study, conducting the research, including the literature review, data collection, and data analysis. TL also wrote the manuscript, integrated the findings, and developed the implications and recommendations presented in the study. SB and CM contributed to the research by providing critical revisions and feedback on the manuscript. They reviewed the manuscript thoroughly, offered valuable suggestions, and made necessary changes to improve the overall quality and coherence of the study. Additionally, SB and CM supported the interpretation of the data and helped refine the conclusions and implications for practice and policy.

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Data availability
The datasets generated and/or analysed during the current study are not publicly available due to the confidentiality of interviews and to protect study participant privacy, but are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate
Ethical approval was obtained from the Nottingham University Business School Ethics Committee on 05/02/2021. Informed consent was obtained from all participants.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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