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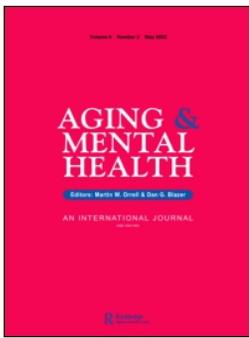
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If I am not for myself, who is for me? The experiences of older migrant home care recipients during their hospitalization

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Objective: Hospitalization is a major risk for older adults; therefore, it is crucial to provide the appropriate treatment during hospitalization. This study examined hospitalized older adults' perceptions regarding three groups of treatment providers: nursing staff, family members, migrant home care workers.

Method: Qualitative interviews were conducted with 17 hospitalized older adults. Data were gathered by in-depth interviews. Content analysis included open coding, axial coding and integration of the main findings using constant comparisons.

Results: Three themes emerged: (1) 'What is my worth?' This theme was focused on the participants' perceptions of themselves as helpless and dependent on others. (2) 'What would I do without them?' This theme referred to the perception of the migrant home care workers and nursing staff as essential. It meant immense gratitude, but also a sense of dependency on paid caregivers. (3) 'They have their own busy life.' This theme concerned participants' low treatment expectations from their family members due to their perception of their family members as having multiple obligations.

Conclusion: Hospitalized older adults prefer to turn to paid caregivers rather than to their families. Findings are discussed in light of the tension between formal and informal care in countries that are transitioning from traditional family values to modern values, placing the care of older adults by paid caregivers.

Keywords: hospitalized older adults; migrant home care workers; nursing staff; family; role division

Introduction

The number of frail older adults receiving acute care services is increasing as the population ages (Bridges, Flatley, & Meyer, 2010). In Israel, as in other countries, older adults make greater use of health services than younger age groups. For example, the average rate of hospitalization of older adults is more than three times higher than that of the general population (461 per 1000 people among older adults compared to 140 per 1000 in the general population) (Brodsky, Shnoor, & Be'er, 2014). Statistical forecasts predict an increase in the rate of hospitalized older adults over the next few years, thus making professional treatment necessity for a growing population of older patients and their families (Garcia-Perez et al., 2011).

Hospitalization is a major risk for older adults, particularly the very old. In many cases, hospitalization is associated with an irreversible decline in functional status, cognitive performance and quality of life (Mudge, O'Royrke, & Denaro, 2010). Furthermore, it is well known that hospital admission can change the course of so-called 'normal aging' due to adverse health outcomes following hospitalization, especially in terms of functional decline and mortality (Palmisano-Mills, 2007). Indeed, according to a systematic review, old hospitalized patients might feel worthless, fearful or with limited control, particularly if they have impaired cognition or communication difficulties (Bridges et al., 2010). Therefore, it is

crucial to provide the appropriate treatment during hospitalization to address the older adults' changing medical, physical and emotional needs (Duffy & Healy, 2011). Past research has shown that the three main providers of care to older patients during their hospital stay are nursing staff, family members and migrant home care workers (Ayalon, Halevi-Levin, Ben-Yizhak, & Friedman, 2013).

Given increases in life expectancy and the tendency for older adults to disproportionately use health care in general and hospitals in particular (Ayalon, Halevi-Levin, Ben-Yizhak, & Friedman, 2015), chances are that the prevalence of such a care arrangement, including three main providers of care, will increase. However, it is possible that a role overlap between nursing staffs, family members and migrant home care workers or role diffusion may occur, when one group lets another group of treatment providers perform activities which are traditionally performed by the former, and as a result the older adults' unique treatment might be harmed.

Previous studies have shown that older adults' perceptions towards their care providers affect their compliance with such care (Ha, Carr, Utz, & Nesse, 2006; Marini, 1999). Therefore, it is important to assess hospitalized older adults' perceptions regarding the existence of three groups of treatment providers. This is because hospitalized older adults might be confused as to whom they should listen to and from whom they should ask for assistance and help. Hospitalized older adults might also avoid

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asking for help and assistance due to the perceived overlap between caregivers' roles and/or role diffusion.

Overall, nurses are the primary health care professionals responsible for nursing treatment in hospital settings (Boltz, Capezuti, & Shabbat, 2011). The nursing staff role can vary between serving as a patient advocate, and/or a family supporter, as well as participating in ongoing disease management and patient education (Phipps & Walker, 2013). Given that older adults are likely to under-report symptoms and problems, the nursing staff needs to collaborate with family caregivers to obtain a full picture of the older adults' needs and health care problems in order to deliver sufficient treatment and care (Lindhardt, Hallberg, & Poulsen, 2008).

Family caregivers play a significant role during the hospitalization of the care recipient. A study conducted in Israel found that about 69% of hospitalized elderly had family caregivers, who provided an average care of 8 hours per day (Auslander, 2011). Studies reflect that during hospitalization, family members provide emotional and physical support (Tzeng & Yin, 2008) as well as information about the patient's medical condition (Lindhardt et al., 2008). It was also demonstrated that family caregivers engaged in the following tasks: monitoring, communicating, supporting and comforting their relatives during hospitalization (Auslander, 2011). However, family involvement in the care of inpatients is met with ambivalence by the nursing staff, whereas some family caregivers are unwilling to participate in caregiving tasks during the hospitalization of their care recipient (Azoulay et al., 2003) while others interfere with the nursing staff's procedures (Fisher et al., 2008). Yet, some family caregivers perceive their care management role as central (Ayalon et al., 2013). The relationship between nursing staff and family members in the hospital setting could potentially be even more complicated, once another group of treatment providers is involved, namely, live-in migrant home care workers.

Live-in migrant home care workers provide round-the-clock personal care to the most vulnerable segments of society (Ayalon et al., 2013). Their presence significantly decreases the family's burden and allows many families to work and lead normal lives (Polverini & Lamura, 2004). This arrangement allows older adults to age in place, thus avoiding or delaying institutionalization (Iecovich, 2011). The employment of live-in migrant home care workers in Israel is based on predetermined eligibility criteria, such as the older adults' physical and mental functioning, financial status and age (National Insurance Institute of Israel, 2011). According to the characteristics of older care recipients who are eligible to live-in migrant home care, chances are that many will be hospitalized over time and thus, will receive treatment from the worker during their hospitalization (Ayalon et al., 2013).

Overall, the treatment and support provided by the nursing staff, family members and migrant home care workers can be divided into five types: (1) emotional support (the expression of positive affect, empathetic understanding and the encouragement of expressions of feelings), (2) informational support (the offering of advice, information, guidance or feedback), (3) tangible

support (the provision of material aid or behavioral assistance), (4) positive social interaction (the availability of other persons to do fun things with the patient) and (5) affectionate support (involving the expressions of love and affection) (Sherbourne & Stewart, 1991). Based on the description of the roles of the three groups of treatment providers (Ayalon et al., 2013; Boltz et al., 2011), there is a possibility for an overlap between their roles. For example, they all provide emotional and physical support (Ayalon et al., 2013; Phipps & Walker, 2013; Tzeng & Yin, 2008).

Despite the increasing prevalence of this caregiving arrangement worldwide (Cho & Kim, 2006; Fouka et al., 2012), the literature discussing hospitalized older adults' perceptions regarding the tasks of these three main groups of treatment providers is limited. For example, it has been found that hospitalized older adults tend to emphasize emotional care as one of the primary family caregiving tasks in contrast to migrant home care workers who do not perceive this as a role that is adequately performed by family members (Ayalon et al., 2013). Older adults in return, expect home care workers to provide them with emotional support, even though this duty is not part of their job requirements (Ayalon et al., 2013). Another study has concluded that older adults have a positive view of the care received from nursing staff which is portrayed as dedicated, loving and humane. These positive views are often accompanied by negative perspectives about nursing staff, which is viewed as being non-communicative and uninformative regarding the older adults' health state (Batista, Fontoura, & Rosa, 2011).

Given the increase in lifespan (Ehrenreich & Hochschild, 2000) and the increasing prevalence of this caregiving arrangement (Ayalon et al., 2013), the aim of the present study was to examine hospitalized older adults' perceptions regarding the roles of three groups of treatment providers: nursing staff, family members and migrant home care workers. Findings will provide valuable information about potential challenges and benefits associated with this caregiving arrangement and will shed light on the particular needs of older adults during their hospitalization.

Method

Participants

Qualitative research is based on small, purposive, non-representative samples (Green & Thorogood, 2006). Accordingly, the current study consisted of 17 qualitative interviews of hospitalized older patients. The sampling criteria were patients aged 65 years or older, accompanied by a migrant home care worker, and having adequate mental status to participate in the interviews per medical record (this evaluation was most often determined by a social worker or a nurse on the unit). The final sample size was determined according to the 'theoretical saturation principle'. Hence, the interviews continued until no new information emerged (Green & Thorogood, 2006). Detailed information about each participant is provided in Table 1.

Table 1. Participants' demographic characteristics ($n = 17$).

Pseudonym	Gender	Age	Education	Number of years receiving care from an MCW*	Number of diseases	Days at the hospital
Rivka	Female	73	5	2	3	3
Ruth	Female	86	15	2	3	4
Moshe	Male	73	12	1	4	5
Judith	Female	85	10	5	4	4
Eli	Male	86	16	5	4	4
Gila	Female	77	3	5	2	2
Ronit	Female	73	6	1	3	4
Lisa	Female	86	12	3	4	3
Neomi	Female	77	10	3	1	4
David	Male	81	12	2	3	5
Dan	Male	75	12	2	3	4
Ron	Male	80	12	4	1	8
Linda	Female	83	10	2	2	3
Lili	Female	84	16	3	3	5
Shosh	Female	79	7	1	2	4
Yael	Female	88	10	2	4	2
Lea	Female	81	12	4	3	4

*MCW = migrant care worker.

Interview

The current study is part of a larger study, in which, family members, nursing staff, migrant home care workers and older adults were interviewed. Due to the rich data, the present study is devoted to analyzing interviews with older adults. Additional themes concerning data derived from interviews with the three providers are available elsewhere (Ayalon et al., 2013, 2015).

Data were gathered by means of semi-structured in-depth interviews. This tool is a flexible framework for examining the meaning of behaviors, feelings, beliefs and perceptions (Shkedi, 2003). An interview guide was constructed, including key questions to stimulate primary descriptions and concepts that participants might use to describe their reality regarding the phenomenon under study (Shkedi, 2003). The interview guide started from broad questions followed by more detailed and interpretive questions (see Appendix 1). In the interviews, demographic information was obtained including age, years of education, number of years receiving care from a migrant care worker, number of diseases and days at the hospital. Data were collected between 2011 and 2012. The present study and consent procedure were approved by the Helsinki Committee of Hadassah Hospital. The participants first received a brief explanation of the general research aims, agreed voluntarily to participate and signed an informed consent form. They were then interviewed individually for 20–40 minutes. The brevity was due to the nature of the hospital setting. The interviews were conducted in Hebrew. Each interview was tape-recorded and later transcribed.

Data analysis

The present study used a phenomenological-hermeneutic perspective, viewing the human world as constructed from multi-subjective realities (McLeod, 2001). The

researchers' aim in using this perspective was to describe and interpret the meaning of the experiences as perceived by those experiencing it, thus enabling an understanding of significant, subjective processes without attempting to refute hypotheses (McLeod, 2001).

The content analysis in this study consisted of the following stages.

- (1) Open coding: The researchers first independently read each interview transcript line by line, jotting down notes to capture and identify initial units of meaning (categories) emerging from the data (Strauss, 1987). Open-coding analysis was also conducted by a graduate student in social work. Differences between the coders were resolved through discussion until consensus was reached (e.g., whether quotations reflected the theme title and whether a particular theme was appropriate).
- (2) Axial coding: In a second reading of the transcripts, the researchers gradually detected associations between themes and sub-themes related to context and content. They compared all completed interviews to consolidate meaning and to reach a theoretical construct (Strauss, 1987).
- (3) Integration: The core themes or main categories that emerged from the data were reordered conceptually and placed back into context, making it possible to analyze and integrate large amounts of data and to generate abstractions and interpretations (Shkedi, 2003). These themes included the abstraction and unification of the findings.

Results

Three major themes emerged from the data. The first theme was identified as 'What is my worth?' and was

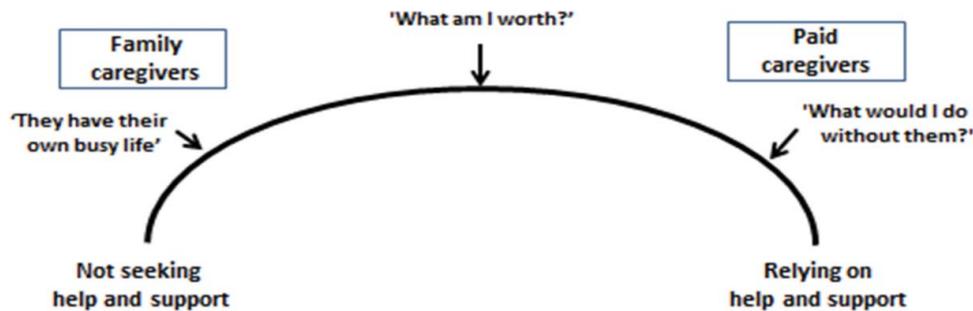


Figure 1. Pictorial presentations of the findings.

focused on the participants' perceptions about themselves as helpless and dependent on others in performing everyday task in general, and during the hospital setting, in particular. The second theme was identified as 'What would I do without them?' This theme referred mainly to the migrant home care workers but also to the nursing staff. It meant immense gratitude, but also a sense of powerlessness and dependence on paid caregivers for support. The final theme concerned participants' low treatment expectations from their family members in the hospital setting due to their perception of their family members as having multiple obligations and duties in addition to their caregiving role. This theme was identified as 'They have their own busy life'. Figure 1 provides a pictorial illustration of the thematic findings that emerged in this study.

What is my worth?

Participants perceived themselves as lonely, helpless and dependent on others in their daily functions. This image was further reinforced by the fact that they have migrant home care workers and therefore they are 'needy', by definition. In the hospital setting, with dramatic decline in the ability to function and the need to adapt to a new framework, dependence on migrant home care workers and nursing staff has become stronger. Feelings of frustration and helplessness as a result of difficulties in functioning were pointed out. This is illustrated by the following quotation from one of the older adults:

...I'm not the same as I used to be...I need help and support almost in everything and this is why she [the migrant home care worker] is here...in the hospital my condition and my dependence on others is much worse...it's really depressing.... Ruth.

Participants described how they used to be in the past, the roles they had in their workplace, among their family and in other social settings. They emphasized the functional and social losses they had experienced in their old age and emphasized their multiple hospitalizations and the reliance on home care workers as amplifiers of their sense of loss. All of these losses raised questions regarding their identity, with participants noting a big discrepancy between their past and present identity. Experiencing these losses had become much stronger in the hospital setting. According to participants, an adaptation to a new place, like the hospital, reinforces a sense of

loss because in the hospital setting there is almost no room for the personal story or individual needs of the patient. This is articulated in the following statement by one older adult:

...I was a teacher and then a school principal...today I can't even take care of myself...I need help in taking a shower, in dressing, in cooking...lost everything...this is not me...in the hospital it is worse as I need even more help now.... Moshe.

What would I do without them?

Older adults described the migrant home care workers' role in two kinds of settings: at home and in the hospital. At home, migrant home care workers' role was perceived as multi-tasking, including (1) assistance in personal care, e.g., bathing, feeding and grooming, (2) helping with household managements, such as preparing meals, cleaning the house, doing the laundry and grocery shopping, (3) addressing emotional and social needs – participants described the migrant home care workers as keeping them company and as adequate partners for conversations.

In the hospital setting, participants' experiences and perceptions regarding the migrant home care workers' roles were intensified. Participants emphasized the way migrant home care workers are aware of their unique personal needs more than anyone else. Furthermore, they expressed the importance of their intimate relationship with the migrant home care workers, especially during hospitalization, when they are exposed to a new environment, new treatments and a new agenda.

... I can't manage without her [without her migrant home care worker]. We do everything together. I can't even think about it...I wouldn't have thought of coming to the hospital and couldn't have come here [to the hospital] without her...I really need her.... Linda.

According to participants, if they needed to adapt to new caregivers (in the hospital setting) it would have been very complicated for them, physically and emotionally. The migrant home care workers' knowledge regarding participants' special needs reduces anxiety and gives a sense of security in a strange and unnatural environment like the hospital setting. Therefore, participants mentioned that many times they prefer to call their migrant home care worker for help instead of the nursing staff.

...She knows me...she knows exactly what I need so she can provide me with the best treatment. They [the nursing staff] do not know me as she does.... David.

In addition, participants described the importance of the migrant home care workers who do not only take care of their basic needs, but also serve positive social interaction, as companions and friends. Furthermore, they stressed that migrant home care workers provide them with love. Older adults described feelings of sadness and emptiness without the presence of the migrant home care workers in the hospital near them. The following reference from one of the older adults serves as a good demonstration of the perceptions and feelings about the important role of migrant home care workers during hospitalization:

...She does everything for me. She takes care of me, sits next to me all day, talks to me, gives me a massage, and most importantly - she loves me...when she is not here, I'm sad.... Lea.

Another older adult argued that in addition to providing for all her basic needs, her migrant home care worker fulfills her emotional and social needs, which are the most important,

...She sits next to me, talks to me, hugs me, loves me and she also responds to my daily needs [help in personal care, e.g. bathing, feeding and grooming].... Neomi.

Besides their significant respect for the migrant home care workers, participants expressed their appreciation to the nursing staff in the hospital setting. They mentioned that the nursing staff makes sure that they feel well,

...They [nursing staff] do what they need to accomplish... whatever they need to accomplish- is done, including special testing and whatever else needs to be done. They want me to feel well.... Lili.

However, participants have also argued that the nursing staff is not always available to them. They explained that the nursing staff experiences a role overload because they have many patients to take care of,

...They [nursing staff] do not have time...so much to do with their patients... every time I call them [the nursing staff] I need to wait for a while...They are not available to me.... Dan.

They have their own busy life

This theme is focused on older adults' family members. The older adults had argued that their family members, especially their children, have important commitments, such as child care, employment and household management. They perceived themselves as a burden and did not want to harass and/or trouble their family members. They also pointed out that they did not need their family's help because they received help and support from their paid caregivers in the hospital setting (nursing

staff and migrant home care workers). This is illustrated by the following quotation from an interview with an older adult:

...My children have their own life...very busy all the time...they need to go to work, taking care of their children, doing this, doing that...they don't need to have me around...the thing is that I even do not need them because I receive here [in the hospital] great help from them [from the nursing staff and the migrant home care worker].... Yael.

However, older adults had also mentioned that they wish their family members had come more often to visit them in the hospital. Their expectations were not focused on the provision of treatment, but just on their physical and emotional presence,

... I wish my daughter would have come a bit more often to visit me... I know she is very busy... I don't need her to take care of me, just to sit next to me.... Rivka.

A common conflict articulated by participants was whether or not to release their family members from the responsibility to provide them with care and support, as one older adult argued,

...On the one hand, she is my daughter and I need her at times of crisis...on the other hand, I know that she is busy so I don't want to bother her...Moreover, my migrant home care worker fulfills her [his daughter] natural tasks.... Ron.

In contrast to their minimum expectations from their families for providing them with personal care, older adults did have high expectations from their family members regarding the provision of instrumental care, such as helping them with their financial affairs. They argued that

...It is important to me to have my son take care of my finances because he is the only one I trust.... Lili. Another older adult emphasized: ...My daughter knows that she is responsible to take care of my money. Only she can do it.... Lisa.

Discussion

Hospitalization is a frequent occurrence in the lives of many older adults as well as a major risk for all-cause mortality and disability (Palmisano-Mills, 2007); therefore, it is crucial to provide the appropriate treatment and care during hospitalization to address the older adults' physical and emotional changing needs. The current study's aim was to assess hospitalized older adults' perceptions regarding three main groups of care providers, namely nursing staff, family members and migrant home care workers.

According to participants and as introduced in theme called, 'What is my worth?' hospitalization has two main consequences for their well-being: physical consequences as well as psychological consequences. Among the physical consequences, participants described how their daily

physical and functional difficulties (e.g., difficulties walking, difficulties taking a shower) have worsened during hospitalization. These findings are consistent with past research demonstrating that hospitalization is associated with an irreversible decline in functional status, cognitive performance and quality of life (Mudge et al., 2010). Moreover, there are medical and physical risk factors associated with adverse health outcomes at discharge from the hospital among older adults (Preyde & Brassard, 2011). It should be mentioned that in the current study, participants were functionally dependent even prior to their hospitalization (they all met the criteria for employing a migrant home care worker) and therefore they were at a greater risk of experiencing physical decline.

Older adults described not only their physical state but also the psychological consequences of their hospitalization. Feelings of frustration and helplessness as a result of functional difficulties were pointed out. Indeed, previous studies have revealed that older adults are not only prone to physical decline during hospitalization and after discharge, but are also at risk for experiencing psychological distress which could lead to hospital readmission (Preyde & Brassard, 2011). Feelings of loneliness, dependency and helplessness among participants have increased their need for help and assistance from other support systems, such as migrant home care workers and nursing staff.

In addition to their significant respect for the migrant home care workers, as introduced in theme called, 'What would I do without them?', older adults expressed their appreciation to the nursing staff in the hospital setting. They mentioned that the nursing staff performs their duties, executes extensive testing, provides treatments and ensure that they feel well, namely, nursing staff provide tangible support as articulated by Sherbourne and Stewart (1991). This finding is in contrast with a previous study which has argued that older adults carry negative perspectives about nursing staff and view them as being uncommunicative or informative about their health state (Batista et al., 2011). This discrepancy could be due to the presence of another type of paid caregivers in the present study, namely migrant home care workers. Compared to the nursing staff, participants mentioned that the migrant home care workers are much more available to them. Participants described the nursing staff as overwhelmed with work demands and as suffering from a staff shortage. This finding is important because it is highly likely that hospitalized older adults who do not have a migrant home care worker do not receive adequate care as migrant home care workers likely capture some of the roles of the nursing staff (Ayalon et al., 2015).

In contrast to previous studies which have demonstrated that family caregivers play a significant role during the hospitalization of their care recipients (Auslander, 2011; Lindhardt et al., 2008; Tzeng & Yin, 2008), our findings indicate that older adults do not perceive their family members as significant 'players' within the hospital settings, as introduced in theme called, 'They have their own busy life'. Despite their complicated medical conditions during hospitalization, older adults preferred to turn to their migrant home care workers rather than to

their families. This finding should be discussed by examining the place of the family in Israeli society. Israel is characterized by traditional and family-oriented values, familial ties and norms of care for the older family members (Lowenstein, Katz, & Daatland, 2005). However, in the past years, Israel, similar to other countries, has experienced a tension between formal (paid) and informal (family members) care providers as a result of transitioning from traditional family oriented values and familial ties (Lowenstein et al., 2005) to more modern values. These transitions have intensified the reliance on paid caregivers in the case of older adults (Cohen, 2010).

In the current study, a common conflict articulated by participants was whether or not to release their family members from the obligation to provide them with emotional and tangible support. On one hand, family members were seen as the natural source of support at times of crisis and need (Auslander, 2011; Lindhardt et al., 2008). On the other hand, nursing staff and migrant home care workers fulfill the family members' traditional tasks by responding to the older adults' needs during their hospitalization. Indeed, past research has revealed that migrant home care workers help to significantly decrease the family's burden and allow many families to work and lead normal lives, while continuing to provide some care for their elderly members, thus filling the traditional role played by family caregivers (Iecovich, 2007; Polverini & Lamura, 2004). In the current study, similar to another study (Chen, Xinxiao, & Aagard, 2012), participants attempted to legitimize their family members' limited involvement during their hospitalization. By legitimizing their family members' limited involvement, older adults ease their own conflict of wanting contact with their family members, yet not wanting to become dependent on them (Donnellan, Bennett, & Soulsby, 2015; Pinquart & Sorensen, 2000). In the current study, it appears as if participants' positive experiences with their migrant home care workers have lowered their expectations from their families and have helped them to meet their growing needs for support outside the family realm.

In contrast to their limited expectations from their families for provision of personal care, participants did have expectations from their family members regarding the provision of tangible support, such as handling their financial affairs. This finding is consistent with previous studies conducted in Israel (Ayalon, 2009). Even though participants felt physically and emotionally close to their migrant home care workers, they still did not fully trust them in handling their financial affairs. Participants still perceived their family members as more trustworthy than all other caregivers.

The present study has several limitations. First, the study was performed in only one hospital ward. It is possible that work environments are different in other hospital wards. In additions, interviews were not conducted with older adults with cognitive impairments. Possibly, the experiences of older adults with cognitive impairments are very different. The qualitative nature of this study and the small sample size preclude our ability to generalize the findings. Nonetheless, we took several measures

to rigor the study including coding of the data by several researchers and using a 'thick description', which consisted of quotes from the interviews to ensure that the findings are transparent (Polkinghorne, 2005) and to allow the readers to judge the proposed interpretations by themselves (Cresswell, 1998). Finally, although information was collected about the number of diseases faced by hospitalized older adults, the information did not include the types of diseases.

Despite these limitations, our study has practical and policy implications. Practically, given the fact that migrant home care workers are perceived by the older adults as a main source of support, it is important to either preserve this workforce and formally allow them to continue to provide their significant personal and emotional support for the older adults or to identify other formal sources of support that will meet the increasing needs of the aging society. Even though the older adults tried not to be a burden on their families, it is still very important to keep families involved in the care of older adults within the hospital setting as well as outside the hospital. Interventions programs for families should stress the significant implications of being involved in the older adults' life while examining concrete and emotional barriers besides solutions. Furthermore, it is equally important to identify hospitalized older adults who do not have family caregivers and may need additional help and support.

From a policy perspective, it is clear that during hospitalization, older adults report significant negative consequences, even when they are supported by their family members, migrant home care workers and nursing staff. The findings highlight the fact that even though the three groups of treatment providers support older adults during their stay, this support does not fully meet their emotional needs and perhaps even intensifies their sense of negative self-worth. In addition, because our findings showed that migrant home care workers are more available to hospitalized older adults, compared to nursing staff, hospitals' policy makers should be aware of this potential role overlap and formal procedures should be put in place to ensure the smooth operation of nursing staff, even in the presence of migrant home care workers.

The findings of this study make a strong case for further research on the perceptions of family members, nursing staff and migrant home care workers regarding their and others' roles in the hospital setting. Future research should evaluate the longitudinal effects of role overlap and role diffusion in the hospital setting, in order to develop more definitive role expectations for each group of providers. In addition, because our findings showed that migrant home care workers are more available to hospitalized older adults, compared to nursing staff, hospitals' policy makers should be aware of this potential role overlap and formal procedures should be put in place to ensure the smooth operation of nursing staff, even in the presence of migrant home care workers.

To sum, our study is the first to examine hospitalized older adults' perceptions' regarding three main groups of care providers available during their hospitalization period: nursing staff, family members and migrant home

care workers. Overall, our findings indicated that hospitalized older adults prefer to turn for help to paid caregivers rather than to their families. Findings are discussed in light of the tension between formal and informal care along with the transition from traditional family values to modern values, which place the care of older adults in the hands of paid caregivers. The findings expand the limited body of existing knowledge regarding hospitalized older adults' perceptions and feelings towards formal and informal caregivers in the hospital setting. The main implications of the study are to more clearly formally articulate the roles of migrant care workers within the hospital setting or to identify other formal sources of support for the care of hospitalized older adults. In addition, it is recommended to keep families involved in the care of older adults within the hospital setting as well as outside the hospital. Future research will benefit from evaluating perceptions about formal and informal caregivers within the hospital setting using survey methods.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Appendix 1. Interview guide

- (1) Tell me about the care received from the various stakeholders (e.g., family members/migrant home care workers/nursing staff)?
- (2) What are some of the advantages for having a migrant home care worker on the unit?
- (3) What are some of the disadvantages for having a migrant home care worker on the unit?
- (4) How are things different given the fact you have a migrant home care worker on the unit?
- (5) What would you recommend a friend concerning having/not having a migrant home care worker?
- (6) What do you think should be the role of the various stakeholders (e.g., family members/migrant home care workers/nursing staff)?
- (7) What are your preferences regarding a care taker? Who is most qualified for the job and why?
- (8) Who made the decision to have a migrant home care worker on the unit?