

Review Article

Applying a Human Rights-Based Approach to Formal Care and Support Provided in the Home: A Narrative Review

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Providing formal care and support in the home has many benefits. Applying a human rights-based approach places the person and their human rights at the centre of all that a health and social care service does. There is a paucity of evidence on how to apply a human rights-based approach in practice when providing homecare. Increasing knowledge and understanding of human rights will empower health and social care practitioners to protect and promote human rights in formal homecare. The aim of this narrative review was to identify and describe human rights-based approaches in homecare, in order to promote awareness and understanding of a human rights-based approach. Five bibliographic databases were searched. Primary research studies pertaining to the delivery of formal homecare that included a human rights-based approach were eligible for inclusion. Sixteen articles were identified for inclusion. Quality appraisal and data extraction were conducted on included studies. A deductive framework analysis was used and concepts of a human rights-based approach that emerged from the literature as relevant to homecare were as follows: dignity and respect, autonomy, equality, participation, and communication. We found that homecare planning and delivery requires the integration of human rights, using approaches, such as person-centred care, partnerships in decision-making, supporting independence, and acknowledging a person's beliefs and cultures, in everyday practice. Findings from this review can support and enable service providers to apply human rights in everyday practice, ultimately for the benefit of people using homecare services.

1. Introduction

There is growing recognition of the benefits of providing formal care and support in the home. Governments internationally have adopted many approaches to promote and support homecare. For example, Australia introduced the Commonwealth Home Support Programme (CHSP) to support older people to live independently and safely at home [1]. The Netherlands introduced the “Buurtzorg model,” which comprises nurse-led services with the

responsibility and authority to provide medical and support services to people in their homes [2]. The English government established a system of homecare regulation giving the regulator, Care Quality Commission, the responsibility to inspect and monitor homecare providers to ensure services provide people with safe, effective, and high-quality homecare [3].

The population worldwide is growing and people are living longer [4]. Thus, there are increased demands on health and social care systems to deliver safe, efficient, and

high-quality care across all health and social care services. The recent COVID-19 pandemic brought to the fore infection control issues associated with congregated settings [5], prompting a focus to move care towards community and home settings and prevention approaches to care and support [6]. This means supporting people to remain in their own homes, to provide safer protection against infectious disease outbreaks [5, 6]. Furthermore, the COVID-19 pandemic has incentivised countries to move away from the traditional model of nursing home care and place more focus on homecare and support, assisted-living, and day-care services [5].

A home has been described as a place to build memories, feel secure, and have the “freedom to do what one wants to do” [7]. These descriptions encompass person-centredness, and researchers have reported limited knowledge on how to enhance person-centred care and effective communication in homecare [8]. Formal homecare refers to a homecare provider providing assistance with: personal care such as washing and dressing; domestic care such as shopping and cleaning; or social support such as companionship. Reports of suboptimal practices such as a lack of training and peer support for homecare workers [9], care that is rushed [10], or task-oriented communication [8] have been published. The aim of homecare is to meet the needs of the person and assist them to maintain as much independence as possible, so they can continue to live at home for as long as possible. This requires maintaining good relationships between service providers and service-users and encouraging people who receive homecare to be autonomous [8, 10].

Maintaining good relationships and a person’s autonomy are deeply rooted in a human rights-based approach. A human rights-based approach (HRBA) places the person and their human rights at the centre of all that a health and social care service does. Human rights are rights that all people should enjoy such as the right to liberty and security; the right to respect for private and family life; and the freedom of thought, conscience, and religion. It can be useful to consider human rights in the context of principles or the core values of fairness, respect, equality, dignity, and autonomy (FREDA) [11]. Applying these principles underpins the fundamentals of good care by promoting a person-centred, safe, and quality service [12]. A key strength of a HRBA is its grounding in legal frameworks and human rights treaties, for example, the European Convention on Human Rights Act 2003 [13], the United Nations Convention on the Rights of Disabled People 2006 [14], and the Charter of Fundamental Rights of the European Union 2000 [15]. As such, this legal footing gives weight to its application in health and social care. However, it has been reported that there is a lack of understanding of how to apply a HRBA to everyday practice [11]. A lack of understanding may be due to limited evidence on how to apply a HRBA in practice in health and social care settings.

A review conducted on the impact of the “Human Rights in Healthcare Programme” in England and Wales reported a lack of evidence to show impact and thus hindered the identification of potential benefits of using a HRBA to improve practice, quality of service delivery, and health outcomes [16]. Preliminary searches of the literature

identified research pertaining to human rights and mental health [17–20]. Empirical research that specifically addresses a HRBA in the broader field of health and social care is scarce. Components of a HRBA include advocacy, autonomy, communication, consent, dignity and respect, empowerment, equality, fairness, participation, and privacy [21]. Components such as dignity and respect [22, 23] and autonomy [24, 25] have been examined in the context of homecare, but studies on this topic are few. There is a gap in examining a HRBA in its totality and how it can be applied to homecare provision. This review aims to identify and describe how a HRBA translates into homecare. This will address a lack of understanding of how to apply a HRBA to everyday practice in homecare.

2. Methods

The present review is a subset of a larger evidence review to inform the development of national standards for homecare and support services [26] and summarises findings under components that make up the principle of a HRBA. It compliments three other principles: safety and well-being, responsiveness, and accountability in the context of supporting homecare providers to deliver safe, high-quality homecare. The aim of the aforementioned review was to identify characteristics of good person-centred practices in homecare services, where people experience safe, high-quality outcomes from the care and support they receive in their home. The present narrative review was reported in line with the Enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) reporting framework (online supplemental file 1) [27].

2.1. Search Strategy. A comprehensive narrative review was conducted that aimed to identify and synthesise studies that examined components of a HRBA in homecare. A search of five bibliographic databases was conducted in May 2021 and updated in February 2023: Embase, APA (American Psychological Association), PsychInfo, Social Services Abstracts, and CINAHL (Cumulative Index to Nursing and Allied Health Literature). The following search terms were used: “adult,” “homecare,” “home help,” “domiciliary,” “healthcare,” “social care,” “person-centred,” “quality,” “safe.” The search was limited to full-text articles written in the English language. The WHO conducted a comprehensive examination of homecare across 31 European countries and published this report in 2012 [28]. This examination provided insights into governance arrangements, funding, management of the care process, and clients using homecare. Our search was limited to published research from 2010 to early 2023 to retrieve an up-to-date landscape of homecare across the literature and to avoid any potential overlap between the WHO report and our findings. The screening stage adopted a researcher “agreement chain” approach where one researcher (YK/JG/CCB/MW/DM) reviewed articles during the screening stages [29]. A second researcher (YK/JG/CCB/MW/DM) then reviewed only the articles the first researcher was unsure whether or not to include. A third

researcher (YK/JG/CCB/MW/DM) then reviewed only the articles where a consensus could not be reached. This chain continued until a decision was made on all articles. This approach was used to accommodate short timelines without sacrificing scientific rigour. All papers retrieved from the search were imported to the Covidence systematic management software [30].

2.2. Study Selection Criteria. Primary quantitative, qualitative, and mixed-methods studies were included in the narrative review. Studies pertaining to providing formal homecare and support to adults (aged over 18 years) living at home and encompassed a HRBA were included (supplemental file 2).

2.3. Data Extraction. Data items from included studies were extracted and populated using a data extraction table in Microsoft Excel [31]. This included general characteristics of the studies and concepts of a HRBA that emerged from the studies. These concepts were labelled according to an evidence review examining the principles underpinning safe, high-quality, person-centred care in health and social care settings [21]. This evidence review identified the following concepts supporting a HRBA: participation, fairness, dignity and respect, equality and diversity, consent and freedom to choose, autonomy, empowerment, and communication. The data extraction table was found appropriate for use during data extraction and thus was not amended.

2.4. Quality Appraisal. Quality appraisal was used to facilitate the researcher's interpretation of the findings with credibility relating to the underlying research [32] as an inclusion criteria. The Mixed Methods Appraisal Tool (MMAT) was used to assess the quality of empirical studies [33]. Assessments were considered low, moderate, or high quality based on answers to questions contained in the tool. The researcher "agreement chain" approach, as described above, was used for quality appraisal, with those studies rated as having high quality being eligible for inclusion in the narrative review.

2.5. Synthesis. Due to the heterogeneity of included studies, a textual storytelling approach was applied to narratively synthesise and interpret the findings from included studies [34, 35]. Findings from included studies were coded using deductive framework analysis based on the concepts that make up a HRBA from the data extraction table. This began with YK reading and re-reading all included studies in full. Data pertaining to second-order constructs in the results and discussion sections of the primary studies were used. Second-order constructs were defined as the researcher's descriptions, interpretations, and statements pertaining to the primary research findings [36].

3. Results

The initial bibliographic database search yielded 25,454 records (Figure 1). After removing duplicates, 20,079 records remained. These records were reviewed by title and

abstract to determine whether they met the inclusion criteria. Six hundred and seventy-six reports were selected for full-text screening as they were deemed to fit the inclusion criteria or a decision could not be made based on the title and abstract. Of the 676 reports read in full text, 463 papers were excluded initially as they were deemed out of scope to answer the research question ($n=412$) or they were the wrong study design ($n=51$), for example, study protocols. The remaining 213 papers were read again in full text, and further 197 papers were excluded for the following reasons: studies did not focus on components of human rights ($n=128$); secondary study designs or out of scope ($n=62$); and assessed as having low- or moderate-quality assessments ($n=7$). Sixteen primary studies were assessed as having high methodological quality (supplemental file 3) and were selected for inclusion in the narrative review.

Of the 16 studies included, 13 were primary qualitative studies, with the majority using focus groups and interviews for data collection [22, 38–49], followed by three primary quantitative studies ($n=3$) comprising a discrete choice experiment [50], a retrospective cohort study [51], and a descriptive cross-sectional study [52].

The studies were conducted in Australia ($n=5$) [39, 42–44, 49], the Netherlands ($n=2$) [40, 45], the United Kingdom ($n=1$) [22], Norway ($n=2$) [38, 48], the United States of America ($n=1$) [41], Canada ($n=3$) [47, 51, 52], Finland ($n=1$) [46], and Ireland ($n=1$) [50]. Cumulatively, the studies represented a total of 121,303 participants. Of these participants, 120,626 represented people using homecare services or living in the community and 677 represented homecare workers. The included studies describe the perceptions and experiences of what living at home means to a person receiving homecare and what their care and support needs are, according to people receiving or providing homecare. Five themes were identified across the studies based on the concepts of a HRBA: dignity and respect, participation, autonomy, equality, and communication. A subtheme, personhood, was created under the theme, participation. The characteristics of the studies and the concepts of a human rights-based approach that the studies focused on are presented in Table 1. A description of the findings of each of the themes is provided below.

3.1. Dignity and Respect. The theme, dignity, and respect emerged from eight studies [22, 38, 39, 42, 43, 46, 47, 50]. Recognising the meaning of the home and homecare to a person underpinned dignity and respect. Respect for a person was influenced by values, beliefs, and ethical sensitivity in human dignity [42, 46]. Ethical sensitivity was described as respecting a person's integrity, being open and honest, compassionate, and attentive to the needs of the person [46]. There was a strong connection among who the person was, that being their identity, their dignity, and their home. The home was where the person lived and carried out their habits and routines every day and this contributed to a personal identity [22]. The home represented the past, present, and future that gave a sense of connection, a place in

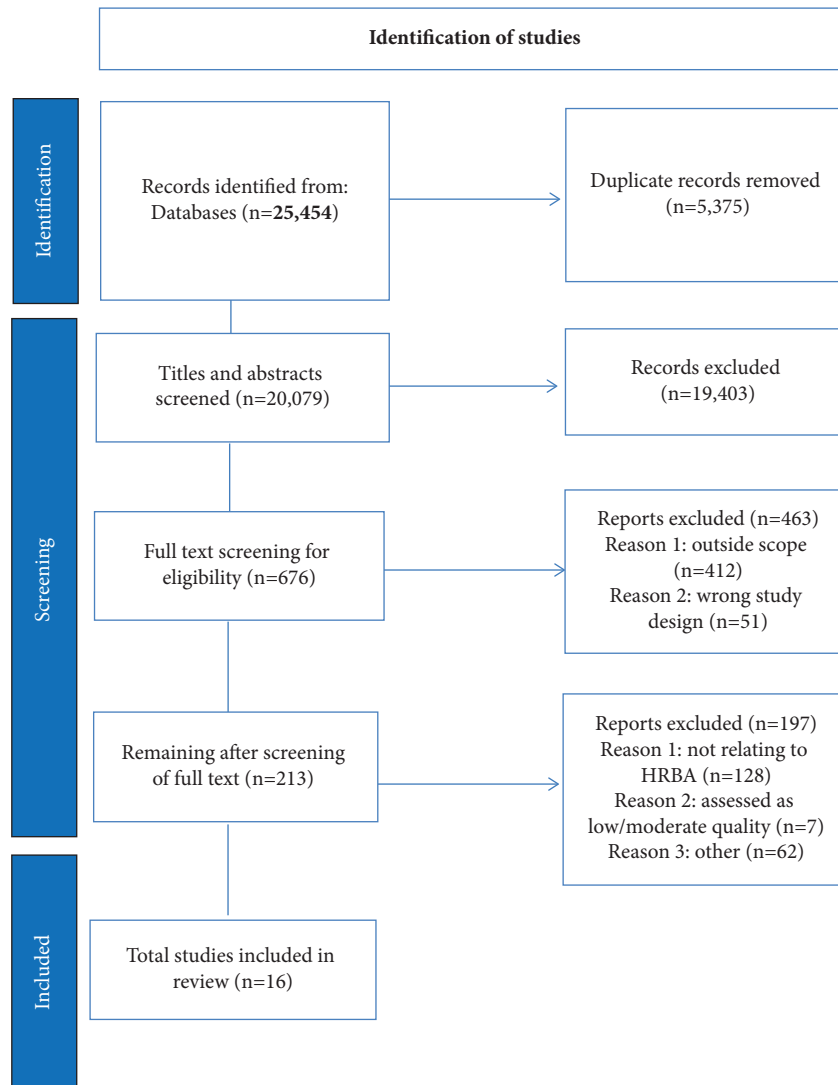


FIGURE 1: PRISMA flow diagram of the study selection process, adapted from Page et al. [37] for a narrative review of applying a human rights-based approach to formal care and support provided in the home.

the world [43], and meaning to one's life [46]. The home had generated nice memories, representing a place to remember happy times and a familiarity that reflected a sense of security and comfort. It offered freedom, for example, freedom to decorate one's own home the way one wanted, a sense of self-management, and staying in touch with friends in the community, including local services and clubs [43]. Normal day-to-day living can be redefined for the individual to maintain their personal identity by tailoring services to an individual's needs [38, 39]. Additionally, the introduction of formal carers and medical equipment had the potential to intrude on personal space and impose a work or clinical environment on the home. A person's home was a private space that was at risk of being influenced by rules and regulations when formal carers entered [22].

Individuals who participated in a study in England to explore older people's experiences of formal homecare reported that bringing care equipment into a home brought

about a sense of a "mini-institution." This subsequently resulted in carers focusing on the task at hand instead of the person [22]. This study highlighted that homecare was optimised by understanding the sense of self and the value that the person placed on their home space. The likes and dislikes of the person were unique to that person and their circumstances, and hence, a generic approach to homecare was not a person-centred care approach.

Studies highlighted that providers needed to support the belief that older people "know best" [42] and adopt a holistic view on ageing [47]. This was described as a "biographical" approach to homecare that supported the person's knowledge and expertise, through awareness of their needs, preferences, and personal past events [22, 47]. In contrast, some study participants shared stories of experiences of carers using a patronising tone of voice or language that was accompanied by assumptions about care needs, sight, hearing, or cognition with older people [47].

TABLE 1: Characteristics of included studies and the concepts of a human rights-based approach that the study examined for a narrative review of applying a human rights-based approach to formal care and support provided in the home.

Author name, year of publication, country of origin	Aim of study	Methodology	Population and sample	Concepts of a human rights-based approach
Aoun et al. (2016), [39] Australia	To describe the lived experiences of older people living with terminal cancer and living alone	Qualitative—interviews	Total $n = 43$, men $n = 22$, women $n = 21$ Age 52–91 years	Dignity and respect, autonomy
Blomqvist et al. (2023), [46] Finland	To explore homecare leaders' perceptions of ethical sensitivity and compassion associated with care quality in homecare	Qualitative—interviews	Total $n = 10$ homecare leaders, women $n = 10$	Dignity and respect, communication
Borg et al. (2011), [38] Norway	To elicit and interpret experiences and meanings of the participants' descriptions of mental health crisis situations	Qualitative—focus groups	Total $n = 6$, men $n = 2$, women $n = 4$ Age 24–64 years	Dignity and respect
Butler (2018), [41] United States of America (USA)	To understand the experiences of lesbians 65 years and older who had health issues requiring homecare services	Qualitative—telephone interviews	Total $n = 20$, women $n = 20$ Age 66–86 years Total $n = 6$, women (informal caregivers) Age 62–76 years	Equality
Giosa et al. (2022), [47] Canada	To determine how client goal-setting practices in home care could be re-oriented around older adults' self-perceived goals, needs, and preferences	Qualitative—semistructured interviews	Total $n = 25$, older adults $n = 13$ (men $n = 4$, women $n = 9$), family/friend caregivers $n = 12$ (men $n = 1$, women $n = 11$)	Communication, dignity and respect, participation
Gregory et al. (2018), [42] Australia	To gain an understanding of what is involved in providing good quality health care for older people who need support to live at home	Qualitative—semistructured interviews	Older people $n = 7$, men $n = 2$, women $n = 5$ Carers $n = 8$, men $n = 0$, women $n = 8$ Key informants $n = 11$ men $n = 1$, women $n = 10$	Participation, dignity and respect, equality, communication
Hatcher et al. (2019), [43] Australia	To understand how older adults conceptualise home to inform policy and practice that will support living at home	Qualitative—focus groups, semistructured interviews	Total $n = 21$, men $n = 7$, women $n = 13$, not mentioned if participant ($n = 1$) is man/woman Age over 65 years	Dignity and respect, autonomy
Hoel et al. (2021), [48] Norway	To explore the experiences of home care services among people with dementia, to understand how the service is adapted to people with dementia, and the extent to which they experience person-centred care and shared decision-making	Qualitative—interviews	Total $n = 12$, men $n = 5$, women $n = 7$ Age over 70 years	Participation

TABLE 1: Continued.

Author name, year of publication, country of origin	Aim of study	Methodology	Population and sample	Concepts of a human rights-based approach
Hughes & Burch (2020), [22] England	To understand older people's experiences of domiciliary care and whether care practices have implications for their sense of self or personhood	Qualitative—interviews, diary with participant reflections	Total $n = 17$ (men $n = 3$, women $n = 14$) Age 67–92 years	Dignity and respect, autonomy
Lai et al. (2021), [52] Canada	To explore the perceptions of home care teams regarding the decisions facing their clients and their perceived involvement in SDM (shared decision-making)	Quantitative—cross-sectional survey	Total $n = 614$, home care providers (nurses, personal support workers, rehabilitation professionals), men $n = 46$, women $n = 558$	Participation
Lo et al. (2015), [51] Canada	To assess sex differences in the quality of publicly funded homecare services	Quantitative—retrospective cohort study home care reporting system database	Total $n = 119,795$, men $n = 36,298$, women $n = 83,497$ Age 65 years and older	Equality
Peek et al. (2016), [40] Netherlands	To explore factors that influence the level of use of various types of technology by older adults who are aging in place	Qualitative—field study involving home visits	Total $n = 53$, men $n = 19$, women $n = 34$ Age 68–95 years	Autonomy
Phillipson et al. (2022), [49] Australia	To explore the perspectives and practices of care planners and case managers involved in supporting home care of people with dementia	Qualitative—telephone interview	$n = 16$ (managers, care planners) number of men and women not mentioned	Participation
Suurmond et al. (2016), [45] Netherlands	To explore barriers to accessing homecare among ethnic minority older adult groups	Qualitative—focus groups and interviews	Total $n = 50$ (focus groups), men $n = 17$, women $n = 14$ Age over 50 years, not mentioned if participants ($n = 19$) were men/women Total $n = 5$ (individual interviews), men $n = 3$, women $n = 2$ Age over 60 years	Equality
Waling et al. (2019), [44] Australia	To explore participants' perceptions and experiences of residential care and homecare services, and the rationale behind decision processes in accessing aged-care services	Qualitative—telephone interviews	Total $n = 33$, men ($n = 14$), women ($n = 19$) Age over 60 years	Equality
Walsh et al. (2020), [50] Ireland	To obtain public preferences for personhood-oriented homecare services for people with dementia	Quantitative—discrete choice experiment (2 attributes; if care provision is flexible and tailored to the individual needs of the person with dementia, and if communication with the person with dementia is expressed in a personalised manner)	Total $n = 551$, men $n = 215$, women $n = 336$ Age over 18 years	Dignity and respect, autonomy, participation, communication

3.2. Participation. The concept of participation was identified in seven studies [22, 42, 47–50, 52]. Participation encompassed shared decision-making and was dependent on the person's own resources, preferences, and relationship building [42]. It required a flexibility to tailor care to the unique nature of the person [47–50]. However, one study reported limited opportunities for people with dementia to participate in decision-making and care planning [48]. Participants shared stories of their care being predetermined by the needs of the homecare service and not tailored to their needs [48]. Flexibility of care described the extent to which a person participated in identifying their own care and support needs [50]. Low flexibility reflected a service provider having overall control in care delivery, and this was more generic in nature. High flexibility reflected a service provider meeting the needs of the person as identified by that person [50]. This study used a discrete choice experiment design and identified that members of the public preferred and valued greater flexibility in care provision to people with dementia who respected autonomy and capacity for self-management. Furthermore, a cultural change was required to reflect this higher flexibility and tailor care to the individual needs of the person using services [50]. Study participants felt that it was important not to assume that a person had lost capacity to take part in making decisions about their care and support because they had a chronic disease or a debilitating condition such as dementia [50].

The meaning of partnerships for older people who needed support to live as independently as possible at home encompassed involvement in decision-making and making contributions, which impacted on health care and health systems [42]. Some study participants voiced concerns that they would offend the service provider if they disagreed with the provider's advice. As such, their involvement in decision-making may not be welcomed or accepted by the provider [42]. Participants felt that a lack of skill and awareness to fully understand older people's needs and preferences were barriers to involving them in their own care [42]. This was a result of service providers not acknowledging and recognising the role of the older person as a partner in health care. A study that examined homecare providers' perspectives on shared decision-making found that a lack of information, confusion regarding information, and pressure from other people were the most frequently reported barriers to decision-making in older adults [52]. These barriers were the complement to the enablers whereby having appropriate information enhanced well-informed decision-making. Homecare providers had a role in explaining and clarifying information and using tailored decision aids were considered potentially beneficial [52]. One study that explored perspectives and practices relating to consumer-directed care (CDC) for people with dementia receiving homecare reported on strategies to enhance supporting choice and control such as asking the person what they want using a "storytelling" approach that included active choices instead of a "form-filling" approach [49] [p2774]. Active choices referred to having options regarding the care plans. Similarly, a study that explored goal-setting practices in homecare reported that a strategy for

participation in one's own care was for care workers to carry out care activities "with" the person rather than "for" the person. This approach was built on trust and an understanding of the person's abilities [47].

3.2.1. Personhood. A subtheme that emerged from "participation" was personhood. This was explored in three studies [22, 42, 50]. Personhood captured the essence of person-centred care and was described as a "sense of self" [22]. It placed a focus on the importance of the whole person being actively involved in their own home and life as this enhanced the sense of meaning to one's life [50]. Personhood required the person to be recognised as a partner in their own care, and subsequently, homecare providers should seek to determine the extent to which a person wished to be involved as a partner in their own care [42]. In doing so, homecare providers needed to accept and acknowledge the values and preferences of a person. However, homecare providers may experience challenges in recognising a "sense of self" or personhood at all levels of a person's functional and cognitive ability [42]. For example, a decline in functional or cognitive ability may lead to a homecare worker feeling challenged to fully involve the person in their own care and support due to time constraints of the homecare visit. Subsequently, this may result in a loss or violation of the person's dignity [42].

3.3. Autonomy. Autonomy was explored in five studies [22, 39, 40, 43, 50]. One study referred to autonomy as "decisional" and "executorial" [22]. Decisional autonomy was described as the ability to make a decision independently. Executorial autonomy was described as the ability to carry out a decision independently. Ultimately, autonomy was a fundamental aspect of homecare and supporting people to make and enact their own choices and decisions should be embedded in homecare delivery [22]. In doing so, homecare workers needed to be aware and understand how a loss of independence impacted on autonomy and freedom. In addition, carers who carried out tasks on behalf of the person receiving care were at risk of disempowering and deskilling the person [50]. This was evident in situations where, for example, there was a perception that it was easier and faster if the homecare worker carried out the task for the person, rather than supporting them to do it for themselves [50].

The fundamental need to remain independent was a prominent theme identified in a study undertaken in the Netherlands that explored the factors that influenced older people to use technology [40]. This study reported that the participants wanted to take part in activities, such as household jobs, hobbies, and voluntary work. Study participants reported that decisions to use technology were influenced by the extent to which technology promoted these activities and subsequently encouraged independent living. However, using technology often required the assistance of other people, which contradicted the ethos of being independent [40]. One study conducted in Australia reported that participants aged between 52 and 91 years who

had terminal cancer and were living alone were reluctant to ask for help because they wanted to hold on to their independence [39]. Other reasons included a fear of being a burden on their families and perceptions that their care needs were too much responsibility for their children [39]. Conversely, some participants redefined normality for themselves by accepting help and compromising their care and thus helping their confidence to maintain independence [39]. This compromise was reflected in accepting formal homecare, so participants could still live independently at home and maintain a sense of self. Overall, participants expressed a strong wish to stay at home with some participants reporting that they lived alone by choice and not by their circumstances [39].

One study that aimed to conceptualise living at home from the perspective of older adults, identified a theme described as “Enabling Freedom,” which reflected a home that was free of constraints [43]. Freedom was described as an ability to self-manage and personalise one’s own activities. It meant having a purpose and performing everyday tasks to live independently without interference from others. Freedom offered a sense of pride and personal satisfaction through achieving these everyday tasks. As such, it facilitated a sense of self-control and autonomy over one’s life and day-to-day living. A study that explored older people’s experiences of domiciliary care in England reported that unscheduled visits effected a person’s autonomy. For example, unscheduled visits could impact the person’s plans for the rest of the day and was viewed as inflexible care and task-centred service delivery [22]. This care was often perceived as rushed and carers had little time to actually chat with the person, leaving a sense of being undervalued and hindering a sense of autonomy [22]. Allowing older people to make their own choices on the care they receive was considered fundamental to their well-being by the study authors [22].

3.4. Equality. Five studies reported on equality [41, 42, 44, 45, 51]. Equality occurred when a person’s life story, knowledge, and experiences were acknowledged and respected without discrimination [42]. Equality in the context of homecare was described as giving a “voice” to the person in their own care to bring about change [42]. This facilitated the person to be seen as having individual attributes and needs, and subsequently built respectful relationships [42]. A study conducted in the Netherlands that examined the utility of homecare services among ethnic minority populations found that ethnic minorities were unable to articulate their needs and abilities, which impacted their access to homecare services [45]. This was associated with a language barrier, a lack of accessible information, and low health literacy. The study participants, aged over 50 years, reported that social networks were not always available to support, share, and exchange information. However, a dominant theme that emerged from the participants’ stories was a cultural preference to have informal carers provide homecare [45]. Authors who conducted a study in Canada recommended the design and tailoring of interventions that targeted the different needs of people

using homecare services as this was necessary to improve the quality of care given in the home [51]. Examples provided by the authors were interventions that address gender differences and gender-specific strategies [51].

Two studies included in this review explored the experiences of lesbian women, aged over 60 years needing homecare services in the USA [41] and Australia [44]. They reported that homecare workers needed to listen and be sensitive to the wishes of the person receiving homecare [41, 44]. Participants shared experiences of homophobia from homecare workers and attributed this to: homecare workers coming from cultural backgrounds that disapproved of homosexuality; a lack of training for homecare workers to learn about and understand lesbian-, gay-, bisexuality-, and transgender-related issues; and age of caregiver, with younger caregivers being reported as less reliable and less invested in the needs of the person [41]. This resulted in participants hiding or not disclosing their sexuality to their homecare workers. Additionally, this resulted in a preference for lesbian caregivers and to live in a lesbian community [41]. Participants reported that they had also experienced isolation from their community networks. They believed that if their identities were understood by homecare providers and homecare workers, it was more likely that older lesbians would feel safe accessing homecare services. A high turnover of staff impacted on the quality of homecare. The high staff turnover resulted in concerns if the new carer was not lesbian or gay-friendly and a need to repeat information to the new carer [44]. This exacerbated fears of discrimination and stigma about sexuality and hence increased vulnerability, as participants felt unable to express their sexuality. Participants perceived staying at home as feeling safe to live freely as a gay man or lesbian woman, which may be threatened by receiving homecare [44]. The authors suggested that lesbian- and gay-inclusive practice policies should be implemented by service providers. Carers should have specific training to support lesbians and gay men to feel safe, be open about their sexuality, and address fears of a disconnect from community. Services should be sensitive to the needs and values of the gay and lesbian population [44].

3.5. Communication. Communication emerged as a theme from four studies [42, 46, 47, 50] and was described as fundamental to providing person-centred care and support [50]. Good communication and listening attentively were indicative of respect for a person’s needs and preferences [42]. Communication was described as a “two-way information sharing” that built relationships and brought humanity into care processes [47]. A discrete choice experiment included communication as an attribute and was associated with a level of engagement from homecare service providers and a person with dementia [50]. Communication related to the extent of getting to know the person to learn how to support their capabilities and preferences [50]. The most appropriate method was talking to the person about their needs, striving to maintain current abilities, holding onto connections with social networks, and enabling good

decision-making to promote well-being. Improving communication to understand and enhance empathy helped to empower people and support them to adapt to changes and engage in activities and relationships [50].

Another study reported that communication should convey compassion, be optimistic and sensitive to a person's characteristics, needs, and concerns [46]. Elements of communication were described as active listening, interpretation, recognition of content, responding appropriately to unplanned reactions, and learning to say sorry. The authors found that carers needed to listen attentively to the person's viewpoints and then respect and understand these viewpoints [46]. This involved listening to the person describing their lives and what mattered to them. Attributes of professional conduct and communication encompassed empathy, emotional intelligence, showing interest in the person, and self-knowledge. People receiving homecare felt more willing to be open about their needs and preferences with carers who displayed these attributes. The concept of ethical sensitivity was also described, whereby professionals needed to be compassionate to understand a person comprehensively, provide a support space to build relationships, and allow the person to process negative emotions [46]. Additionally, silent listening played an important role in building a connection with the person. A homecare provider can influence a supportive environment for its staff by having regular ethical discussions, listening to staff, offering advice, and encouraging social interactions that are collective and collaborative [46].

4. Discussion

Concepts of a HRBA that was the main focus studied in the literature related to dignity and respect, participation, autonomy, equality, and communication. Dignity and respect were reported in the majority of studies, followed by participation. Acknowledging a person's life experiences, skills, and values was prerequisites to treating a person with dignity and respect. Providing person-centred care, supporting a partnership approach, and involving the service-user in decision-making processes were approaches to enhance a person's participation in homecare and thus would uphold human rights. Supporting a person to be as independent as possible while living in their home enhances autonomy. Adopting a non-discriminatory approach creates equal opportunities for people receiving homecare, and using effective communication skills promotes relationship building. All of these concepts are interdependent and in many instances overlap, but they set out the actions that homecare services can take to uphold human rights. Weight given to each concept is dependent on the situation under consideration, and hence, a greater weight is given to some human rights values over another, based on the best outcome for an individual [11]. Other concepts such as consent and empowerment were not retrieved from the literature. This perhaps suggests a gap in the literature exploring the role of these concepts in providing homecare.

A comparable review relating to applying a HRBA to homecare was not sourced. Preliminary searches of the

literature identified existing research on human rights and health and social care pertaining to discussion reports and opinion papers [53–57]. The relationship between human rights and health was described by Cardenas et al. as bi-directional, meaning that “health is a human rights issue” and “human rights are a health issue” [57]. Cardenas et al. reported on the application of human rights to nutritional care. They described the right to nutritional care under human dignity and ethical principles. The right to nutritional care is categorised according to the right to food, the right to be fed, and the right to health [57]. Each right can be fulfilled by undertaking actions, for example, mandatory nutritional screening, diagnosis and assessment of malnutrition, and nutrition care plans. While Curtice and Excworthy advocated for translating human rights into everyday practice, they focus on translating them for frontline staff [11]. Cardenas et al. focused on integrating human rights into public health policy [57]. Similarly, Brennan et al. reported that governments globally have core obligations to provide equitable, non-discriminatory health care as part of public health strategies [58]. They refer to such obligations as including the provision of education to healthcare professionals [58]. Education was also described as fundamental to applying human rights in everyday practices [11, 57]. Study authors reported that targeted training should be made available to frontline staff and services as a whole, in order to embed human rights into organisational cultures [11]. One study included in this review suggested that service providers hold workshops or “ethical rounds” to further support the homecare workers to be compassionate and ethically sensitive to the needs and preferences of the person receiving homecare [46]. A scoping review that investigated the care and support needs of older people in the United Kingdom who were receiving homecare highlighted many challenges for older adults living with chronic illness such as a lack of understanding of the needs of the older adult, a lack of information sharing, and a lack of continuity of care [59]. Researchers of reviews (systematic and integrative) recommended: mandatory training for homecare workers to reduce inequalities such as homophobia and thus increase inclusivity across homecare providers [60]; targeted training, information, and support to enhance communication skills for carers, homecare providers, and family members [61]. Homecare workers using effective communication skills would result in an increased sense of security and well-being for service-users [61]. The “Empowered Project” in Australia, which aimed to raise awareness about upholding human rights in aged care for people living with dementia used education and awareness-raising campaigns [62]. They targeted service-users such as families and individuals living with dementia. The overall aim was to empower individuals and enhance engagements in decision-making processes. Similar to aforementioned reports [57, 58], Jessop and Peisah recommended that aged care and human rights were integrated and that policy-makers approach the Australian legislation pertaining to aged care using a human rights lens, with an emphasis on the concepts of dignity, respect, and preferences. They noted that areas most effected by a lack of

a HRBA were failure to respect autonomy, failure to obtain consent in advance of administering chemical restraint, and lack of participation in decision-making [62].

It is noteworthy that human rights are reflected in ethical principles underpinning codes of professional conduct, such as nursing [63], allied health professionals [64], and medicine [65], and, thus, suggests that human rights are very much embedded in health and social care. However, it has been reported that there is still a need to translate them into healthcare services [11]. There is a scarcity of literature that captures experiences applying a HRBA into everyday health and social care delivery. Moreover, this narrative review retrieved a relatively low number of primary studies assessed as having high methodological quality that examined a HRBA specifically for homecare. There is a gap in the literature providing supportive evidence on a human rights-based approach. Furthermore, comprehensive and rigorous explorations of translating a HRBA into everyday practices are needed. This perhaps suggests that qualitative study designs, for example, case studies, may be appropriate to capture unique contextual factors influencing a human rights-based approach. Human rights should be central to everything that a homecare service does, where people using services are protected and promoted in all aspects of service delivery. This should also inform and empower policy developers, homecare providers, and health and social care practitioners on how to collaboratively improve health outcomes for people using homecare services.

4.1. Implications for Practice. Human rights belong to everyone [66]. This review presents findings from the literature that report on experiences from people providing and receiving homecare. These experiences have been categorised according to the concepts associated with a HRBA. This has broadened the knowledge and understanding of what home and homecare means to a person. Strategies can be developed to optimise the application of a HRBA in homecare to support ongoing dignity and respect, participation, autonomy, equality, and communication. Furthermore, the findings from this review can assist policy developers, homecare providers, and health and social care practitioners when reflecting on their approaches to care delivery and assist in striving to uphold human rights in everyday practice. This will inevitably improve person-centred care, experiences, and health outcomes for people receiving homecare.

4.2. Strengths and Limitations. This narrative review has been informed by a comprehensive search of the literature and offers methods of translating a HRBA into homecare, advancing the knowledge on its application in practice. Some components of a HRBA were not retrieved from the literature, and thus, approaches to achieve these are missing from this review. It is likely that there are many other important approaches that echo a HRBA to homecare. Nonetheless, the studies reviewed have provided in-depth insight into understanding a HRBA and have demonstrated how it can be successfully applied in homecare.

The emergent narrative descriptions are predominantly rooted in perspectives and experiences of those receiving and providing homecare. The findings present real-world stories and thus are more likely to influence understanding and relatability of strategies to translate HRBA into everyday practice. The single screening of titles and abstracts and full-text studies during the selection process may have resulted in potentially missed studies that may have been relevant to this review. However, a researcher agreement chain approach was used throughout the screening stages that were carried out by subject matter experts with experience in reviewing the literature. The research team had regular meetings throughout the screening stages that provided a sounding board for open discussions, sharing ideas, and decision-making. This review was conducted on a short timeline so as to enable its inclusion in the development of national standards to support the provision of homecare. A systematic methodological process is presented to provide transparency and reliability in judgements made.

5. Conclusion

It is well recognised that failing to apply a HRBA has adverse effects on a person's health outcomes. This narrative review of the literature provides a systematic and transparent approach to analysing the research and offers evidence of best practice on translating a HRBA into practice in the homecare setting. Furthermore, this review presents important insights for researchers, standard-setting bodies, policy-makers, homecare providers, and health and social care practitioners who seek to broaden their knowledge on applying a HRBA to care and support in the home. Providing person-centred care is central to treating a person with dignity and respect. Acknowledging and respecting a person's life story, knowledge, and experiences when designing and delivering care and support upholds equality in practice. The culture of homecare needs to be flexible in ensuring the service-user's knowledge, skills, values, and cultures are included in their care and support plans. A service-user's involvement is at the core of an effective homecare service. Supporting a person to make their own choices and decisions should form an integral component of upholding human rights in service delivery.

Data Availability

The data used to support the findings of this study are included within the article and the supplementary information files.

Additional Points

What Is Known about This Topic. (i) An increase in the population of older adults and infection control issues associated with congregated care settings have led to an increased focus on the provision of safe high-quality care to people at home. (ii) Applying a human rights-based approach improves person-centred care and experiences for people receiving homecare. (iii) There is a gap in the literature on how to apply a human rights-based approach to

formal home care. *What This Paper Adds.* (i) The components of a human rights-based approach that emerged from the literature as relevant to home care were; dignity and respect, autonomy, equality, participation, and communication. (ii) Person-centred care is central to treating a person with dignity and respect. Supporting a person to make informed decisions and be as independent as possible is integral to upholding human rights in a non-discriminatory manner. (iii) Home care providers should ensure the person's knowledge, skills, values, and cultures are included in their care plans and that the provision of services does not create a clinical feeling within the home.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Authors' Contributions

Yvonne Kelly was responsible for conceptualization, data curation, formal analysis, investigation, project administration, validation and visualization of the study, wrote the original draft, and reviewed and edited the study. Judy Gannon was responsible for conceptualization, data curation, investigation, project administration, supervision, validation and visualization of the study, and reviewed and edited the study. Carolina Bassul and Michelle Williams were responsible for conceptualization, data curation, investigation, project administration, and validation and visualization of the study. David Morrissey was responsible for data curation and investigation. Joyce McKee was responsible for supervision and reviewed and edited the study. Laura M Keyes was responsible for supervision and validation and, reviewed and edited the study. Niamh O'Rourke and Rachel Flynn were responsible for resources, supervision, and validation and, reviewed and edited the study. Niamh O'Rourke and Rachel Flynn share senior authorship for this work.

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Supplementary Materials

Supplementary files accompany this manuscript (three in total). Supplemental file 1 is the Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ Checklist. Supplemental file 2 is a table that sets out the inclusion and exclusion criteria for this narrative review. Supplemental file 3 is the quality appraisal assessment for studies included in this narrative review. (*Supplementary Materials*)

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