


ORIGINAL ARTICLE

Experiences of residents, family members and staff in residential care settings for older people during COVID-19: A mixed methods study

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Abstract

Aim: The aim of this study was to explore the COVID-19 pandemic as it was experienced by people on the front line in residential care settings for older people in the Republic of Ireland (ROI).

Background: The COVID-19 pandemic had a disproportionate effect in residential care settings for older people in Ireland.

Methods: A two-phased mixed methods study was conducted, consisting of an online survey administered shortly after the first wave of the virus to staff, residents and family members and one-to-one interviews with family members shortly after wave 2 of the virus.

Results: Isolation, loss of connectedness as well as a reduction in the level/quality of care provision led to significant adverse impacts for both residents and their families. Staff reported high levels of stress, trauma and burnout. Family input to care was suspended, with adverse consequences.

Conclusion: The pandemic had an extremely adverse impact on residents, family members and staff in care settings for older people.

Implications for Nursing Management: Strategies to ensure that residents' physical, emotional and social needs and staffs' professional and personal needs are appropriately supported during future waves of the pandemic should now be implemented.

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KEYWORDS

COVID-19—Impact and experiences, nursing management, older people, residential care settings

1 | BACKGROUND

On 11 March 2020, the World Health Organization characterized COVID-19 as a pandemic (World Health Organization, 2020). The first case of the virus in the ROI was confirmed on 29 February and the first notification to the Department of Health of a suspected/confirmed outbreak of COVID-19 in a nursing home in Ireland was received on the 13th March (Health Information and Quality Authority (HIQA), 2020). By mid-July the pandemic had had a disproportionate impact on residents in care settings for older people with 56% of all deaths (1748) occurring in this population (Health Protection Surveillance Centre, <https://www.hpsc.ie/>).

In response to the high mortality rates in this population a *Special Committee on Covid-19* was established by the Dáil (an arm of government) on 6 May 2020 to consider and take evidence on the State's response to Covid-19. Their report pointed to a series of systemic weaknesses and proposed a series of recommended actions including the need for a public inquiry and a review of the impact of privatization of Ireland's nursing homes (Houses of the Oireachtas 2020).

A *COVID-19 Nursing Home Expert Panel* was also established by the Minister for Health in May 2020. The expert panel consulted with a wide range of stakeholders across the sector and published their report in August 2020 (Kelleher & Twomey, 2020). The report highlighted multiple areas for improvement including - public health measures, infection prevention and control, outbreak management, admissions protocols, management, visiting, communication, palliative care, community support, staffing and workforce, education, GP roles, regulations and statutory care supports for older people.

In July, 2020 the *Health Information and Quality Authority* (HIQA), an independent statutory authority published their report on nursing homes in Ireland (HIQA, 2020) detailing the impact of the COVID-19 pandemic on nursing homes and highlighted the need for reform in the care provision offered to older people in Ireland including improved clinical oversight, single occupancy rooms, supplementary or complementary models of care, better governance, staffing numbers and skill mix as well as enhanced infection control and prevention strategies and a focus on person-centred care with a human rights approach.

A recent report (Phelan et al., 2022) which explored the experiences of Directors of Nursing of Residential Care settings during early stages of the pandemic showed the challenges for Directors of Nursing in balancing competing demands, values, strategies and regulatory frameworks in order to provide effective and safe care for vulnerable older people. The research also highlights the physical and psychological demands that were placed on nurses at this time

and the lack of expert gerontological nursing expertise in the system.

In this study we set out to explore the experiences of residents and family members who were at the frontline of COVID-19 in the residential care sector in Ireland when the pandemic occurred.

2 | METHODS

2.1 | Aim, design and setting

The aim of this study was to explore the pandemic as it was experienced by key stakeholders (staff, residents and family members) at the front line of COVID-19 in order to gain insights about preparedness, impact, supports and training needs and priorities which could be applied in the event of future waves of COVID-19 or new epidemics or pandemics.

We used a mixed methods approach, in two phases. An anonymous survey was administered to staff who had been working in residential care settings during the pandemic as outlined below. We opted for an anonymous survey for staff so that they could freely provide answers without fear of being identified. We also sent an anonymous survey to residents and family members with an option to be contacted for a follow up one-to-one interview in case interesting or important issues requiring deeper exploration emerged. Both surveys were administered in the period from June–August 2020.

2.1.1 | Phase 1

An online anonymous survey was developed and disseminated to

1. Owners/managers and staff of residential care settings for older people.
2. Residents and/or their family members.

No existing survey was available to capture the impact of the pandemic so we developed one specifically for the purposes of the study. Slightly different versions of the survey were developed for staff and family members/family carers as some of the questions could only be answered by staff. The staff survey contained 45 questions and took about 35 minutes to complete. The residents and family member survey contained 22 questions and took about 20 min to complete. The online surveys (see supporting information) focused on the key areas of interest to the study including demographics, level of institutional preparedness, extent of disease spread, factors relating to virus spread, impacts on staff and residents,

supports available, level of care during the pandemic, perception of prioritizes for future waves of the virus and level of trust in the facility. These areas of exploration were selected because they were the key areas emerging in the related literature available at the time, from government reports, the Health Service Executive, the National Public Health Emergency Team and the Media at the time. The survey was circulated by URL link via our networks in nursing and health care by email and through social media platforms and was open to respondents in the ROI only. *Nursing Homes Ireland* and *SAGE*, both advocacy agencies for older people, supported the dissemination of the survey to residents and family members.

2.1.2 | Phase 2

As the study team wished to explore further some areas that had emerged in the survey, all family members who completed the survey were invited to take part in a one-to-one qualitative interview. Participants who agreed to take part were invited to provide an email address and phone number at the end of the survey, which was not linked to the data. All survey participants who provided contact details were subsequently contacted and 11 family members consented to be interviewed online by zoom, using a semi-structured topic guide developed specifically for the purpose of the study (see supporting information). Kallio et al.'s (2016) framework was utilized for the development of the semi-structured topic guide in this study and was informed by the literature. The topic guide included open-ended questions concerning the participants' views in relation to how the pandemic was experienced in residential care settings. Opinions relating to the impact on care and implications for future care delivery in this sector were also explored. The qualitative data was collected shortly after the second wave of the virus (November–December 2020).

2.2 | Ethics

Research Ethics Approval was obtained from Dublin City University (reference number DCUREC/2020/158). Consent to take part in the online survey was obtained online. Consent to take part in the qualitative interviews was gathered electronically via signed and returned consent forms. All methods were performed in accordance with the relevant guidelines and regulations.

2.3 | Data analysis

The quantitative data was analysed descriptively (frequencies, means, standard deviations) using Excel Microsoft. The qualitative data was recorded on zoom and transcribed by a transcription company. The data were transferred to NVIVO and analysed by thematic analysis to generate overall themes.

3 | RESULTS

The demographic profile of staff participants are illustrated in Table 1.

The health care facilities who responded were as follows—Health Service Executive (HSE) facilities ($n = 34$, 49%) privately owned facilities ($n = 30$, 43%) and other types of facilities, that is, section 38 and voluntary ($n = 5$, 7%). Geographically most of these facilities were based in Dublin ($n = 47$, 67%) and 13 other counties in the Republic of Ireland were also represented. There are 576 facilities in Ireland (meaning we heard from 1 in 7.5 residential settings).

3.1 | Residents/family members

Twenty-eight family members completed the online survey (15 daughters, 3 sons, 1 husband, 1 wife, 1 sister, 3 nieces, 2 granddaughters and 2 daughter-in-law). Two residents completed the survey. Five of the family members/residents were from a HSE facility, 20 of them were from a privately owned facility and the remainder said other facilities (such as supported housing and voluntary facilities). Fifty-six percent of the respondents said that COVID-19 had infected residents at their facility.

3.2 | Qualitative interviews

Eleven one-to-one semi-structured interviews with family members were conducted remotely during December 2020. Eight females and two males consented to be interviewed regarding their experience of their family members care in residential facilities during the first wave of the pandemic. One participant was interviewed twice by two different researchers regarding her experience of care at both her

TABLE 1 Demographic profile—Staff survey

Profile of staff	Number	Nurse manager	Staff nurse	Student nurse	HCA	Other	Admin
PIC/manager	22						
PIC/owner	5						
Owner/manager	1						
Staff members	49	12	10	2	11	13	1
Total	77						

mothers and her aunt's residential care facilities. There was a mix of HSE and private run residential care facilities reported across the 11 interviews in Dublin and in other parts of the country.

4 | MAIN FINDINGS

This study generated a lot of data so for the purposes of presenting the quantitative and qualitative findings in a logical and succinct manner the main findings emerging from both the staff and residents/family members survey and the one-to-one interviews were integrated (triangulated) and are presented below. Quantitative findings from the staff survey are also presented in Figures 1–6.

4.1 | Being prepared

Being adequately prepared was regarded as essential by the majority of research participants—this emerged from both the quantitative and the qualitative findings. For staff respondents, being adequately prepared meant—good infection prevention and control protocols, sufficient and timely preparation and training, good management and governance structures, isolation and infection control resources, adequate staffing and access to medical expertise and support. The percentages of staff who perceived their service as well prepared (52%) or ill prepared were roughly equal (48%). Among those who identified a lack of preparedness, respondents highlighted—poor management and leadership, not having a pandemic plan/protocols, slow implementation of infection control measures/government guidelines, for example, visitor/staff movement restrictions and Personal Protective Equipment (PPE) training/provision. Fundamental governance issues were also raised, for example; lack of

communication with staff, lack of teamwork, low staff/patient ratios, high staff turnover, high levels of junior/inexperienced/agency staff. The main reasons cited by staff as to why their facility was adequately prepared/not adequately prepared for the pandemic as illustrated in the quantitative survey with staff are captured in Figures 1 and 2 below.

5 | DISEASE SPREAD, MORTALITY AND MORBIDITY

Figure 3 below illustrates the main factors cited by staff in the survey as contributing to virus spread at their facility. Some respondents felt that years of under-investment in state facilities had led to residents sharing bedrooms, poorly ventilated common areas which has both facilitated viral spread. Others felt that the transfer of infected patients from the acute hospital sector and movement of staff across different sites had resulted in increased virus spread. A high proportion of staff and family carers believed that the rate of infection could have been reduced by more effective/diligent infection control measures. Family members felt strongly that the residential care homes had not provided clear guidance regarding COVID-19 infection prevention and control protocols to their staff and that staff were not clear on how to use PPE.

Advanced age and poor physical and mental health was cited as increased risk factors for higher morbidity/mortality among residents. Family members believed that residents who did not have family members to advocate for them were at higher risk during the pandemic.

Inadequate access to medical support and expertise were also cited as reasons contributing to the spread of the virus at the facility. A third of staff surveyed reported that more could have been done to reduce the number of deaths that occurred.

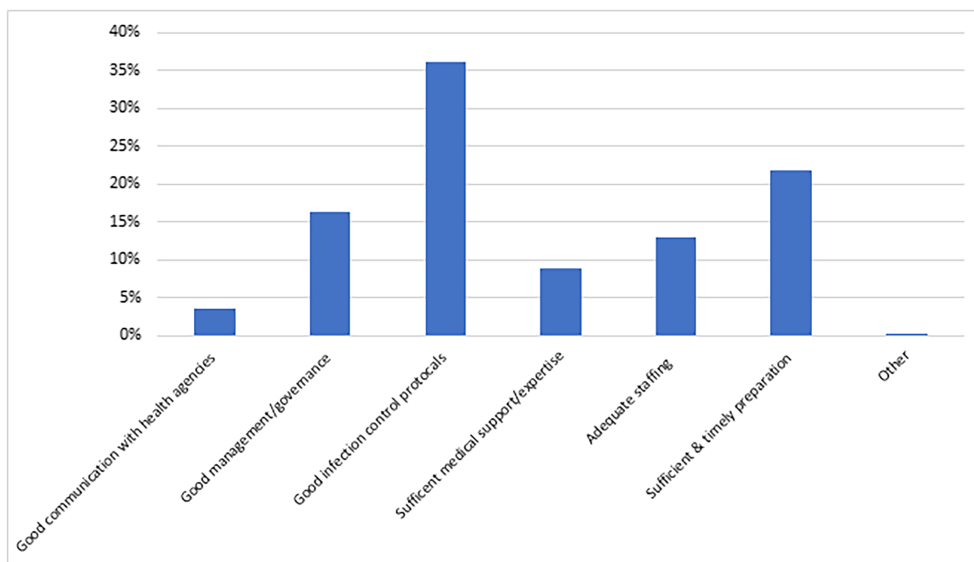


FIGURE 1 The figure illustrates the reasons cited by staff as the reasons why their facility was adequately prepared for the pandemic

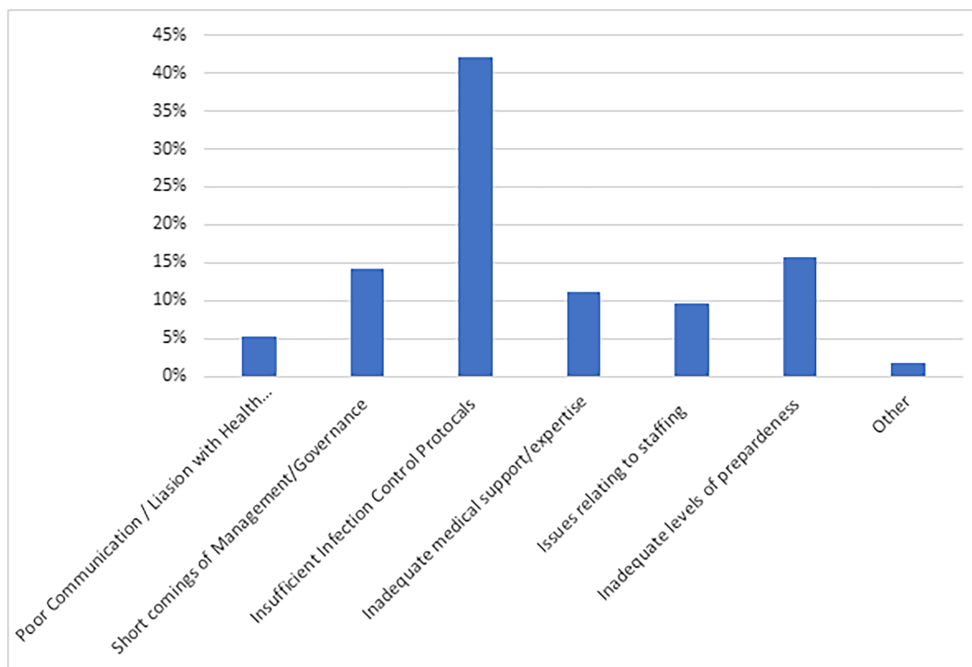


FIGURE 2 The figure illustrates the reasons cited by staff as to why their facility was not adequately prepared for the pandemic

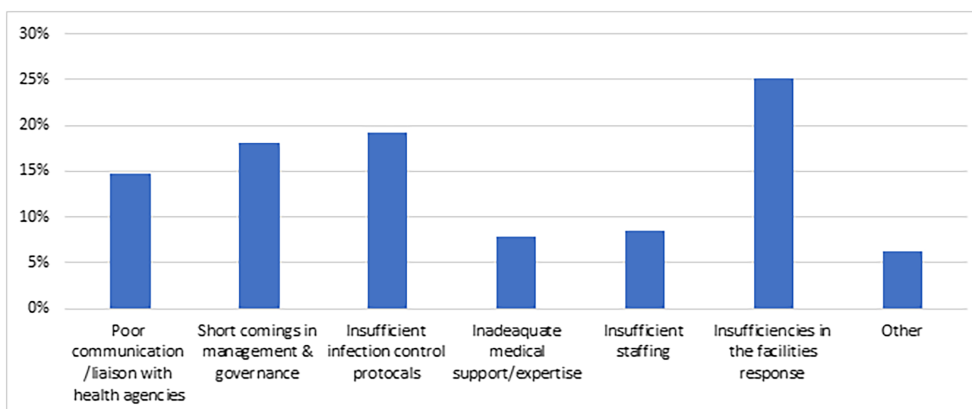


FIGURE 3 The figure illustrates the factors cited by staff as contributing to virus spread at their facility

5.1 | Comparisons between state and private care provision

Staff in private facilities reported higher standards of accommodation (space and single rooms), staff training, infection control practices and governance structures. However, a deficit in medical support and clinical leadership in private care facilities was a limiting factor.

Higher rates of clusters occurred in state facilities compared with privately run facilities, attributed mainly to congregated, unsegregated, poorly ventilated areas, frequent movement of staff and patients through various care units and poor uncoordinated governance in state provided facilities. However, it was evident that residents had better access to medical care, physiotherapy and occupational therapy/psychosocial supports in state run care than in private facilities.

Our findings showed that there was a perception of higher staffing levels in private facilities but this was not evident in our analysis of our questionnaire where it was approximately equal. Twenty-five of the facilities reported that the state had provided them with additional staff and that this was most welcome.

6 | IMPACTS ON RESIDENTS

6.1 | Mental health/social health

Staff reported that at least one third of residents were confined to their own room without company during the first wave of the pandemic. For many residents, psychosocial activities were suspended for wave one of the pandemic. Staff observed many adverse psychosocial

impacts for residents and families, the most significant issue being that they were unable to see their loved ones during the pandemic. This resulted in loneliness and lack/loss of connection. Staff and family members reported that the majority of residents (98%) could connect remotely with their family members during the pandemic using mobile phones/smartphones for video calls, window visits and brief visitations in the garden or other outside areas of the facility. However, this apparent high level of remote connectedness was deemed to be of poor quality and unreliable by many family participants in the qualitative interviews. Family members placed great emphasis on the need to maintain direct contact with residents and felt that staff had prioritized the public health imperative over the psychological and emotional needs of residents and families

‘the whole situation is really worrying, it’s really unsatisfactory, the social isolation, the lack of movement, the lack of activities. I asked again when I was on with the CEO, “Can we pay more money?”’ Participant 5

The interviews with families starkly demonstrated the impact of the visiting restrictions on connectedness with family members; not having the opportunity to see loved ones for long periods of time, grandchildren not being able to hold hands, challenges to maintaining meaningful relationships/intimacy. Speaking through Perspex or glass or using technology was identified as less than ideal, especially when residents were trying to communicate their fears of contracting COVID-19, knowing that other residents had died of the virus; anxiety about loneliness and isolation and fears of dying without their loved ones near. The cognitive and expressive abilities of residents were an important determinant of the success of remote visits and hearing and vision also played a role in this regard. The weather was also a deterrent to connectedness.

6.2 | Physical health

Staff and family members and families reported that the usual care of patients who did not contract COVID-19 was reduced or neglected during the pandemic. Figure 4 illustrates the main adverse impacts on residents as reported in the staff surveys. While there was an acknowledgement that physical decline was to be expected in residents due to their age and pre-existing morbidities, families described an acute decline in their loved one’s physical health which included weight loss, reduced mobility, pressure sores, dehydration, and unkempt appearances, which some found shocking and distressing during the pandemic. One family member commented.

‘I could not believe what I saw. My mum has lost a lot of weight in that month; she was grey, drawn, she had weeping eyes, and her lips were all desiccated, very, very, dry, dehydrated. I was really taken aback. I was thinking, God how did she go downhill this quickly’.

6.3 | Impacts on family members

Family members felt the impact of the pandemic on behalf of residents and themselves. This included fear, distress, anxiety, loneliness, helplessness, frustration and some participants experienced physical challenges such as being outside in all weathers trying to communicate via a window. A strong theme which emerged from the qualitative interviews was the disruption to their customary caregiving role. The majority of families did not perceive themselves to be visitors, but regarded themselves as continuing in their caregiver role in the residential environment.

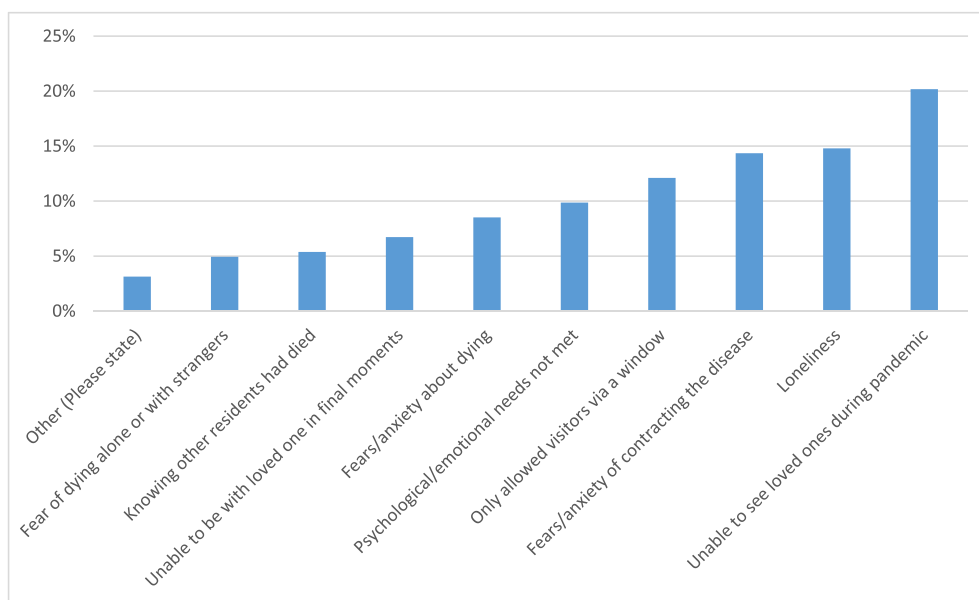


FIGURE 4 The figure illustrates the main adverse impacts on residents as reported in the staff surveys

'We used to feed her. We would go up with the night time food. We would know what we would give her. She could not feed herself that well. You would have to be very patient and stay with her till she finished it. If she was left to eat it by herself, she probably would not do it'. Participant 3

6.4 | Staffing levels

Multiple issues relating to staffing were highlighted, including low staff-to-patient ratios, due to staff shortages arising from self-isolating, illness, redeployment and not showing up for work. One site reported that there were only two healthcare assistant (HCA) staff to 30 residents some days during the pandemic. A family member at interview noted that

'When you do not have enough staff, people get neglected. ...' (Participant 7)

Other staffing issues of concern included high turnovers, too few senior staff, staff who lacked the specific skills required, as well as too many agency staff. Family members highlighted the need for a more stable staffing structure which would ensure familiarity with the facility and the resident's individual needs and wishes. These deficits were of major concern to the majority of family members interviewed.

The lack of medical and ancillary/psychosocial support interventions put additional pressure on staff workloads. However, the state provision of some additional staff during this period was welcomed and staff participants reported that the redeployment of student nurses as HCAs really helped to ease the burden.

Many family participants praised the work of the facility staff who they perceived as committed and working to the best of their abilities to keep residents safe in a confusing and stressful context.

7 | IMPACTS ON STAFF

The most frequently reported adverse impact on staff was the level of stress and burnout experienced, followed by concerns about virus transmission, trauma, fear about death of residents and self. The impacts on staff as captured in the staff survey are illustrated in Figure 5. Many alluded to the personal toll it had taken on them, ranging from information overload, physical and mental exhaustion, supporting their peers and covering for colleagues while off sick, in addition to managing their own fears. Maintaining work life balance was very difficult. The majority of staff had put the needs of residents above their own needs. Many staff expressed their distress at witnessing the impact of the virus on vulnerable people who were traumatized, alone and fearful. Others were angry and distressed about the numbers of care staff who contracted the virus and felt unsupported and that their well-being and safety had not been valued or protected.

7.1 | Trust and responsibility/blame

Most staff perceived that the virus itself was responsible for mortality rates among residents but that their age had made them more vulnerable. Figure 6 below illustrates from the survey data where staff felt responsibility for the deaths at their residential centres lies.

Some expressed anger about what they regarded was the slow governmental response in their sector. Many staff felt that government agencies did not prioritize the health and safety of residents and staff, particularly in wave one and this caused huge anger and distress. Staff placed trust in their own services in which they worked and the majority (89%) said they would trust their facility to provide safe care for residents in the event of future waves.

Family members questioned the role of the relevant government agencies and the priority and pace of the response in this sector.

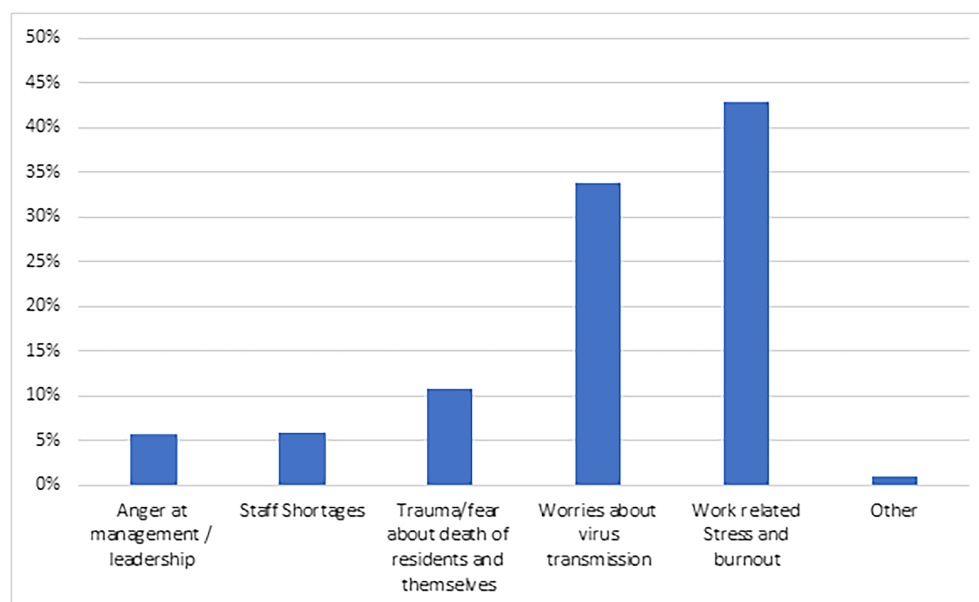
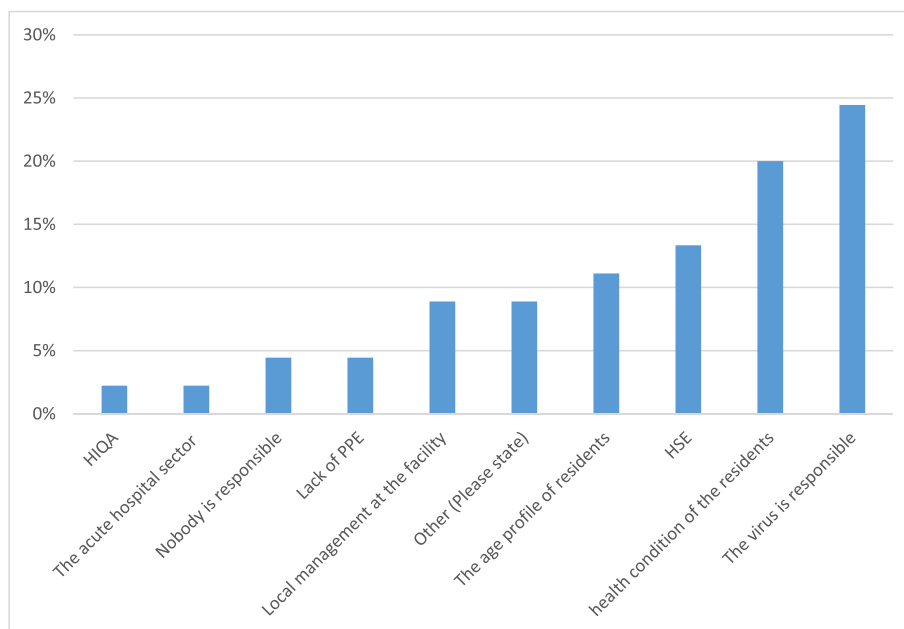


FIGURE 5 The figure illustrates the main adverse impacts experienced by staff

FIGURE 6 The figure illustrates where staff felt responsibility lies for the deaths at their residential centres



Several family members likened the experience of the residents to being ‘prisoners’ with no rights and no freedom. One family member noted ‘*that there had been more public disquiet about the closing of pubs than there had been about the fatality rates in nursing homes*’.

It was articulated that facilities with good leadership/management/governance prior to the pandemic fared better than with those with obvious poor performances prior to it. Nonetheless, a high percentage of family members said they would trust their facility to provide safe care for residents in the event of future waves of the COVID-19 pandemic.

7.2 | Role of the media

While media reports were regarded as important in highlighting the issues in residential care in relation to the rapid viral spread and the need for prompt intervention, some staff and families were distressed at the level of media sensationalization and blaming. These headlines of failures and fatalities caused distress to residents and families and made some staff feel ashamed and embarrassed by where they worked.

8 | DISCUSSION

This research provides novel insights grounded in lived experiences regarding levels of preparedness, factors contributing to the spread of the virus, impacts of COVID-19 and the associated effects on residents, their family members and staff. The study also highlights the governmental and health system response to the pandemic in this sector and informs priorities for future waves/future pandemics.

Our findings are reflected in other studies, for example; ineffective/slow implementation of recognized infection control measures by government and residential service sectoral management (Daly, 2020), lack of/slow implementation of service pandemic plans/protocols (Tan & Seetharaman, 2020) excess staff/visitor/patient movement (Ouslander & Grabowski, 2020), lack of/ineffective staff pandemic training/support (Kelleher and Twomey, 2020) and issues with staffing levels and skill mix (Davidson & Szanton, 2020). These findings have significant implications for structural governance and management.

Other longstanding governance issues were highlighted, for example; poor management awareness of service characteristics, absence of communication with staff and a lack of teamwork. Wider systemic failures were also identified in relation to infrastructure and interdisciplinary support. Participants identified under-investment in state run accommodation which had facilitated virus spread in congregated settings. Conversely, privately run facilities appeared to have better estate infrastructure but did not have the interdisciplinary network, medical and training support available to the state run services. Daly’s (2020) study of COVID-19 in nursing homes in the UK points to years of austerity and resource cutting, weak regulation and the de-politicization of social care with an accompanying pre-eminence of acute/medically focused state National Health Service (NHS) system. This critique resonates with Ireland where 79% of residential care provision is provided by private care facilities. There were marked differences in the private and public sector in terms of clinical and interdisciplinary expertise and infrastructure. Other studies highlight a lack of recognition/inclusion of the residential home sector in policy making, in particular Kelleher and Twomey (2020) identify poor regulation of standards in the Irish private residential home sector. This has resulted in a lack of investment in staff recruitment and training,

poor health care support and out of date infection control regulation and resources.

The adverse effects of the pandemic on the social functioning and mental health of a range of populations has been widely reported Brooks et al. (2020). Older people, and particularly those in residential care were further socially isolated and unable to access alternative measures of psychological support due to cocooning guidelines and visitor/contact restrictions in residential care (Health Service Executive (HSE), 2020). The high levels and detrimental effects of isolation among nursing home residents in COVID-19 has been reported elsewhere (Cocuzzo et al., 2020; Ouslander & Grabowski, 2020). Tan and Seetharaman (2020) identify the challenges for people with dementia and communication/behavioral issues in the context of the pandemic and report an increase in restraint use and falls due to imposed isolation. In our study, physical and mental health impairments as well as declining sight, hearing and voice projection seriously hampered successful communication in this socially distanced technological world. Although staff perceived that e-technology and online communication was adequate and effective, family participants countered this staff impression, reporting that this system was dependent on staff availability and the ability of residents/families to use the technology.

Although it was not possible to interview residents for the study, families and staff identified a range of emotions experienced by these elderly people which are echoed in other contemporary research, for example loneliness and disequilibrium at reduced family contact, fears of contracting the virus, grief and shock at the death of co-residents and fears of dying alone (Parks & Howard, 2021). The opportunities to receive comfort, reassurance, presence and human touch were vastly diminished. Parks and Howard (2021) emphasize the importance for elderly residents 'to have access to those who love them and view them as special, particular individuals', and it is these connections that often hold the identities of the elderly residents in place. Many staff and family participants observed a decline in residents' mental health and attributed this directly to the visiting restrictions imposed at the time. Family members felt that care staff prioritized the public health imperative over the psychological and emotional needs of residents and families and that their relational needs for human connection of residents were not adequately recognized or supported by staff. Initiatives such as limited visiting/appointing a designated visitor with full infection control measures and antigen testing have been suggested and used during the pandemic (Health Protection Surveillance Centre, 2021). Timely, honest and consistent communication between managers, staff, residents and families throughout the pandemic experience is essential. Studies also point out that the pandemic has highlighted the need for advance planning with residents/families regarding end of life care (Selman et al., 2020).

In addition to mental health impacts, the deterioration of residents' physical health was a strong finding from our study with family participants expressing shock and distress at this rapid decline. Some of this deterioration may have been COVID-19 related but in many cases it resulted from the reduction or absence of usual care. Our study highlights the extent to which family members had hitherto

provided direct care, and the importance of this to their loved ones. The contribution of families and partners to elder care in residential homes has been highlighted by Phillips et al. (2020) who describe family caregivers as the 'invisible workforce'. Davies and Nolan (2006) and O' Caoimh et al. (2020) claim that the nature of this family caregiving role within residential care home settings is poorly understood, undervalued and under researched. Many families do not perceive themselves to be visitors, but rather regard themselves as continuing in their caregiver roles in the residential environment. In our study, family participants voiced concern that they were not in a position to advocate for their relatives COVID-19 related care. Several family members likened the experience of the residents to being like 'prisoners' with no rights and no freedom.

The loss of the caregiving role was a major source of distress to family members particularly when they observed the mental and physical deterioration of their loved ones which arose from them being prevented from providing care. This is a novel and important finding from our study and supports the recent research by O' Caoimh et al. (2020) who found that COVID-19 visiting restrictions had negative psychological effects on family visitors because of disrupted caregiving roles.

It is important to note that many family participants perceived the staff as committed and working to the best of their abilities to keep residents safe in a confusing, stressful and under-resourced context. Staff distress, emotional and physical exhaustion were observed by family members and reported in their interviews. As in the research by Kelleher and Twomey (2020), these reports were accompanied by a high level of concern and care for the wellbeing of staff.

Our findings in relation to staff wellbeing reflect those of Navarro Prados et al. (2021), in that staff experienced information overload, physical and mental exhaustion, as well as fears about personal and patient contagion and death. Staff expressed anxiety at witnessing the impact of the virus on vulnerable people who were traumatized, alone and fearful and distressed that they were unable to meet the palliative care needs of patients during the pandemic. The most frequently reported adverse impact was the level of stress and burnout which compromised staff physical and mental wellbeing, a finding also reported by Maben and Bridges (2020), Ouslander and Grabowski (2020) and Tan and Seetharaman (2020). Despite the mammoth challenges they faced, staff kept going and appeared to put the residents' needs and safety considerations ahead of their own. This is echoed in a UK study which reported on the dedication of staff and their commitment to fulfill their duty of care which was described as 'Herculean ... the extra work and hours that have been put in to support the NHS' (Bennett et al., 2020).

Kitson et al. (2021) highlight that the neglect of frontline nurse worker stress would not be tolerated in other high-stress professions such as the army or police. Nurses in our study and other COVID-19 elder care research cited feelings of abandonment by the government and the wider health care sector (Sarabia-Cobo et al., 2021). Delays in attaining quality PPE, infection control equipment and training led them to feeling uncared for and undervalued (Navarro Prados et al., 2021).

In our study staff and families were distressed at the level of media sensationalization and blaming. Headlines of failures and fatalities caused distress to residents and families and feelings of shame to staff regarding their practice environment and their level of competence.

9 | CONCLUSION

Our study shows that COVID-19 caused much anxiety, grief, fear, isolation and distress for residents, families and staff and highlighted the important role that family members have in residential care setting for older people. In future communicable disease outbreaks, the needs and rights of residents to see loved ones should be balanced with the public health imperative.

A limitation of this study was that it did not capture the views of a representative sample of staff in residential care settings in Ireland, as there is no central electronic mail list available to access them. Nonetheless the views of those captured in this study are important and add to the emerging evidence base.

10 | IMPLICATIONS FOR NURSING MANAGEMENT

This study has practice, education and policy implications which are highlighted in this section. Practice: Residential care management needs to ensure that visiting restrictions are balanced with the rights and needs of residents. The important supplemental caregiving role of family members needs to be recognized, valued and supported by management and staff. All sites should facilitate access to one designated family member who would visit residents on an ongoing basis even in the event of a pandemic; this person would be mandated to avail of basic training in the principles of Infection Prevention and Control. Mandatory staff skill mix requirements and staff-to-patient ratios should be agreed at national level and implemented at local level by residential care management and staff. Residential care managers should proactively work on strategies to enhance the retention of their staff and reduce their reliance on agency staff. Managers need to advocate for, and introduce adequate psychological support, debriefing and practice supervision systems for staff urgently. Residential care settings should upgrade their IT infrastructure and upskills staff, residents (where appropriate) and family members. Holistic patient centred and ethical decision making is essential at all times. Education: Specialist infection control programmes for those working in residential care settings should be developed and made mandatory training for all staff. Managers need to ensure that infection control protocols and staff training are up-to-date at all times and ready to deploy immediately should the need arise. Policy: Agreed national principles and minimum standards should be implemented for improving governance/management, infrastructure/facilities and access to GP and other allied health professionals. This should include considerations around single room provision, shared

spaces and outdoor spaces with coverage. Many of our findings echo the findings of the HIQA report (HIQA, 2020), the Expert panel report (Kelleher & Twomey, 2020) and the Phelan et al. (2022) study about the impact of COVID-19 in this sector and concur with the wide ranging actions now warranted.

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CONFLICT OF INTEREST

There are no conflicts of interest to declare.

FUNDING INFORMATION

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ETHICS STATEMENT

Research Ethics Approval was obtained from Dublin City University (reference number DCUREC/2020/158). Consent to take part in the online survey was obtained online. Consent to take part in the qualitative interviews was gathered electronically via signed and returned consent forms. All methods were performed in accordance with the relevant guidelines and regulations.

AUTHOR CONTRIBUTIONS

MRS had the original idea for the study; she designed the study, applied for and obtained ethical approval, designed the materials, administered the survey, and co-analysed and interpreted the data and co-wrote and approved the final manuscript. AB co-analysed the quantitative data. CW conducted, analysed and wrote up the qualitative interviews. MV conducted, analysed and wrote up the qualitative interviews. BC contributed to study design and co-wrote the final manuscript. PB supported the set-up of the online survey on qualtrics. AS supported the design of the quantitative survey. All authors approved the final manuscript.

DATA AVAILABILITY STATEMENT

Data available on request from the authors.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher’s website.

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