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JOURNAL OF LONG-TERM CARE

A Rapid Review on the Preparedness and Practice Needs of the Home Care Workforce to Support Older LGBTQ+ People

RESEARCH

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ABSTRACT

Context: Little is known about the preparedness of the home care workforce to support older LGBTQ+ (lesbian, gay, bisexual, trans, queer, and other marginalised sexual orientations or gender identities) people. By preparedness, we mean the skills, knowledge, and confidence to provide affirmative support.

Objective: To identify the current evidence on the preparedness and practice needs of the home care workforce to support older LGBTQ+ people, with a particular focus on workforce perspectives.

Method: We carried out a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) and Cochrane-compliant rapid review of the academic and grey literature. There were no search date or study design restrictions, and we assessed the quality of all evidence as well as the confidence in the findings. Thirty-nine documents were included in the final review.

Findings: Findings suggest preparedness in the home care workforce is underdeveloped, evidenced by incidences of discrimination, a limited understanding of LGBTQ+-specific care needs, heteronormative and cis-normative attitudes, and low workforce confidence. Studies highlighted the distinct training needs of the home care workforce and indicated a need for better workforce support in the form of lived-experience-informed training and inclusive policies.

Limitations: Several limitations were identified. The rapid review method may have increased the risk of errors. The included evidence lacked diversity, and evidence specific to home care was limited.

Implications: Implications for policy and practice concern the careful consideration of system-level barriers to practice improvement. Implications for future research include the examination of effective training using rigorous study designs and larger home care samples.

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INTRODUCTION

In response to challenges relating to population ageing, long-term care systems in both the United Kingdom (UK) and internationally are characterised by a policy shift towards 'ageing in place' and supporting independent living in the community, of which home-based care is a core provision for achieving this (Chen, Jiang and Xuezeng, 2024; Department of Health, 2014; Department of Health & Social Care, 2021; Department of Health & Social Care, 2025; Genet *et al.*, 2011; Monitor, 2015; Palesy *et al.*, 2018; Schuchman, Fain and Cornwell, 2018). Simultaneously, international evidence suggests that a majority of older people prefer receiving home care over moving to a care home (Kasper, Wolff and Skehan, 2018; Lehnert *et al.*, 2019). It is estimated that in the UK, where the research team is based, nearly 1 million people receive home care (Berg, 2025); in Australia, this is approximately 1.2 million (Townson, 2025); in the United States, 3.3 million (CDC, 2026); and within the European Union, close to 11 million people (Eurostat, 2026). Moreover, demand is projected to rise globally in line with an ageing population (Dhiman and Chavali, 2024; The King's Fund, 2025; United Nations, 2016). Ageing in place is described as potentially providing a sense of freedom, independence, identity, and community connection. In principle, the home is framed as the place where one can safely be oneself (Gibson *et al.*, 2024; Hatcher *et al.*, 2019; Wiles *et al.*, 2011).

This seems particularly pertinent to older people who identify as lesbian, gay, bisexual, trans, queer, or another marginalised sexual orientation or gender identity (LGBTQ+) (Hafford-Letchfield and Cocker, 2024; King and Stoneman, 2017), many of whom have experienced interpersonal and institutional discrimination in their lifetime (Fredriksen-Goldsen and Muraco, 2010; Fredriksen-Goldsen *et al.*, 2023; Jones, Almack and Scicluna, 2018; Kum, 2017). There is a lack of robust data, and sources vary, but estimates suggest that the older LGBTQ+ population includes a substantial number of people. It is estimated that worldwide 5 in 100 older people identify as LGBTQ+ (Ipsos, 2024), including 120,000 to 1 million people in the UK (Age UK, 2020; ONS, 2023a, ONS, 2023b), 3 million in the United States (Flores and Conron, 2023; Sage, 2025), and 53,000 in Australia (Australian Institute of Health and Welfare, 2025), but many countries do not routinely collect these data. Their home can be one of the few safe spaces that affirms their identity (Waling *et al.*, 2019; Wang, Miao and Wang, 2024; Willis, Raithby and Maegusuku-Hewett, 2018). Carers coming into LGBTQ+ older people's home spaces can change the meaning and safety of those spaces (Hafford-Letchfield and Cocker, 2024). Indeed, research confirms strong preferences for home care compared to other long-term care options in the older LGBTQ+ population (Buczak-Stec *et al.*, 2023). At the same time, this population is more likely to need formal long-term care support compared to non-LGBTQ+ older people due to a greater likelihood of living alone, absence of informal support from biological family traditionally relied upon for caregiving and various disproportionate health risks (Breder and Bockting, 2023; Buczak-Stec *et al.*, 2023; Buczak-Stec *et al.*, 2025; Fredriksen-Goldsen *et al.*, 2013; Guasp, 2011; Kneale *et al.*, 2021). These health inequalities are compounded by minority stress, described as the increased risk of health problems stemming from a lifetime of discrimination, social exclusion, and institutional erasure as well as the historical criminalisation and pathologisation of LGBTQ+ identities (Kneale *et al.*, 2021; Meyer, 2003; Savage and Barringer, 2021). Consequently, it is important that home care workers are well prepared to provide LGBTQ+ inclusive, affirmative care. By preparedness, we mean whether the home care workforce has the skills, knowledge, and confidence to provide affirmative support to the LGBTQ+ population.

To the best of our understanding, research thus far has only examined care workforce preparedness to provide LGBTQ+ inclusive care in residential care, extra care, and health care settings and demonstrates that many providers hold discriminatory assumptions about LGBTQ+ people rooted in ageism, heteronormativity, and cisnormativity (the assumption that cisgender people, whose sex assigned at birth corresponds with their gender identity, are the norm) (Caceres *et al.*, 2020; Simpson, Almack and Walthery, 2018; Willis *et al.*, 2014; Women and Equalities Committee, 2019). Whilst several studies have attempted to address inequalities for older LGBTQ+ people in these settings and improve workforce preparedness (Hafford-Letchfield *et al.*, 2018; Jurček *et al.*, 2020; Keemink *et al.*, 2025; Rhoten *et al.*, 2022; Willis *et al.*, 2014; Willis *et al.*, 2021), large-scale practice change remains elusive. Many older LGBTQ+ people still report experiences of discrimination, neglected care needs, and erasure of life experiences (Caceres *et al.*, 2020; Chubb, 2023; Jones *et al.*, 2018; Kneale *et al.*, 2021; Shippee *et al.*, 2023; Willis *et al.*, 2023). Nevertheless, to our knowledge, little is known about the preparedness of the home care workforce to provide LGBTQ+ inclusive care, and home care settings seem to have been overlooked in improvement initiatives (Daley and MacDonnell, 2011). This knowledge might be useful to support the home care workforce to develop inclusive practice, as well as to ensure safe and affirmative home care for older LGBTQ+ people, in line with the English Care Act (Department of Health, 2014) and the Welsh Social Services and Well-being Act (National Assembly for Wales, 2014). This seems particularly important because home care takes place in people's private domestic spaces, often with limited direct supervision, and may therefore raise distinct questions about privacy, disclosure, safety, and trust.

To our knowledge, there have been no reviews investigating the home care workforce's own perspectives

on their preparedness to support older LGBTQ+ people. Existing reviews have either focused on the experiences of older LGBTQ+ people, were limited to evidence from the United States, or examined different segments of the long-term care workforce. (Caceres *et al.*, 2020; Duffy *et al.*, 2024; May and Crist, 2023; Smith and Wright, 2021). The current rapid review extends earlier work by gathering and synthesising evidence on the preparedness and practice needs of the home care workforce to support older LGBTQ+ people, with a particular focus on identifying workforce perspectives and including grey literature. We also included evidence from the perspectives of older LGBTQ+ people and their partners or informal carers, where this evidence provided insights into workforce preparedness or practice needs in home care.

This review is part of a larger study investigating the preparedness of the home care workforce in England and Wales to support older LGBTQ+ people. The review included evidence from any country where available, but its interpretation is informed by the UK policy and practice context of the wider study. Findings may therefore be relevant to other care systems, particularly those with similar home care arrangements, but should be interpreted with attention to differences in the organisation, funding, regulation, and professionalisation of long-term care internationally.

METHODS

RESEARCH QUESTION

The research question this review aims to answer is: What is known about the preparedness and practice needs of the home care workforce to support older LGBTQ+ people? This question arose from the identified gaps in the literature described above and was formulated in consultation with an older LGBTQ+ person with lived experience of home care during the funding application stage of the project.

DESIGN

This study employed a rapid review design, offering time efficiency whilst maintaining methodological rigour (Garritty *et al.*, 2021), to support rapid dissemination to policymakers and care providers and to ensure the wider research study addresses the most prominent evidence gaps. Following Cochrane recommendations for rapid reviews (Garritty *et al.*, 2024), we streamlined the review process by limiting the number of outcomes, search databases, and reviewers for each step of the review process (see details below). Whilst the rapid methodology may increase the risk of errors in the review process, we have attempted to minimise the risks by registering (PROSPERO CRD420251038242) and publishing the review protocol following peer review (Keemink *et al.*, 2026) and by following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines and interim guidance for rapid reviews (Page *et al.*, 2021; Stevens *et al.*, 2025) and Cochrane guidelines (Garritty *et al.*, 2024). The completed PRISMA checklist can be found in Appendix 1.

PICO STATEMENT AND TERMINOLOGY

The two populations (P) under examination are the home care workforce, including any type of role involved in home care provision (management, frontline, or other), and the older LGBTQ+ population, including any person over 60 years of age identifying as LGBTQ+. The intervention (I) is home care (see definition below). This review does not include a comparison (C) measure. The outcomes (O) of interest are the preparedness and practice needs of the home care workforce to care for older LGBTQ+ people. Preparedness is defined as the skills, knowledge, and confidence to support older LGBTQ+ people. Practice needs refer to the gaps in skills, knowledge, and confidence and how these can be addressed.

To aid clarity and understanding, we have defined key terms below.

- **Home care** is defined as the frontline delivery of health and social care in people's own homes (World Health Organization, 2008), including personal care (support with personal hygiene and dressing) and reablement services (care after illness or hospital discharge). Globally, many different terms for home care are used, which has been reflected in our search strategy (see Table 2).
- **Long-term care** comprises a wide range of social, medical, and personal services that are provided over an extended period to support people to maintain a level of functional ability (World Health Organization, 2022). This includes, but is not limited to, home care. In some countries, long-term care may be described as social care or adult social care. These terms have been included in the search strategy to ensure that studies that examined long-term care in its entirety (including home care) were not missed.
- The **care workforce** refers to staff working in long-term care, including frontline care workers, supervisors, managers, coordinators, administrative staff, and ancillary staff. We have used the term 'home care workforce' when specifically referring to staff working in home care. In this review, studies that reported data about the preparedness of the home care workforce (in any role) were included, including studies where the home care workforce was a small part of a larger long-term care participant group.
- The term **LGBTQ+** encompasses various marginalised sexual orientations and gender identities, including but not limited to lesbian, gay, bisexual, trans, and queer. The + sign acknowledges the diversity

within the community and represents all sexual orientations and gender identities not specified by the letters (Stonewall UK, 2026). Whilst these various marginalised identities form a community, it is important to acknowledge the heterogeneity within this population, which might affect their experience of care. Terminology to describe the LGBTQ+ community has changed (and will likely continue to change) over time. We selected LGBTQ+ as it is inclusive and most commonly used in the UK, where the research team in based.

ELIGIBILITY CRITERIA

An overview of the exact inclusion and exclusion criteria is outlined in Table 1. We did not impose any restrictions on year of publication or country for thoroughness. The review therefore included international evidence but did not aim to compare national care systems. We only included documents published in English, as Cochrane recommendations propose that rapid reviews can limit their search to documents in English. Whilst this may pose a risk to the completeness of the evidence, exclusion of non-English publications does not seem to significantly alter review conclusions (Nussbaumer-Streit *et al.*, 2020). We considered evidence regardless of methodological quality but have reported quality in line with Cochrane recommendations. Cochrane recommendations also suggest exclusion of grey literature is acceptable for rapid reviews. Nevertheless, based on the authors' subject expertise, it was decided that grey literature would be considered for two reasons. First, there is a scarcity of research on older LGBTQ+ people and care (Almack and King, 2019; Westwood *et al.*, 2020), and we therefore believed it was important to consider all available evidence. We were aware of several key advocacy organisations, for example, that have produced reports on this topic and often include the voices of older LGBTQ+ people. Second, by including grey literature, we extend previous reviews, none of which have considered grey evidence.

We included studies that examined perspectives of the home care workforce on their own preparedness and studies considering perspectives of older LGBTQ+ people and their partners. Whilst the latter have been discussed in previous reviews, we included both perspectives for comprehensiveness and to allow for comparison between perspectives. As described above, globally, there are varying definitions of what comprises home care and the different roles within its workforce. For completeness, we did not exclude studies based on how home care was defined (as long as it involved delivery of care in someone's own home) or on type of home care role.

DATA SEARCH AND EXTRACTION

The search strategy was developed by the research team in consultation with a university librarian. The final search strategy can be found in Table 2. Search terms were searched in titles, abstracts, and keywords. The search was carried out between August and November 2025. Cochrane recommends limiting the search for a rapid review to two databases. In this case, we searched Scopus and Web of Science because they are multidisciplinary databases with broad coverage of peer-reviewed research across health, social care, and social sciences. We also searched reference lists of related reviews for any missed documents. Grey literature was identified in subject-specific databases that were selected based on relevance. Because of the rapid nature of the review, we limited the number of databases and

PARAMETERS	INCLUSION	EXCLUSION
Context	International	None
Language	English	Non-English publications
Time	Any publication year	None
Population	Older (60+) LGBTQ+ people, also studies focused on specific sexual orientations or genders (e.g. only gay men). And/or The home care workforce (any role), including studies where the home care workforce was a small part of a larger long-term care participant group.	Studies exclusively considering care for LGBTQ+ people under 60 years. Studies exclusively examining other parts of the care workforce (e.g. care homes).
Interest	Studies examining preparedness and practice needs of the home care workforce to support older LGBTQ+ people (from the perspective of the home care workforce) OR include evidence from the perspective of older LGBTQ+ people and their partners or informal carers.	Studies exclusively examining other types of social care delivery (e.g. care homes, nursing homes, supported living, day care centres, hospice care).
Study type	Peer-reviewed, academic and grey literature	Unpublished literature
Study design	Any review type (e.g. systematic, realist, scoping, meta-analysis), observational studies, cross-sectional studies, qualitative interview studies, randomised control trials).	

Table 1 Inclusion and Exclusion Criteria.

excluded more generic databases that may have been applicable. We searched a total of seven websites: key social care sector support organisations in England and Wales (Skills for Care, Social Care Institute for Excellence, Social Care Wales, and Homecare Association), as well as leading organisations in advocacy and service provision for LGBTQ+ populations (Stonewall, LGBT Foundation, SAGE US). These organisations were selected because they are key producers of grey literature informing UK home care practice and LGBTQ+ inclusion, and their guidance directly shapes workforce training and policy. SAGE US was included as an internationally recognised leader in LGBTQ+ ageing that produces practicefocused materials not available from UK bodies. Their websites do not support the academic search strategy outlined in Table 2, so instead we used keywords relating to home care and older LGBTQ+ people in search fields (home, home care, older, elderly, elders; LGBTQ+, LGBT, lesbian, gay, bisexual, trans, sexual orientation, and gender identity). Search terms from the academic search were trialled for the grey literature website to determine which terms were most relevant and prevalent.

The combined results from the academic search were exported to Zotero (Corporation for Digital Scholarship, 2025); duplicates were removed, and following this, results were uploaded to Rayyan (Ouzzani *et al.*, 2016) for abstract review. As per Cochrane recommendations, abstracts of the 159 identified documents were screened by one reviewer, and a second reviewer reviewed all excluded abstracts. Following this, 80 full texts of eligible articles were independently screened against the eligibility criteria by one reviewer, and reasons for exclusion were noted. A second reviewer screened all excluded documents. Any disagreements were resolved with a third reviewer. In addition to the academic documents identified through the two databases, four academic documents were recommended by colleagues, and four were identified through citation searching. Thirty-five academic documents were included in the final sample.

The grey literature search yielded 1,024 hits. In the absence of abstracts, one reviewer skim-read documents to assess relevance. A second reviewer was consulted in cases of uncertainty. Subsequently, 76 documents were reviewed in full, 16 were assessed by multiple reviewers to make a decision about inclusion, and 4 were included in the final sample. The main reason for exclusion for both academic and grey literature was a lack of significant content about home care provision for older LGBTQ+ people. The final sample for this review included 39 documents (35 academic, 4 grey). Figure 1 provides a detailed overview of the search process in a PRISMA flowchart.

A data extraction form was developed by the research team and piloted using three documents to refine and finalise extraction categories most relevant to the research question. The extraction table included information about authors, title, year, country, study design, setting, sample, outcomes related to preparedness and practice needs of the home care workforce, and key findings (see data extraction matrix in Appendix 2). One reviewer independently extracted data from all included documents, and a second reviewer reviewed and verified all entries. Reviewers discussed extraction results and resolved any discrepancies. Table 3 provides an overview of the included documents, and a more in-depth description of included documents and extracted data can be found in Appendix 3.

QUALITY APPRAISAL

Following Cochrane recommendations, we completed quality assessments of included documents. The academic literature was appraised using the Quality Assessment with Diverse Studies tool (QuADS) (Harrison *et al.*, 2021), previously used by the research team in a published review (Keemink *et al.*, 2023). As this tool was not appropriate for the identified grey documents, we used the AACODS (Authority, Accuracy, Coverage, Objectivity, Date, Significance) tool (Tyndall, 2008) to assess grey

CONCEPT	SEARCH TERMS
Preparedness	prepared* OR comfort* OR training OR readiness OR competence OR "cultural competence" OR knowledge OR attitude* OR skill* OR confidence OR perception* OR awareness OR abilit* OR capabilit*
AND	
Home care	"home* care" OR homecare OR "domiciliary care" OR "personal care" OR "social care" OR "adult social care" OR reablement OR "long term care" OR "home service*" OR "community care" OR "home help" OR "in-home care" OR "home assistance" OR "home health care" OR "care at home"
AND	
LGBTQ+	LGB* OR "sexual minorit*" OR "sexual orientation" OR "gender identit*" OR "gender minorit*" OR "sexual minorit*" OR gay* OR bisexual* OR lesbian* OR trans* OR queer* OR asexual* OR non-heterosexual* OR "marginali* sexualit*" OR "marginali* gender*"
AND	
Older people	"older adult*" OR "older people" OR elder* OR senior* OR "older person*" OR aging OR ageing OR "senior citizen*" OR geriatrics OR retired OR aged OR older

Table 2 Search Strategy for the Academic Literature.

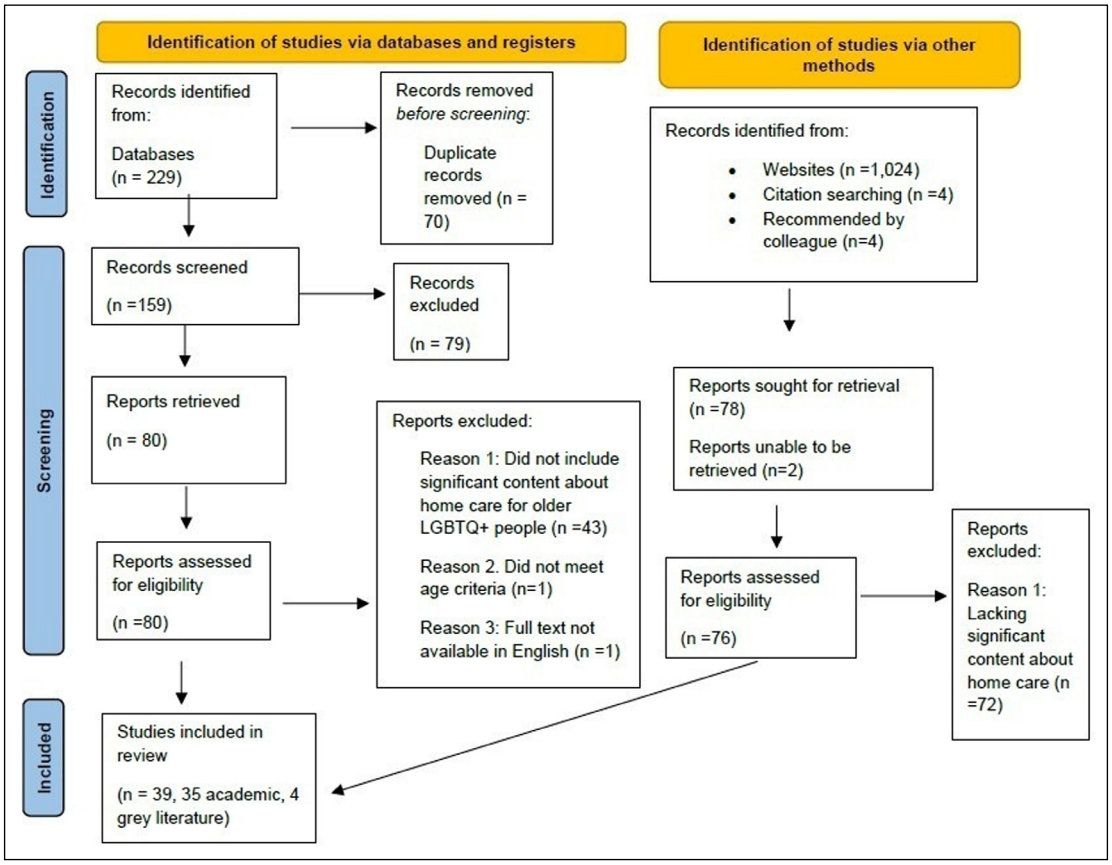


Figure 1 PRISMA 2020 flow diagram.

*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).

**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

Source: Page MJ, et al. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

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literature. The QuADS tool requires a rating from 0 to 3 across 13 domains: theory, aims, setting/population, design, sampling, rationale and appropriateness of data collection tools, procedure, recruitment data, rationale and appropriateness of analysis methods, stakeholder engagement, and limitations. A higher score indicates higher quality of the evidence. Appendix 4 provides the total QuADS scores of the academic literature included in this review. The AACODS tool provides a structured approach to evaluating the quality of grey literature and considers the source, authority, accuracy, coverage, objectivity, date, and significance of documents. It does not involve scoring but allows researchers to describe the credibility of the source. Appendix 5 presents the AACODS table for the grey literature included in this review. One reviewer assessed all documents, and a second reviewer verified all assessments.

DATA ANALYSIS AND SYNTHESIS

Data from included documents were categorised according to study design (qualitative, review, quantitative). To ensure robustness, we used tailored analysis and synthesis approaches for each data type. Review studies predominantly included qualitative data, and therefore the analysis and synthesis approach for review and qualitative data converged. The analysis and synthesis of qualitative data drew on various approaches to thematic synthesis, which has been identified as the first choice for rapid qualitative evidence synthesis (Booth *et al.*, 2024). Data were synthesised using a narrative, configurative approach, drawing on principles of thematic synthesis outlined by Thomas and Harden (2008) and Gough, Thomas and Oliver (2012). Findings reported within each included study were coded deductively against the outcomes of interest (workforce preparedness and practice needs) and inductively to capture recurring patterns relating to the home care context for older LGBTQ+ people. This involved an initial coding of text and development of descriptive themes that remained close to the primary studies, followed by the generation of analytical themes, which were summarised descriptively, with attention to convergence and divergence across studies and perspectives (workforce vs older LGBTQ+).

For synthesis of the quantitative data, we flexibly used the Synthesis Without Meta-analysis (SWiM, Campbell

et al., 2020) reporting guidelines intended for reviews examining the quantitative effects of interventions. These are not completely applicable to the current review, so we selected the reporting items that were suitable. Since there was no homogeneous pattern to the design of the very small number of quantitative studies included and the majority of data were descriptive, it was not possible to statistically synthesise the findings. Therefore, we describe the identified quantitative data relevant to the review question and narratively compare the findings from different studies to draw conclusions. Once these analyses were completed and associated descriptions had been generated, we compared and combined outcomes from the two analyses to finalise our findings. This involved multiple rounds of immersive reading and mapping, enabling final descriptions to emerge. As the overlap between the outcomes of the different data types was substantial, no discrepancies were identified, and combining analyses was straightforward.

In the presentation of findings, we grouped findings according to perspective: the workforce perspective or the older LGBTQ+ population perspective. Within these categories, we present findings related to the preparedness of the home care workforce and findings on their practice needs. Subsequently, we compare findings from each perspective.

ASSESSMENT OF CONFIDENCE IN REVIEW FINDINGS

Cochrane guidelines recommend assessing certainty of evidence during data synthesis using the GRADE (Grading of Recommendations, Assessment, Development and Evaluations) considerations (Guyatt *et al.*, 2011). As this review predominantly included qualitative data, we deemed the use of the GRADE CERQual (Lewin *et al.*, 2018) most appropriate. GRADE CERQual assesses the level of confidence in an identified body of evidence using four considerations: methodological limitations, coherence, adequacy, and relevance. Combining these four components, overall confidence for each outcome of the review is judged as high, moderate, low, or very low. Scores from the quality appraisal were included in this judgement. If there was more high-quality evidence, confidence in the findings was more likely to be higher, and vice versa. For this review, we had four outcomes for which confidence was assessed: (1) preparedness from the perspective of the workforce; (2) preparedness from the perspective of older LGBTQ+ people; (3) practice needs from the perspective of the workforce; and (4) practice needs from the perspective of older LGBTQ+ people. The assessment was carried out by one reviewer and verified by a second reviewer.

PUBLIC INVOLVEMENT

Cochrane encourages the direct involvement of key stakeholders, which we pursued in two ways. Firstly, an older LGBTQ+ person contributed to the funding application for the project, which included the proposed question, definition of key concepts, and method for this rapid review. Secondly, we sense-checked the interpretation and contextualisation of the findings with two older LGBTQ+ people (60+ years of age) who are involved in the project as co-researchers, which shaped the focus of our discussion section. Their perspectives highlighted the importance of understanding the context in which education of the home care workforce takes place, as well as considering factors to ensure that training does not become a tick-box exercise. Lastly, the review was discussed at two study steering group meetings, including several home care staff, during which these members provided input.

AMENDMENTS

For transparency, we report two minor changes to the review process compared to what we stated in the protocol. (1) We added the use of the AACODS table to aid the appraisal of the grey literature. (2) We opted for the GRADE CERQual rather than the GRADE assessment, as this version seemed more fitting to the data in this review.

ETHICS

Ethical approval was not required for this review.

RESULTS

OVERVIEW OF STUDY CHARACTERISTICS

Thirty-nine documents met the inclusion criteria and provided information about the preparedness and practice needs of the home care workforce in relation to supporting older LGBTQ+ people. We derived qualitative data from 28 documents, quantitative data from 5 documents, and review data from 8 documents. Please note that some documents included both quantitative and qualitative data, making the total larger than the number of studies included in the review. An overview of included documents, including study design, can be found in Table 3. Twenty-seven documents exclusively presented the perspective of older LGBTQ+ people (AARP New York, 2021; Arthur, 2015; Boggs *et al.*, 2017; Butler, 2017; Butler, 2018; Duffy *et al.*, 2024; Dunkle, 2018; Equality and Human Rights Commission, 2011; Furlotte *et al.*, 2016; Genke, 2014; Grigorovich, 2015a; Grigorovich, 2015b; Grigorovich, 2016; Hoekstra-Pijpers, 2020; Hong, 2024; Jihanian, 2013; Kneale *et al.*, 2021; Löf and Olaison, 2020; McMillan *et al.*, 2025; McMullen-Roach *et al.*, 2025; Sharek *et al.*, 2015; Smith and Wright, 2021; Stein, Beckerman, and Sherman, 2010; Waling *et al.*, 2019; Walker, Powers and Witten, 2023; Williams, Dakin and Lipschutz, 2022; Willis *et al.*, 2021), eight documents centred around the workforce perspective

AUTHORS/ DATE	STUDY DESIGN/MEASURES	COUNTRY	SAMPLE
AARP NY, AARP Foundation & SAGE (2021)	**Grey literature:** policy/advocacy report drawing on previous data. Explored feelings/ concerns that LGBTQ+ older people have about future care.	USA	Older adults (50 +) who identify as LGBTQ and are living in New York State- no specific population size.
Arthur, D.P. (2015)	**Conceptual and practice-based review of literature:** assessed barriers to care/health disparities among LGBT elders.	USA	No empirical sample (conceptual), focused on LGBT elders (age 60+) facing EOL care challenges) and social work practitioners/students.
Age UK (2021)	**Grey literature:** investigated how sexual identity can be erased in home care and difficulties with disclosure.	UK	Older LGBTQ+ adults (age 50+) who use health, care, and support services and the staff of these services.
Benbow & Kingston (2022)	**Qualitative service evaluation:** individual interviews & focus groups that explored trans people's engagement with health/social care.	UK	Group 1: older trans people (age 50–79) with experience of receiving social care (n = 16). Group 2: health and social care practitioners (n = 22).
Bjarnadottir *et al.* (2019)	**Qualitative descriptive study:** interviews & focus groups explored current practices documenting sexual orientation and gender identity.	USA	Nurses working in the home health care agency (n = 24).
Boggs *et al.* (2017)	**Qualitative, community-based participatory evaluation study:** interviews and focus groups identified perceptions of aging in place.	USA	LGBT people between ages 50–69 (n = 73)
Butler, SS. (2017)	**Qualitative, exploratory study:** semi-structured phone interviews explored the relationship between the home care workers and women receiving care.	USA	Group 1: lesbian women age 66 to 86 with experience of receiving home care (n = 20). Group 2: informal caregivers of the participants in group 1 (n = 6). Group 3: home care workers who provided care for group 1 (n = 5).
Butler, SS. (2018)[1]	**Qualitative, exploratory study:** semi-structured phone interviews. explored the relationships between older lesbians and home care workers.	USA	Group 1: lesbian women aged 66 to 86 with experience of receiving home care (n = 20). Group 2: informal caregivers of the participants in group 1 (n = 6).
Caceres *et al.* (2020)	**Systematic Review:** included both qualitative and quantitative research.	USA	Research studies on long term support services and training on LGBT older people and their health needs/care experiences (n = 19).
Daley & MacDonnell (2015)	**Qualitative study:** focus groups and individual interviews. Explored experiences of and suggestions for LGBTQ education.	Canada	Home care service providers who had between 10- and 20-years practice experience (n = 15).
Duffy *et al.* (2024)	**Scoping review:** included peer-reviewed primary research studies.	Various	Research that explored homecare experiences of LGBTI older people (n = 12).
Duffy *et al.* (2025)	**Mixed methods (grey literature):** qualitative interviews with older LGBTQI adults assessed home care experiences and a survey for care workers.	Ireland	Qualitative: LGBTQI adults ages 51 to 63 (n = 14). Quantitative: Health care assistants, home support workers, or home care workers (n = 63).
Dune *et al.* (2020)	**Systematic review:** included peer-reviewed primary research studies.	Various	Studies that investigated care experiences of older (55+) lesbian and bisexual women, majority involved qualitative approaches (n = 18).
Dunkle, J.S. (2018)	**Qualitative exploratory study:** focus groups explored knowledge, attitudes, and experiences of funded services/current needs.	USA	Gay and lesbian participants ages 54 to 80 years old (n = 31).
Equality and Human Rights Commission (EHRC) (2011)	**Grey literature:** evidence gathered focus groups and interviews.	UK	Older people, their relatives, home care providers, and voluntary sector organisations.
Furlotte *et al.* (2016)	**Qualitative study:** In-depth interviews explored health, discrimination experiences, LTC/ home care expectations, and needs.	Canada	Same-sex couples ages 39–75 (n = 12).
Genke, J. (2014)	**Qualitative and conceptual case-based analysis:** grounded in the author's experience as a social worker.	USA	Primarily white, educated, middle-class, urban gay men aged 60 and older (unclear how many cases informed the findings).
Grigorovich, A. (2015b)	**Qualitative case study design:** semi-structured interviews explored wider experiences in home care.	Canada	Older (55+) lesbian, bisexual, or queer women who had a range conditions requiring home care support (n = 16).
Grigorovich, A. (2015a)	**Qualitative case study design:** semi-structured interviews explored disclosure of sexuality and overall care experiences.	Canada	Older (55+) lesbian, bisexual, or queer women who had a range conditions requiring home care support (n = 16).

(Contd.)

AUTHORS/ DATE	STUDY DESIGN/MEASURES	COUNTRY	SAMPLE
Grigorovich, A. (2016)	**Qualitative case study design:** semi-structured interviews explored "quality home care".	Canada	Older (55+) lesbian, bisexual, or queer women who had a range conditions requiring home care support. (n = 16)
Hoekstra-Pijpers, R. (2020)	**Mixed-methods study:** survey and follow-up interviews with subset of participants investigated experiences with caregivers.	Netherlands	Survey participants were majority gay or lesbian, ages 65 and older, 74% were currently receiving monthly care services (n = 115). Interview participants all used care services on a weekly basis (n = 10).
Hong, H. (2024)	**Qualitative, exploratory study:** semi-structured interviews explored long-term care services amongst LGBTQ+ individuals.	Taiwan	Gay/bisexual men ages 66–73 (n = 5).
Jihanian, L.J. (2013)	**Qualitative study:** in-depth interviews and focus groups investigated long term care provider responsiveness to LGBT older adults.	USA	LBGT older adults, ages 60–85 (n = 7).
Jurček *et al.* (2020)	**Systematic review:** empirical studies evaluating educational interventions on needs of older LGBT+ adults for health and social care professionals.	USA and Canada	9 studies included, participants were health and social care practitioners and students.
Kneale *et al.* (2021)	**Systematic scoping review:** included studies assessed social care and end-of-life care, discrimination and violence in care settings.	UK	42 studies, majority qualitative, participants were LGBT adults aged 50+.
Löf and Olaison (2020)	**Qualitative study:** semi-structured interviews explored everyday life and aging amongst LGBTQ+ adults.	Sweden	LGBTQ+ adults aged 65–80 (n = 15).
May and Christ (2023)	**Integrative review:** included original research on health care workers' relationship to the LGBTQ+ older adult population.	Various	10 studies included, participants were registered nurses, social workers, and home health aides.
May, JT & Rainbow, JG (2023)	**Qualitative study:** semi-structured interviews explored the training direct care workers (DCWs) received and experiences of caring for LGBT people.	USA	DCWs currently working in LTC, assisted living facility or home health agency in the USA (n = 11).
McMillan *et al.* (2025)	**Cross-sectional, online survey:** explored support services, perceived barriers and enablers to continuing care.	Canada	People 50 and older who were receiving HIV care at a clinic (n = 316), 52% identified as gay.
McMullen-Roach *et al.* (2025)	**Qualitative systematic review and meta-synthesis:** analysed views and experiences of long-term care systems and services.	Various	Qualitative studies (n = 55) from 11 countries, included over 3,000 LGBTI+ older adults aged 50–92.
Rataj *et al.* (2024)	**Survey study:** a pre and post film survey evaluated change in knowledge, attitudes, and anticipated behaviours of providers.	USA	Participants (n = 108) were healthcare providers, social care providers, small number of home care providers (about 1%).
Sharek *et al.* (2015)	**Mixed methods study:** survey and semi-structured interviews explored perceptions and experiences of long-term or residential care.	Ireland	Survey participants (n = 144) and interview participants (n = 36) were LGBT individuals between the ages of 55 and 69.
Smith & Wright (2021)	**Systematic review:** peer-reviewed studies of any design explored perceptions and experiences of home care.	Various	Studies (n = 7) included LGBT people from 39–86 years.
Stein *et al.* (2010)	**Qualitative, exploratory study:** focus groups explored feelings of safety and acceptance in care, attitudes toward care.	USA	Two participant groups: one group of lesbian and gay elders who live at home, ages 60 to 84; second group was gay men living in a long-term care facility, ages 65 to 75.
Waling *et al.* (2019)	**Qualitative study:** semi-structured interviews. explored perceptions of aged care.	Australia	33 participants (14 gay men, 19 lesbian women) aged 60+. Only 4 out of 33 were using home care services.
Walker *et al.* (2023)	**Multiple method analysis:** survey data and open-ended responses assessed fears/ concerns about care needs when aging.	United States and Canada	Transgender people (n = 829) ages 18–70 years (20% of participants were > 60).
Wang *et al.* (2024)	**Qualitative descriptive study:** semi-structured interviews explored healthcare needs and training.	Taiwan	Care providers and staff members from LGBT organisations (n = 25).
Williams *et al.* (2022)	**Qualitative study:** semi-structured interviews. explored health and social service experiences.	USA	LGBT+ people ages 60 and over (n = 11).
Willis *et al.* (2021)	**Qualitative study:** two-part interviews. explored experiences/expectations of health and social care services.	UK	Participants who identified as trans/gender nonconforming ages 50 to 74 years (n = 22).

Table 3 Overview of included studies.

(Bjarnadottir *et al.*, 2019; Daley and MacDonnell, 2015; Dune *et al.*, 2020; Jurček *et al.*, 2020; May and Christ, 2023; May and Rainbow, 2023; Rataj, Porter and Dugan, 2024; Wang, Miao and Wang, 2024) and four documents considered both perspectives (Age UK, 2021; Benbow and Kingston, 2022; Caceres *et al.*, 2020; Duffy *et al.*, 2025). Of the documents including workforce perspectives, only two documents examined the home care workforce in isolation (Daley and MacDonnell, 2015; Bjarnadottir *et al.*, 2019) (as opposed to other articles that looked at home care workers as a small part of a larger participant group consisting of the wider long-term care workforce). Most studies originated from North America (N = 24), followed by the UK (N = 6). Included documents were published between 2011 and 2025.

Findings will be organised by perspective. First, we will discuss findings regarding the workforce perspective on their preparedness and practice needs. Then we will consider evidence from the perspective of older LGBTQ+ people. Finally, we draw out similarities and differences between the two perspectives.

QUALITY OF EVIDENCE

We included evidence regardless of quality because of the scarcity of research on older LGBTQ+ people and care (Almack and King, 2019; Westwood *et al.*, 2019), and we therefore believed it important to consider all available evidence. Appendix 4 provides an overview of the quality of the included academic papers using the QuADS tool (Harrison *et al.*, 2021). Overall, the quality of the included papers was relatively high, with a mean score of 29. Scores ranged from 16 to 37, indicating considerable variability. Domains where most studies demonstrated quality included 'clear description of research aims' and 'clear description of research setting and target population'. Domains where quality was most often lacking were 'evidence of stakeholder consideration' and 'critical discussion of strengths and limitations'. The quality of the included grey literature was considered using the AACODS tool (Tyndall, 2008); an overview can be found in Appendix 5. The grey evidence was published by reputable organisations (strong in the Authority domain), but some resources lacked information on methodology and data sources (the Accuracy domain). The quality of the evidence was considered in the overall assessment of the confidence in the findings, using the GRADE CERQual (Lewin *et al.*, 2018); see below.

HOME CARE WORKFORCE PERSPECTIVE

Evidence on preparedness

Across included studies, workforce *preparedness* to support older LGBTQ+ people was commonly characterised as limited, including gaps in knowledge, confidence and inclusive practice. Workforce-focused evidence indicated that the majority of staff in long-term care, including those in home care settings, reported not feeling prepared to support LGBTQ+ older adults (Benbow and Kingston, 2022; Bjarnadottir *et al.*, 2019; Daley and MacDonnell, 2015; Duffy *et al.* 2025; May and Christ, 2023; May and Rainbow, 2023; Rataj, Porter and Dugan, 2024; Wang, Miao and Wang, 2024). For example, a study focused on the care for older trans people highlighted how care workers expressed that they 'hadn't a clue' how to address trans clients' needs sensitively, and therefore the onus was on trans people to educate care workers about their identities and needs (Benbow and Kingston, 2022). A handful of intervention studies further confirmed low levels of preparedness; baseline knowledge of LGBTQ+ issues was low in home care settings, sometimes lower than in hospital and educational contexts (Rataj, Porter and Dugan, 2024; Jurček *et al.*, 2020). Workforce comfort and confidence were described as higher among providers who had previous LGBTQ+ training or personal familiarity with LGBTQ+ people, reinforcing the role of targeted competence-building in supporting inclusive care delivery (Caceres *et al.*, 2020).

One area in which a lack of preparedness was clearly demonstrated was the *perceptions and attitudes* of the workforce about older LGBTQ+ people receiving care. For example, one study suggested care workers perceived older LGBTQ+ adults as either receiving better care (due to being a 'novelty') or worse care (due to negative attitudes) (May and Rainbow, 2023). Contrasting this finding, other studies found that most care workers did not see sexual orientation and gender identity as relevant to care needs and believed a 'treat everyone the same' approach was the best policy (Bjarnadottir *et al.*, 2019; Caceres *et al.*, 2020; May and Christ, 2023; Rataj, Porter and Dugan, 2024). Care worker attitudes also seemed influenced by existing stigma, particularly around HIV. One study provided evidence that some providers appeared reluctant to send carers to older adults living with HIV (Wang, Miao and Wang, 2024).

Although several studies reported home care-relevant findings, much of the evidence was indirect, with home care frequently included as a subset within broader long-term care or mixed health and social care contexts (Caceres *et al.*, 2020; Dune *et al.*, 2020; Rataj, Porter and Dugan, 2024).

Evidence on practice needs

Throughout the evidence, *practice needs* were consistently described as multi-level, encompassing training, practical guidance, service design features, and system-level safeguards. Training was repeatedly highlighted as a practice improvement priority, including the need for home-care-specific LGBTQ+ education and cultural competency content (Benbow and Kingston, 2022; Bjarnadottir *et al.*, 2019; Caceres *et al.*, 2020; Daley and MacDonnell, 2015; Duffy *et al.*, 2025; Jurček *et al.*, 2020; May and Christ, 2023; May

and Rainbow, 2023; Rataj, Porter and Dugan, 2024; Wang, Miao and Wang, 2024). In addition to general competence-building, home care staff specifically expressed a need for guidance on inclusive terminology, communication, and understanding LGBTQ+-specific health issues (Age UK, 2021; Bjarnadottir *et al.*, 2019; May and Christ, 2023). Another example of a practice need was the need to build care worker confidence to implement knowledge and motivation to ask about sexual orientation and gender identity in order to sustainably change their care practice (Bjarnadottir *et al.*, 2019).

Existing evidence on *training effectiveness* in home care to address practice needs was sparse; only two studies provided evidence on potential interventions to improve workforce preparedness (Jurček *et al.*, 2020; Rataj, Porter and Dugan, 2024). Using a pre-post survey design to test the training effectiveness of a documentary about the lives of six older LGBTQ+ people, Rataj and colleagues (2024) found significant improvements in preparedness, suggesting that exposure to lived experience stories might be an important way to improve preparedness. In their review of LGBTQ+ competence training for the long-term care workforce, Jurček *et al.* (2020) found some evidence to suggest that improvements were smaller among home care staff compared to the wide long-term care workforce, suggesting that the home care workforce may have specific educational needs.

Only one study considered potential *barriers* to accessing training to address practice needs. May and Rainbow (2023) suggested that suboptimal salary conditions and care worker burnout may affect access to training in the home care workforce specifically, limiting their ability to address underpreparedness.

LGBTQ+ PERSPECTIVES

Evidence on preparedness

Included research consistently suggested that older LGBTQ+ people perceive home care staff to be *underprepared* to provide affirmative support. This was evidenced by many studies, including older LGBTQ+ people with actual home care experience reporting instances of homophobia, biphobia, and transphobia, as well as experiences of poor care because of LGBTQ+ status (Age UK, 2021; Butler, 2017; Butler, 2018; Duffy *et al.*, 2024; Duffy *et al.*, 2025; EHRC, 2011; Genke, 2014; Grigorovich, 2015a; Grigorovich, 2015b; Grigorovich, 2016; Hoekstra-Pijpers, 2020; Kneale *et al.*, 2021; Sharek *et al.*, 2015; Smith and Wright, 2021). For example, one study described how a care worker refused to wash a lesbian participant's clothes because the worker thought they belonged to a man (Grigorovich, 2015a). Another study described care worker religiosity impacting the quality of care negatively (Butler, 2018). Experiences of partner misrecognition and heteronormative assumptions (e.g., referring to same-sex partners as 'friends' or 'roommates') were also reported, contributing to feelings of being 'othered' in one's private space (Kneale *et al.*, 2021).

Identity concealment and service avoidance were reported as important *consequences* of staff unpreparedness. For example, older LGBT people described how they removed signs of their sexual orientation and/or gender identity from their homes to prevent negative reactions (Benbow and Kingston, 2022; Caceres *et al.*, 2020; Duffy *et al.*, 2024; EHRC, 2011; Genke, 2014; Kneale *et al.*, 2021; McMullen-Roach *et al.*, 2025; Smith and Wright, 2021). This perceived need to hide one's LGBTQ+ identity was an important reason to delay seeking or completely avoid home care (Genke, 2014; Jihanian, 2013). One older gay man stated that he refused to receive home care due to a feeling of 'being held prisoner in one's own home by once again having to pass as straight' (Genke, 2014). Experiences of homophobia impacted LGBTQ+ adults' sense of safety and diminished their confidence that home care workers would provide affirmative services (Duffy *et al.*, 2025; EHRC, 2011; Grigorovich, 2015a). Conversely, one study highlighted how positive connections with home care workers can reduce isolation and promote well-being (Butler, 2018).

In addition to actual experiences of home care, several studies explored participants' feelings and expectations about *anticipated home care experiences* (AARP New York, 2021; Dunkle, 2018; Furlotte *et al.*, 2016; Löf and Olaison, 2020; Sharek *et al.*, 2015; Stein *et al.*, 2010; Waling *et al.*, 2019; Walker *et al.*, 2023; Williams *et al.*, 2022; Willis *et al.*, 2021) and reported similar findings of (expected) unpreparedness. Anticipated concerns were centred around disclosure (Löf and Olaison, 2020; Stein *et al.*, 2010; Williams *et al.*, 2022; Walker *et al.*, 2023), and older LGBTQ+ people feared that they would have to 'straighten up the house' to avoid homophobia (Dunkle, 2018). Trans and gender-diverse older adults were particularly concerned about discrimination and personal care situations where their bodies or gender history might be visible (Benbow and Kingston, 2022; Walker *et al.*, 2023) and expected that home care workers would not be prepared to support needs around hormone therapy, surgical recovery, or gender presentation changes (Willis *et al.*, 2021). LGBTQ+ people worried that their same-sex relationships would not be recognised or respected by carers (Sharek *et al.*, 2015) and felt that being treated the same as heterosexual couples was not acceptable; they needed home care staff to be explicitly inclusive and affirming (Furlotte *et al.*, 2016).

Evidence on practice needs

In line with evidence from workforce-focused studies, older LGBTQ+ people expressed the *need for ongoing training* on LGBTQ+ health and identities to address the unpreparedness of the home care workforce (AARP New

York, 2021; Boggs *et al.*, 2017; Caceres *et al.*, 2020; Duffy *et al.*, 2024; Genke, 2014; Grigorovich, 2015b; Grigorovich, 2016; Hoekstra-Pijpers, 2020; Hong, 2024; Jihanian, 2013; McMillan *et al.*, 2025; McMullen-Roach *et al.*, 2025; Smith and Wright, 2021). Evidence underscored the importance of any training, including guidance on using neutral and inclusive language when addressing people receiving care and sensitive enquiry about relationships and family structures to support inclusive engagement and assessment (Arthur, 2015; Hoekstra-Pijpers, 2020). For example, trans participants described feeling more supported when care workers used correct pronouns and preferred names, even when not reflected in formal records (Benbow and Kingston, 2022). HIV awareness and support were found to be another essential element for training courses (McMillan *et al.*, 2025).

Several studies also underscored the importance of *service-level signals* of inclusion and explicit non-discrimination, which may support trust and access. Older LGBTQ+ people reported valuing visible markers of inclusivity (e.g., statements and symbols) that communicate acceptance and safety and reassurance that staff are trained, as well as options to receive care from LGBTQ+-affirming or trained providers (Smith and Wright, 2021; Duffy *et al.* 2024). Similarly, research emphasised the importance of clear organisational policies, such as the option to include sexuality and gender identity information on care records to avoid repeated 'coming out' experiences (Caceres *et al.*, 2020; Hoekstra-Pijpers, 2020; Smith and Wright, 2021) and policies on improved continuity of care.

Home care was consistently presented as a distinctive context requiring particular attention to privacy, safety and *safeguarding* due to care being provided unsupervised in the person's own home. Safeguarding and reporting mechanisms were identified as important to implement to support safety and address concerns, particularly where service users feel vulnerable receiving care alone in their homes (McMullen-Roach *et al.* 2025; AARP New York, 2021).

High staff turnover was perceived as a system-level *barrier* to developing supportive relationships with carers and led to continuous uncertainty about whether a carer would be safe and supportive.

COMPARING PERSPECTIVES

Findings from the perspectives of the workforce and older LGBTQ+ people suggest that both groups recognise limited preparedness in the workforce. Staff working in home care indicate feeling unprepared (Benbow and Kingston, 2022; Bjarnadottir *et al.* 2019; Daley and MacDonnell, 2015; Duffy *et al.* 2025; May and Christ, 2023; May and Rainbow, 2023; Rataj, Porter and Dugan, 2024; Wang, Miao and Wang, 2024), and older LGBTQ+ people anticipate care workers to be unprepared as well as experience unpreparedness in the actual care they receive (Age UK, 2021; Butler, 2017; Butler, 2018; Duffy *et al.* 2024; Duffy *et al.*, 2025; HRC, 2011; Genke, 2014; Grigorovich, 2015a; Grigorovich, 2015b; Grigorovich, 2016; Hoekstra-Pijpers, 2020; Kneale *et al.*, 2021; Sharek *et al.*, 2015; Smith and Wright, 2021). Specific areas of underpreparedness were highlighted by both groups, including the personal care and support needs of trans and gender-diverse older adults and HIV awareness and support (Benbow and Kingston, 2022; McMillan *et al.*, 2025; Walker *et al.*, 2023; Wang, Miao and Wang, 2024; Willis *et al.*, 2021). We also found similar views on practice needs, most notably a strong need for consistent LGBTQ+ competency training and practical guidance (AARP New York, 2021; Benbow and Kingston, 2022; Bjarnadottir *et al.*, 2019; Boggs *et al.*, 2017; Caceres *et al.*, 2020; Daley and MacDonnell, 2015; Duffy *et al.*, 2024; Duffy *et al.*, 2025; Genke, 2014; Grigorovich, 2015b; Grigorovich, 2016; Hoekstra-Pijpers, 2020; Hong, 2024; Jihanian, 2013; Jurček *et al.*, 2020; May and Christ, 2023; May and Rainbow, 2023; McMillan *et al.*, 2025; McMullen-Roach *et al.* 2025; Rataj, Porter and Dugan, 2024; Smith and Wright, 2021; Wang, Miao and Wang, 2024).

There were, however, also some differences in the assessment of workforce preparedness. Several studies presented evidence that the perceptions and attitudes of many care staff include a 'treating everyone the same' approach. Research including older LGBTQ+ people highlights that this erases their unique experiences and needs rather than affirming their identity (Bjarnadottir *et al.*, 2019; Caceres *et al.*, 2020; Furlotte *et al.*, 2016; May and Christ, 2023; Rataj, Porter and Dugan, 2024; Sharek *et al.*, 2015). The few studies that included data from both perspectives confirm intersecting findings from both perspectives and highlight the gap between the unmet needs of older LGBTQ+ adults and the unpreparedness of the home care workforce (Age UK, 2021; Benbow and Kingston, 2022; Caceres *et al.*, 2020; Duffy *et al.*, 2025). Overall, this review mostly identified overlap in how workforce and older LGBTQ+ adults assess workforce preparedness. This suggests a fruitful starting point to address the evident gaps in workers' knowledge, skills, and confidence.

CONFIDENCE IN REVIEW FINDINGS

Following the GRADE CERQual assessment, confidence in the findings for our four outcomes was assessed as moderate (see Table 4 for the Summary Table). The full assessment and evidence profile, including explanations, can be found in Appendix 6. Confidence was deemed moderate for all findings, as we only identified minor concerns regarding the adequacy and relevance of the findings and some moderate concerns with respect to methodological limitations. GRADE CERQual guidelines indicate that moderate confidence means it is likely that the review finding is a reasonable representation of the phenomenon of interest.

REVIEW FINDING RELATING TO EACH OUTCOME	QUALITY ASSESSMENT OF CONFIDENCE IN THE EVIDENCE	EXPLANATION OF THE QUALITY ASSESSMENT	STUDIES CONTRIBUTING TO THE REVIEW FINDING
Preparedness – workforce perspective. The home care workforce assesses their skills, knowledge, and confidence to support older LGBTQ+ people as very limited, although many believe 'treating everyone the same' is a good approach to support.	Moderate confidence	Minor concerns in adequacy relating to the limited richness of data collected from home care workers specifically. Moderate concerns regarding the relevance of the data because of the limited number of studies exclusively examining home care (majority of studies examined the wider long-term care workforce).	Benbow & Kingston 2022; Bjarnadottir *et al.* 2019; Caceres *et al.*, 2020; Daley & MacDonnell 2015; Duffy *et al.* 2025; Dune *et al.* 2020; Jurček *et al.* 2020; May & Christ 2023; May & Rainbow 2023; Rataj *et al.* 2024; Wang *et al.* 2024
Preparedness – LGBTQ+ perspective. Older LGBTQ+ people deem the home care workforce unprepared to provide affirmative support based on experiences of discrimination, lack of inclusive language, and poor care.	Moderate confidence	Minor concerns about methodological limitations, as some included studies lack details on methodology used. Minor concerns regarding relevance as some studies examined long-term care experience more broadly, not home care specifically.	(AARP New York, 2021; Age UK, 2021; Benbow & Kingston, 2022; Butler, 2017; Butler, 2018; Caceres *et al.*, 2020; Duffy *et al.* 2024; Duffy *et al.*, 2025; Dunkle, 2018; EHRC, 2011; Furlotte *et al.*, 2016; Genke, 2014; Grigorovich, 2015b; Grigorovich, 2015a; Grigorovich, 2016; Hoekstra-Pijpers, 2020; Jihanian, 2013; Kneale *et al.*, 2021; Lof & Olaison, 2020; McMullen-Roach *et al.*, 2025; Sharek *et al.*, 2015; Smith & Wright 2021); Stein *et al.*, 2010; Waling *et al.*, 2019; Walker *et al.*, 2023; Williams *et al.*, 2022; Willis *et al.*, 2021
Practice needs – workforce perspective. The home care workforce recognises their practice needs are pervasive, encompassing the need for training, practical guidance, and dedicated policies.	Moderate confidence	Minor concerns regarding adequacy relating to the limited richness of data collected from home care workers specifically. Moderate concerns regarding relevance as some studies examined the long-term care workforce more broadly, and not the home care workforce specifically.	Age UK, 2021; Benbow & Kingston, 2022; Bjarnadottir *et al.*, 2019; Caceres *et al.*, 2020; Daley & MacDonnell, 2015; Duffy *et al.*, 2025; Jurček *et al.*, 2020; May & Christ, 2023; May & Rainbow, 2023; Rataj *et al.* 2024; Wang *et al.* 2024).
Practice needs – LGBTQ+ perspective. Older LGBTQ+ people highlight the need for training and guidance for the home care workforce, as well as improved service design and policies.	Moderate confidence	Minor concerns regarding methodological limitations as some included studies lack details on methodology used. Minor concerns regarding relevance as some studies examined long-term care experience more broadly, not home care specifically.	AARP New York, 2021; Arthur, 2015; Benbow & Kingston 2022; Boggs *et al.*, 2017; Caceres *et al.*, 2020; Duffy *et al.*, 2024; Genke, 2014; Grigorovich, 2015; Grigorovich, 2016; Hoekstra-Pijpers, 2020; Hong, 2024; Jihanian, 2013; McMillan *et al.*, 2025; McMullen-Roach *et al.* 2025; Smith & Wright, 2021

Table 4 GRADE summary table.

DISCUSSION

This rapid review examined what is known about the preparedness and practice needs of the home care workforce to support older LGBTQ+ people. We were particularly interested in exploring preparedness from the perspective of the home care workforce, as to our knowledge this had not been examined before, but we also included evidence from the perspective of older LGBTQ+ people and compared perspectives. We identified 39 documents that met the inclusion criteria. Across perspectives, we consistently found evidence of workforce underpreparedness to support older LGBTQ+ people, illustrated by incidences of discrimination, a limited understanding of LGBTQ+-specific care needs, heteronormative and cis-normative attitudes (experienced and anticipated), and low workforce confidence. With respect to practice needs, there were clear requirements for improved training offers, practical guidance, and explicit organisational policies. The identified literature suggested significant agreement between workforce and LGBTQ+ perspectives, although very few studies directly compared perspectives. The identified lack of knowledge and confidence in the home care workforce aligns with studies examining preparedness in other segments of the long-term care and health care workforce (Balik *et al.*, 2020; Kneale *et al.*, 2021; Simpson *et al.*, 2018; Willis *et al.*, 2014; Women and Equalities Committee, 2019). Together, this body of literature highlights the negligence of the experiences and needs of older LGBTQ+ people in care as well as the limited effort and system support to foster the required skills and knowledge in the wider care workforce.

ADDRESSING UNPREPAREDNESS: IMPLICATIONS FOR HOME CARE PRACTICE AND POLICY

There are several points to consider when thinking about addressing the identified underpreparedness. As noted earlier, this review was part of a wider study set in the UK. Some of the considerations described below may not completely apply to other care systems; however, they follow from the review findings, which included international evidence, so they have some international relevance.

Firstly, there are reasons to suggest that the home care workforce may have specific needs with regard to addressing their underpreparedness. For example, there was some evidence indicating that improvements from training interventions were smaller among home care staff compared to the wider long-term care workforce, suggesting a distinct approach to training might be required. This may have implications for those organising training for the home care workforce (e.g. managers, commissioners), as well as for home care workers seeking out training. It might be useful to tailor training to the specific context of home care to ensure effectiveness.

Secondly, the employment conditions of those working in home care and how this affects their ability to improve their LGBTQ+ preparedness should be considered. For example, in the UK, where the research team is based, home care workers are often employed on precarious, zero-hours contracts with only client contact time paid for and little opportunity for progression. This leaves other work-related activities such as training and development to be completed in unpaid time, which as a result are often neglected (Homecare Voices, 2023; Rubery *et al.*, 2015). It could be questioned to what extent individual home care workers can be expected to improve their preparedness or change their practice if the wider system limits their capability and opportunity to do so. As Bennett, Honeyman and Bottery (2018) highlight: '*If you don't give them the right skills and training and remunerate them enough, they're not going to do a very good job*'. This is a serious contextual concern that might be useful to consider by policymakers involved in addressing workforce preparedness in relation to equality, diversity and inclusion. Compensated time for training might be beneficial for practice improvement.

Thirdly, it could be argued that improving preparedness to support older LGBTQ+ people is not merely a voluntary, individual decision, but rather a legal obligation to fulfil. For example, local authorities and care providers in England and Wales have the legal, actionable obligation to promote dignity and protect care recipients from abuse under the Care Act (Department of Health, 2014) and Social Services and Well-being Act (National Assembly for Wales, 2014). Furthermore, care recipients have the right to be treated equitably in line with the Human Rights Act (UK Government, 1998) and the Equality Act (UK Government, 2010). This implies that providers and commissioners have a legal duty to ensure that home care provision is LGBTQ+ inclusive.

Lastly, there is the consideration of the unique context of home care for older LGBTQ+ people, for many of whom the home is one of the few 'sanctuaries' where they feel truly safe to be themselves and express their identities and orientation. This sense of safety can be disturbed by carers whose attitudes are unknown coming into someone's home and personal space (Waling *et al.*, 2019; Wang, Miao and Wang, 2024; Willis *et al.*, 2018). Hafford-Letchfield and Cocker (2024) refer to this as 'spatial inequalities', which are particularly pertinent for older LGBTQ+ people who often experience social marginalisation outside of their home space. Home care workers require specific knowledge to navigate this sensitively and ensure that the home remains a safe and affirmative space. Those involved in organising workforce training are advised to include lived experience perspectives so that care workers have the knowledge and insights to understand and achieve this.

Taken together, it could be argued that system-level changes are required to allow home care workers to improve their preparedness in relation to LGBTQ+ inclusive care. An overreliance on individual responsibility to change behaviour may overlook the system-level barriers that considerably limit home care workers' ability to improve their practice.

SUGGESTIONS FOR IMPROVED WORKFORCE TRAINING

Most studies included in this review called for increased access to good-quality training. Without consideration of what good quality training comprises and how we can ensure it is sustainably effective in context, this may be perceived as a meaningless statement at risk of becoming a tick-box exercise. Several developments of training and learning materials for the UK health and social care sector have been initiated (see, for example, Hunt *et al.*, 2019; Keemink *et al.*, 2025; Skills for Care, 2023; The Diversity Trust, 2019), but robust, long-term effectiveness and a unified system-wide approach to implementation have yet to be achieved. Bids for training have the underlying unfounded assumption that knowledge transfer is sufficient to achieve behaviour change, and robust study designs and outcome measurement are lacking (Hunt *et al.*, 2019). An international review on health and care training on LGBTQ+ inclusion echoes similar issues (Jurček *et al.*, 2020). Similarly, there is limited evidence for the effectiveness of diversity training more generally and very few robust evaluations of training interventions internationally (Devine and Ash, 2022).

Following this, there are several suggestions that might be helpful for training development and evaluation. With respect to training development, it might be useful to understand what works with respect to successful behaviour change in the workforce. As

highlighted above, system-level barriers to behaviour change should not be overlooked. We recommend training is informed by robust models such as the COM-B model (Michie, Van Stralen and West, 2011) that account for both individual- and system-level factors influencing behaviour change. Training might also be guided by existing evidence on effective elements of education such as exposure to life stories and personal interaction with the LGBTQ+ population (Hunt *et al.*, 2019; Higgins *et al.*, 2019). Additionally, a 'calling-in' approach might be helpful in which the workforce is supported to share and confront their prejudices, rather than a 'calling-out' approach that might foster shame and distance (Hafford-Letchfield *et al.*, 2021; Gorman, 2025). Future investigations to measure the effectiveness of such training programmes might benefit from robust study designs and careful consideration of how effectiveness is measured.

Finally, we argue for the consideration of the wider implementation context in both training development, evaluation, and roll-out. Upholding equality standards is not solely the responsibility of an individual care worker but should be supported by the wider context, including commissioning and regulating bodies. Without meaningful and system-wide integration of training expectations within nationally set requirements that hold providers accountable, widespread and sustainable change is unlikely to materialise.

LIMITATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH

Whilst this review provides valuable novel insights, it is important to acknowledge the limitations pertaining to the method and the identified data. First, employing a rapid review method may increase the risk of errors in the review process (Moons, Goossens, and Thompson, 2021; Schünemann and Moja, 2015). These risks have been mitigated by registration and publication of the review protocol (Keemink *et al.*, 2026) and by following established review guidelines (Garritty *et al.*, 2024; Page *et al.*, 2021; Stevens *et al.*, 2025). Nevertheless, the number of databases searched is limited within a rapid review, which may have led to missed publications. Second, the limited amount of quantitative data available, originating from studies using heterogeneous analysis approaches, made the use of the recommended SWiM guidance (Campbell *et al.*, 2020) for synthesis not completely suitable. The guidance is more suited to intervention trial research, whereas the quantitative data included here was predominantly descriptive. We have, however, applied this guidance as best as possible and reported transparently. Another limitation concerns the stakeholder involvement in the review. Whilst several older LGBTQ+ people were involved in the design and conduct of the review, we did not involve home care workers directly. This perspective would have been a helpful addition to the interpretation of findings. Lastly, systematic application of theoretical models to situate the findings could have strengthened this study. We make reference to useful models, but these were not systematically applied. Future reviews may be strengthened by addressing these limitations.

There were also limitations to the included evidence. Only two studies examining the workforce perspective exclusively involved home care participants (Daley and MacDonnell, 2015; Bjarnadottir *et al.*, 2019). In all other workforce-focused evidence, home care participants were a small subset of a larger long-term care sample, and findings specific to home care were challenging to isolate. This seems reflective of the wider issue of underrepresentation of home care participants in research, particularly in the UK, which is slowly being addressed (Beresford and O'Rourke, 2024). Additionally, most included studies exclusively focused on individual markers of preparedness and did not consider system-level factors that might have a considerable impact. It is recommended that future research examine the home care workforce in isolation and consider system-level barriers to preparedness to substantiate conclusions about their preparedness and practice needs. Further, samples of older LGBTQ+ participants often lacked diversity in terms of ethnicity, gender identity, and geographic location. There was little consideration for the unique experiences of different sexual orientations and gender identities within the LGBTQ+ population, specifically bisexual and trans and gender-diverse people. This complicates the generalisability and representativeness of the findings and calls for more diverse and representative sampling in future studies. Another limitation pertains to the origin of the evidence. Most studies were conducted in North America or the UK, and evidence is highly limited from other countries. It is recommended that future studies examine this subject in other countries to better understand home care workforce preparedness globally. Relatedly, caution should be taken when applying findings to other countries with different care systems. As noted above, organisation of the care system might affect preparedness and the way preparedness is addressed.

CONCLUSION

In conclusion, this rapid review presented evidence from both the workforce perspective and the perspective of older LGBTQ+ people that allows us to conclude with moderate confidence that the home care workforce is underprepared to support older LGBTQ+ people. We highlighted what this means for home care policy and practice and provided considerations for future research and education which may help ensure that the home care workforce feels prepared to provide LGBTQ+-affirmative care.

DATA ACCESSIBILITY STATEMENT

No new data were collected or analysed in this study. All studies included in the review can be found in Table 3 and Appendix 3.

NOTE

1 Butler, SS (2018) used the same data set as Butler, SS (2017) but did not include the data from home care workers.

ADDITIONAL FILE

The additional file for this article can be found as follows:

- **Appendices.** Appendix 1–6. DOI: https://doi.org/10.31389/jltc.598.s1

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COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR CONTRIBUTIONS

Jolie R. Keemink: Conceptualisation, methodology, investigation, formal analysis, writing—original draft, visualisation, supervision, project administration, and funding acquisition. Shannon O'Rourke: Investigation, formal analysis, writing—original draft, writing—review and editing and visualisation. Willem J. Stander: Conceptualisation, methodology, investigation, formal analysis, writing—review and editing, and funding acquisition. Benjamin Thomas: Conceptualisation, methodology, writing—review and editing, and funding acquisition. Paul Willis: Conceptualisation, methodology, writing—review and editing, supervision, and funding acquisition.

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