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Experiences of Communication and Working During the Covid-19 Pandemic Among Nursing Home Staff: A Qualitative Interview Study

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ABSTRACT

Aim: To describe nursing home care staff's experiences of encounters and communication with colleagues, residents and residents' family members as well as their experiences during the Covid-19 pandemic while working in a multicultural environment.

Design: A qualitative descriptive study.

Methods: Interviews with 17 care staff from nursing homes in Sweden were analysed using qualitative content analysis.

Results: Care staff reported different working experiences related to their possibility to prepare themselves, and some felt more supported than others by their managers. Feelings of pride were experienced when Covid-19 infections were prevented. Overall, they received information about Covid-19, but not initially. Acceptance of colleagues with limited Swedish language skills was reported, but frustration and impaired communication were common. Negative mental health effects from working with critically ill residents and taking care of the deceased were reported.

Conclusion: Employers did not provide care staff with sufficient information and support, and strategies are needed to maintain communication with and between care workers. Further support is needed to maintain care workers' mental health and well-being during critical working conditions.

Implications for the Profession and/or Patient Care: Nursing home management needs to implement clear structured tools for communicating essential information. These tools should take language skills into consideration. During pandemics, care workers must receive the support they need to maintain their mental health and well-being.

Patient or Public Contribution: No patient or public contribution.

1 | Introduction

Communication was reported to be one of the most difficult aspects of dealing with the Covid-19 pandemic at nursing homes (NHs) (Shrader et al. 2021). The communication problems involved, among other things, providing staff with information and using Personal Protective Equipment (PPE). Additionally, the environment at many NHs today is multicultural, as staff, residents and their relatives originate from different countries and speak different languages. At present, most European societies are multicultural due to extensive ongoing migration and thus include people of several different cultures, including beliefs, languages, customs, traditions, etc., making them characterised by cultural and linguistic diversity (International Organization for Migration 2020). In the context of NHs, this means encountering staff from different cultures and with

different native languages and language skills (Xiao et al. 2017). The communication problems become even greater when residents' hearing and cognitive difficulties are considered.

2 | Background

During the Covid-19 pandemic, communication became difficult when NH staff followed national and regional recommendations regarding PEE, such as wearing a visor, a face mask and keeping a distance. The PPE hampered communication with residents, especially those with impaired hearing and cognitive impairment (Eriksson and Hjelm 2022b). During visiting restrictions, staff were given new tasks when helping residents maintain communication with their family members using Information and Communication Technologies (ICTs), for example, remote communication through phone calls and video calls (Feder et al. 2021; Sacco et al. 2020; Schuster and Cotten 2022). Moreover, staff facilitated visits between visitors and residents using plexiglass barriers, thus keeping a social distance. Despite staff's efforts to maintain residents' communication with family members, residents were affected by the visiting restrictions and their behaviour changed, mainly negatively (Hugelius et al. 2021; Leontjevas et al. 2020; Zhao et al. 2021). Furthermore, the relationship between residents and care staff became more important as residents had very limited social contact with others outside the NHs (Eriksson and Hjelm 2022b).

Previous studies have shown that having limited Swedish language skills is a problem for residents, their relatives and NH staff (Eriksson et al. 2023; Eriksson and Hjelm 2022a, 2022b). Globalisation has resulted in an increase in migrant healthcare workers (International Organization for Migration 2020), and NHs are attractive workplaces for them because there are many unfilled positions. About 20% of the Swedish population of 10.5 million were born abroad, and about one in three associate nurses working in care for older people was born abroad (Statistics Sweden 2021a, 2021b). It is mainly women with low education who work in care for older people, although in Sweden approximately one in three young employees in the municipalities are male, and the number of males working as care assistants and associate nurses has increased since 2011. A large proportion of males in these professions have a foreign background, thus contributing to increased diversity (The Swedish Association of Local Authorities and Regions 2022). For this reason, in recent years, communication among staff, residents and relatives of residents has changed due to the many languages represented by foreign-born staff at NHs.

The work environment in care for older people has been described as demanding, both physically and mentally, for healthcare workers even before the Covid-19 pandemic (Walton and Rogers 2017). During the pandemic, care staff at NHs encountered increased workload, stress, risk of becoming infected, stigmatisation (e.g., being socially discredited, devalued, or discriminated against due to a particular characteristic) and high working demands (Cabarkapa et al. 2020; Nyberg et al. 2022; van Tol et al. 2021; Zhao et al. 2021). Further, when employees became ill, understaffing was common (Jones et al. 2021; Teigné et al. 2021), and visiting restrictions raised ethical dilemmas for care staff (Hugelius et al. 2021).

Reports from care for older people in Sweden during the Covid-19 pandemic show a similar picture. The National Board of Health and Welfare stated that healthcare staff experienced a high workload with limited time for rest, also pointing out the lack of competence among healthcare staff at NHs (The National Board of Health and Welfare 2020). The Corona Commission (Government Offices of Sweden 2020) directed sharp criticism at the working conditions in care for older people, as there was a high number of temporary staff. It stated that employers must provide more security and care staff continuity by reducing hourly employment and increasing the number of permanent positions. Regarding the dissemination of information about Covid-19, the Corona Commission (Government Offices of Sweden 2022) concluded that much of the general advice issued by the Public Health Agency of Sweden was unclear. Advice and recommendations also put even higher communication demands on non-Swedish speakers or on those who, for other reasons, have difficulties taking in the message. Providing information in many different languages is not enough, but information needs to be designed in a way that is clear to all target groups. Furthermore, the Corona Commission reported that translations of information about Covid-19 into other languages took time (ibid.).

In summary, communication and dissemination of clear information to the public and NHs have been identified as difficulties during the Covid-19 pandemic. However, few studies have investigated how healthcare staff experienced and handled communication with colleagues with limited skills in the country's main language (in the present case Swedish) during the pandemic.

3 | The Study

3.1 | Aim

The aim of the present study was to describe NH care staff's experiences of encounters and communication with colleagues, residents, and residents' family members, as well as their experiences during the Covid-19 pandemic while working in a multicultural environment.

4 | Methods

4.1 | Design

A qualitative descriptive study design was used to gain deeper knowledge of the studied phenomenon (Patton 2015). Semi-structured interviews were selected for data collection, as they enable participants to share their experiences freely within specific areas.

4.2 | Setting

The study setting was NHs in a Swedish county with eight municipalities, including approximately 380,000 inhabitants. These NHs have from one to several wards. Associate nurses and auxiliary nurses usually work on one ward, while registered

nurses are commonly responsible for residents in several wards. During data collection, the national restraining order preventing relatives from visiting residents at NHs had ended, and the residents were offered the Covid-19 vaccine. Vaccination of healthcare personnel at NHs started during the data collection period. However, management at NHs was encouraged to prevent the spread of Covid-19 by, for example, keeping a distance between staff and residents when possible and providing masks and visors for staff delivering direct care.

4.3 | Sample and Procedure

Purposive sampling was used to get in contact with care staff at the different NHs. First, operations managers for official care for older people in the eight municipalities were contacted to obtain approval for the study. Thereafter, the principal investigator (PI, first author) contacted first-line managers at the NHs ($n = 72$) by email and phone and informed them about the study. Given the strained situation related to resource and staffing shortages at the NHs, 23 first-line managers declined to take part in the study. The first-line managers who accepted the invitation then informed the staff about the study by email and, in some cases, verbally at staff meetings. The PI also presented the study in staff meetings through video calls at some nursing homes. Staff who were interested were encouraged to reply by email or phone. In a few municipalities, the operation managers informed the first-line managers about the study themselves, and those who were interested in participating were encouraged to contact the researchers. Of the NHs that participated, one was privately owned and six were publicly owned by a large municipality. Participants' characteristics are presented in Table 1; most of them were born in Sweden and worked as associate nurses. The majority had more than 10 years of working experience but had worked fewer than 4 years at the present NH.

4.4 | Data Collection

Between January 2021 and September 2021, the PI, a registered nurse and a researcher, experienced in qualitative research, conducted semi-structured interviews in Swedish. The participants were invited to phone interviews; however, video calls were used in two interviews on request from participants (sound recorded by mp3 player). The interviews lasted between 25 and 45 min (mean 31 min). Offering different types of interviews may enable more participants to partake, as they can choose the type they are most comfortable with (Saarijärvi and Bratt 2021). Data collection proceeded until no new data were added to the data analysis (Patton 2015).

An interview guide, developed by the authors and based on literature and the authors' previous expertise in the field, was used covering background questions and six areas: (1) participants' characteristics, (2) communication with NH residents and their relatives, (3) communication and interaction with other NH staff, (4) how the Covid-19 pandemic had affected their communication/relationship with the residents and their relatives and (6) communication with care staff. The interviewer had no relationship with the NH care staff, operation

TABLE 1 | Characteristics of the study population, staff.

Variable	Staff, $N = 17$
Age (years)[a]	44 (22–61)
Gender (*n*)	
Female	16
Male	1
Level of education (*n*)	
Primary school (< 9 years)	1
High school (≥ 9–12 years)	11
Education at university level < 2 years	3
Education at university level ≥ 2 years	2
Family status (*n*)	
Married	5
Unmarried	3
Cohabiting	5
Divorced	4
Profession	
Nursing assistant	3
Associate nurse	12
Registered nurse	1
Occupational therapist	1
Current working conditions	
Full time	14
Part time	3
Work experience (years)[a]	14 (3–35)
Number of years working at the current nursing home (years)[a]	5 (2–21)
Country of birth (*n*)	
Sweden	10
Eritrea	2
Finland	1
India[b]	1
Iraq[b]	1
Serbia	1
Syria	1
Number of languages staff reported understanding (*n*)	
≤ 2	6
≥ 3–4	9
≥ 5	2

(Continues)

TABLE 1 | (Continued)

Variable	Staff, $N=17$
Languages staff reported they could understand (*n*)	
Swedish	17
English	15
German	5
Arabic	5
Tigrinya	2
Bosnian	1
Ethiopian	1
Finish	1
Croatian	1
Kurdish	1
Russian	1
Serbian	1
Macedonian	1

[a]Values are median (range).
[b]Grew up in Sweden.

managers or management at the nursing homes prior to data collection.

4.5 | Data Analysis

Qualitative content analysis was applied, and the data were analysed inductively (Patton 2015). The interviews were transcribed verbatim (by a professional secretary). Each interview was considered a unit of analysis. The transcripts were exported to Open Code (ICT Services and System Development and Division of Epidemiology and GlobalHealth 2013), a computer application that assists with organising data. The first author started the analysis process by reading the transcripts to get an overview of the content. Next, text and phrases related to the study aim were identified, and meaning units were marked in the transcripts. In the next phase, meaning units were coded and compared for similarities and differences between them. The codes were read several times, and codes with common attributes were structured into subcategories, and categories, and were given labels that were as close to the text as possible.

4.6 | Rigour

The PI performed the data analysis, and both authors coded and compared two interviews (Patton 2015). Both researchers reflected on the code labels and category names, and any disagreements concerning these labels and names were resolved through discussion until consensus was reached. The content of the categories was then checked by the second researcher (a nurse and researcher with vast experience in qualitative research and issues of migration). To strengthen credibility further, participants varied in age, profession, working experience and number of languages they spoke. To enhance dependability, an interview guide was used to ensure that the same questions were posed to all participants. Moreover, only one interviewer conducted the interviews. Rich descriptions of the data collection process, the participants' characteristics and the setting are provided to help the reader judge the transferability of the results to other contexts. Furthermore, confirmability was achieved by illustrating the categories using quotes from the participants' responses. In addition, the Consolidated Criteria for Reporting Qualitative Research (COREQ) were followed (Tong 2017).

4.7 | Ethics

The study conformed to the ethical principles defined in the World Medical Association Declaration of Helsinki (WMA Declaration of Helsinki n.d.) and prior to data collection, approval was obtained from the Swedish Ethical Review Authority (Reg. no. 2020–03636 and 2020-07193). Written informed consent was obtained before the interviews began. Participants were informed that they could withdraw from the study at any time, without any consequences for themselves. Transcripts were de-identified, coded and digitally stored in a space intended for research data.

5 | Findings

The data analysis resulted in four categories: the art of communicating during a pandemic, managing language obstacles and using different strategies to bridge language barriers, mixed experiences and support during the pandemic. These categories and the 12 subcategories are presented in Table 2.

5.1 | The Art of Communicating During a Pandemic

Information about Covid-19 and related restrictions was most often communicated to care staff, although participants reported that hygiene instructions could change quickly. Participants described strained communication with residents due to PPE and the adoption of remote communication with residents' family members.

5.1.1 | Limited Access to Information and Different Messages—Demanding Clear Leadership and Communication Channels

Participants reported having received information about Covid-19 from the media and verbal and written information from their first-line manager. Overall, participants were satisfied with the information they received continuously via email: 'I feel we've had very good communication the whole time, continuously. As soon has something has happened, we've received an email or been called to a meeting, and at all the staff meetings we've talked about Covid' (R13). However, those who dealt with Covid-19-infected residents early in the

TABLE 2 | Overview of categories and subcategories, staff.

Categories	Subcategories
The art of communicating during a pandemic	• Limited access to information and different messages—demanding clear leadership and communication channels • Managing changed communication methods with residents and relatives
Managing language difficulties and using different strategies to bridge language barriers	• Important but difficult to work with colleagues with limited Swedish language skills • Residents' and relatives' experiences of communication challenges due to staff members' limited Swedish language skills • Using different strategies to bridge language barriers
Mixed experiences and support during the pandemic	• Being prepared or not being prepared for unusual situations • Experiences of infection prevention measures • Facing hard times when residents and staff became ill but proud as long as Covid-19 could be prevented • Dealing with one's own and others' feelings and ways of reacting during a pandemic • Feeling supported but also left alone

pandemic reported a lack of information and information that came too late: 'But we got nothing. Us nurses, we sat there and Googled things and read the health authority's website and made a PowerPoint for the associate nurses so we could train them' (R4).

Although most managers provided the participants with information, the participants reported that information had not reached all staff or reached staff members at the same time, which created uncertainty among them. Furthermore, participants reported having to take in a great deal of information and that directives concerning, for example, the use of face masks/visors changed often. Participants reasoned that it was up to them to keep up to date and that they had to inform themselves by reading on the intranet and email at work. One lesson learned was that changed directives should be communicated clearly, both verbally and in writing: 'maybe it was reinforced when there were changes so that the message would reach people, so maybe there was email, verbally, maybe you put up signs' (R14).

5.1.2 | Managing Changed Communication Methods With Residents and Relatives

Communication with residents became very strained when staff used PPE. Participants reported that residents could not hear them, read their lips or see their body language and facial gestures. To enable communication, they had spoken loudly, articulated, stood closer to residents, took off face masks and some reported having felt completely exhausted: 'you have to try to speak louder, it's exhausting... it feels like you're going around screaming' (R11).

According to the participants, communication with residents' relatives changed considerably during the pandemic. Although the first-line manager provided information to relatives via email, relatives called more often and sometimes participants sent pictures and set up video calls for relatives to communicate during the visiting ban: 'Relatives called me all the time. What they were most worried about was their mother forgetting them or their father, or whether their mother had asked about them' (R11). Participants mentioned having tried to be calm in their communication as some relatives were experiencing a crisis. Participants reported having come closer to relatives and needing, during visiting bans, to give relatives more information, although it was time-consuming.

5.2 | Managing Language Difficulties and Using Different Strategies to Bridge Language Barriers

Care staff talked about the importance of being able to communicate with colleagues, but understanding what had been said was made difficult by some colleagues' limited Swedish language skills. Furthermore, participants needed to deal with residents and relatives who turned to them when they could not communicate with staff who had limited Swedish language skills. Care staff reported several strategies for communicating with both colleagues and residents with limited Swedish language skills.

5.2.1 | Important but Difficult to Work With Colleagues With Limited Swedish Language Skills

Working with colleagues with limited knowledge of Swedish could function well in some care situations, but not in others. Furthermore, some care staff reported more impaired communication than others did. Participants mentioned colleagues with limited Swedish language skills who did not understand them or who did not always understand information correctly. Therefore, misunderstandings were common concerning, for example, not helping a resident with a shower, a resident's

food allergies, taking a resident's temperature, assisting a resident with clothing, documentation, phone calls and cleaning. Although mostly minor misunderstandings were reported, it took extra time to resolve them, which led to feelings of irritation and frustration: 'Anyway it's another thing you have to think about. Because when the telephone rings or a relative comes by and asks questions or provides information, major misunderstandings can occur and that means extra work' (R13). Some participants reported having been forced to contact the nurse in charge when misunderstandings could affect the resident's health. Moreover, some colleagues could not respond to or provide feedback on various issues or manage care tasks, such as having a short talk with residents in need of social support. On the other hand, participants respected that colleagues born outside of Sweden could not possibly know all words in Swedish and that all staff had to help them with their Swedish. Some participants mentioned the importance and benefits of having colleagues from different cultures who spoke languages other than Swedish.

5.2.2 | Residents' and Relatives' Experiences of Communication Challenges due to Staff Members' Limited Swedish Language Skills

Participants reported how limited Swedish language skills among staff affected residents in various ways. They described situations in which residents could not understand what had been said. Especially residents with impaired hearing or dementia had difficulties hearing and understanding some staff members. Sometimes, the impaired communication resulted in conflicts between residents and staff or increased anxiety and tensions among residents. Furthermore, some residents did not want to receive assistance from some staff: 'And then the older person doesn't want help from that staff member because the older person doesn't understand what the staff member is saying and the staff don't understand what the older person is saying, so there are conflicts' (R6). Participants also experienced that residents' relatives were frustrated when they perceived that some staff did not understand them. Further, when it was problematic for relatives to communicate with staff with limited Swedish language skills, the relatives contacted them instead: 'then maybe they [relatives] think they [staff] don't understand, and they get angry and irritated, and then they [relatives] call me and they're angry and irritated' (R13).

5.2.3 | Using Different Strategies to Bridge Language Barriers

To ease communication with colleagues with limited Swedish language skills, participants used a variety of strategies, for example, pictures, gestures, repetition, being very clear, choosing different words or asking follow-up questions to check whether the colleague had understood. Some participants experienced that showing how something should be done took more time, but was safer: 'So they are with you and watch, and you notice if something is misunderstood, so you can demonstrate physically or they are there watching you' (R14). The method of allocating staff to NH departments depending on the language level of the staff was commonly used by some participants, especially on weekends and over the summer when regular staff were on vacation. Some participants mentioned language assistants, who were tasked with helping staff develop their Swedish language skills, however, participants also reported that the language assistants could not help all staff members in need. Most staff were hesitant to use translating applications to facilitate communication in daily work, also mentioning that this approach did not work in communication between staff and residents with dementia.

Strategies to facilitate communication with residents with limited Swedish language skills were also mentioned, such as using body language, changing language, having a word list, using relatives as translators or finding staff who spoke the resident's native language. Most reported that somehow communication with these residents was feasible, however, some mentioned residents who were socially excluded because they could not communicate in any language spoken by other residents or staff at the NH. Some arranged activities for residents where communication was not essential, such as painting, and letting residents sit in the garden 'activities that aren't so dependent on language. Instead, they can paint or .... well, make things up that they can ... don't need to have ... communicate with' (R11).

5.3 | Mixed Experiences and Support During the Pandemic

The work situation was experienced differently depending on whether or not one was prepared for the unusual and changed working conditions during the pandemic. Moreover, some care staff reported having had access to PPE, whereas others had experienced a lack of PPE. A few participants had experienced mental effects and reported still having flashbacks from taking care of deceased residents. Although the participants said they had received support during the pandemic, some mentioned that the support provided by the employer was insufficient.

5.3.1 | Being Prepared or Not Being Prepared for Unusual Situations

The participants reported very different experiences of working during the pandemic. Some described the beginning of the pandemic as difficult, as no one had experienced Covid-19 before, no one was prepared, and knowledge about how to work was limited: 'Well, it was really hard at first, when it began. No, that wasn't any fun at all' (R6). It was difficult getting used to a new situation involving a very heavy workload and stress, seeing colleagues get ill, and working during staff shortages. Moreover, many regular activities had been cancelled, such as staff meetings and courses. Other participants reported having had time to prepare for the pandemic: 'But then we rethought things, "we have to be prepared," and then we had an emergency kit [containing PPE] we packed and moved from the main storage to the ward on Fridays' (R7). They had access to PPE, food and extra staffing. They described an unusual time, but also how they were used to working with other diseases requiring extra

hygiene procedures: 'I think it worked well. It's been, well, different, like I said' (R12).

5.3.2 | Experiences of Infection Prevention Measures

All participants had experiences of using stricter hygiene routines during the pandemic. While some reported always having been good at following basic hygiene routines, and having participated in hygiene courses, others mentioned having had to encourage and nag at colleagues to adhere to the routines. Some had felt left out because they had not been offered courses in, for example, putting on/taking off PPE. Furthermore, staff had little time to clean, thus their workplace had become very messy and dusty. Also, care staff reported having had mixed experiences of cohort care and quarantine of Covid-19 infected residents: 'We tried to stick to cohort care, but it didn't always work, and they went between healthy and sick residents. Even we nurses, went between them. But then of course we started with the healthy ones and went to the sick ones. We did the best we could' (R4). Some thought it had worked well, while others reported that cohort care has been difficult because residents forgot they were sick and did not want to be isolated in their rooms: 'Because it's hard to explain to a person with dementia why they can't leave their room, that they have to stay in their room' (R16, 17). Participants working with infected residents at the beginning of the pandemic did not have face masks, visors and other PPE: 'Well so there was a bit of a shortage of protective gear at first, but now we have it' (R10), whereas other participants reported having had access to the necessary equipment during the whole pandemic. One hygiene representative doubted the content of hand sanitizer: 'Sometimes there was no ingredients list on the bottles we got, so I don't know what we were getting at times' (R6).

Generally, participants reported having felt stress about the procedure to test residents for Covid-19 infection. However, testing ran smoothly when extra staff came to the NH and carried out the testing. Regarding vaccination for Covid-19, participants felt more relaxed once residents had been vaccinated. A few mentioned colleagues not wanting to take the Covid-19 vaccine: 'At first there were quite a few who didn't get vaccinated. But then you had to or you weren't allowed to leave the country, and then many did it' (R11). In the interviews, participants reasoned about the lessons learned, for example, to always have an extra stock of PPE, higher staffing levels and the importance of basic hygiene routines: 'I think about how important basic hygiene is, how well it works. That we are careful about it' (R16, 17).

5.3.3 | Facing Hard Times When Residents and Staff Became Ill but Proud as Long as Covid-19 Could Be Prevented

Participants reported mixed experiences regarding Covid-19 infected residents and staff. Some participants described residents with few or mild symptoms and were proud that they had their first cases 10 months after the outbreak of the pandemic. Some felt lucky because only a few staff members had been ill, whereas others described hard times when both staff, residents and temporary staff were ill: 'That was a difficult period, but the others ... even the temporary staff got sick' (R6).

According to the participants, in some care institutions, new routines for taking care of the deceased came suddenly: 'The first one to die here. We asked what we should do. No one knew anything. The whole day went by. We didn't get any information until 2.30 in the afternoon. We were supposed to wrap them up in plastic' (R6). Those who reported being told to put the deceased in a plastic bag described it as unworthy, horrible treatment of older people: 'You think, they don't deserve this. But we can't do anything. There's a pandemic on. ... And I still think about it today sometimes. It's really hard' (R7). Participants described how calm it had been when residents died, pointing out that staff were with them in that moment. However, in the interviews, it emerged that residents could have been alone at the moment of death because the staff could not be with them all the time.

5.3.4 | Dealing With One's Own and Others' Feelings and Ways of Reacting During a Pandemic

According to the participants, the pandemic raised questions about what is important in life, the fear of being infected with Covid-19 or risking infecting someone else, like residents or their family members. Some described having felt shock and panic at the beginning of the pandemic. They had followed the restrictions, such as keeping a distance, minimised their social life and followed hygiene routines carefully. A few who had taken care of deceased residents reported having flashbacks: 'You get them all the time, flashbacks, images all the time. And they stick with you somehow. It makes you sad, sorrowful' (R7). However, others reported not having been afraid of getting Covid-19, reasoning that they were young and healthy, vaccinated and adhered to hygiene procedures: 'On my part, I've felt safe with, I mean, the PPE and hygiene routines we've had. So, I haven't been worried about getting it' (R12).

In the interviews, participants described how they had experienced residents' responses to the PPE, restrictions and visiting ban: 'They didn't want the help then. And I understand them. It looks very strange when we come in with a visor covering our faces, face masks so they don't really hear what we say, and then we're wearing other protective gear too. It looks kind of crazy and they're taken aback, try to lift the visor to see who it is' (R13). They needed to comfort residents who were sad, anxious and missing their family members and friends and to find alternative activities for residents when social activities at the NH were cancelled. Furthermore, some participants reported that residents' relatives had been upset and angry at the staff while realising the relatives were angry at the situation the pandemic had created.

5.3.5 | Feeling Supported but Also Left Alone

Regarding support during the pandemic, participants mentioned that they had talked with the nurse, administrative staff, colleagues and had taken initiatives to form small groups: 'We had small groups that could sit down and talk, but we were the

ones who took the initiative, because we felt we needed it. Staff on our ward choose to have our small meetings' (R16, 17). Some mentioned having received support from a psychologist, though talking in a group with a psychologist was considered difficult: '... a psychologist who led group discussions with ten staff, for an hour // And then to sit in a group, ten of us but I know, many thought it was a little difficult to sit and talk about... well, but they were such difficult topics' (R4).

Some participants reported that their first-line manager had asked them about their well-being during the pandemic, but time for reflection was limited. Others mentioned that their first-line manager had worked from home, and they desired more credit for their work and a more present manager. A few said they knew how to contact the occupational healthcare provider if they wanted to.

6 | Discussion

The present study provides unique insights into care staff's experiences of communication, including communication with colleagues with limited Swedish language skills, as well as their experiences of working at NHs during the Covid-19 pandemic. Thus, comparison to previous studies can only be partial.

Overall, care staff reported receiving information about Covid-19 from their employer regularly, mostly by email, notes and staff meetings, but initially, there was limited information. However, the lack of information about Covid-19, what PPE should be used and when, and the handling of the deceased was also reported. Our results emphasised nurses' exposed role at Swedish NHs when the nurses had to search/Google for information that was then used to educate direct care staff about Covid-19. Our research adds to other reports regarding inadequate dissemination of information and knowledge about Covid-19 to NH care staff (Government Offices of Sweden 2022; Jones et al. 2021) highlighting the need to provide timely and accessible information to NH managers and direct care workers. Communication of clear information during crises, such as the Covid-19 pandemic, is challenging when knowledge about a new disease is limited, but crucial to successful management and avoidance of misleading information (Sachs et al. 2022; The Swedish Association of Local Authorities and Regions 2023). Thus, structured tools for communication and care planning need to be implemented and ready to use in times of crisis (Gaur et al. 2020). Participants in this study who had access to information and time to prepare themselves at the workplace, for example, knowledge about and access to PPE, felt better prepared to handle the pandemic. Another study on nurse turnover intent during the Covid-19 pandemic found that higher quality of employer communication about Covid-19 and greater preparedness were associated with higher job satisfaction among direct care professionals in NHs (Cimarolli et al. 2022).

However, communication requires that messages are understood by those to whom they are addressed (Clark and Wilkes-Gibbs 1986). Although most staff in the present study understood three or more languages, at times, it was difficult to communicate with colleagues and/or residents. Our findings reveal impaired communication among care staff due to limited Swedish language skills among their colleagues. National reports (Government Offices of Sweden 2020; The Swedish Association of Local Authorities and Regions 2023) have stated that a large proportion of NH care staff lack sufficient knowledge of the Swedish language. Besides creating frustration, the impaired communication took time, and a new finding is that the participants described that they had to use several strategies to facilitate communication, for example, presenting pictures, demonstrating how to perform a task like taking a resident's temperature, or doing it themselves. We agree with the national commission (Government Offices of Sweden 2020) that Swedish municipalities must implement language training initiatives for NH care staff, but also develop strategies for how to handle hampered communication among staff. Further, future studies should investigate what language training initiatives are effective in these settings.

Encouragingly, participants in this study reported accepting the fact that their colleagues born outside of Sweden may not be able to learn all Swedish words. This acceptance indicates that there is room for learning, particularly concerning language. Therefore, NH employers should not be afraid of starting language training initiatives for care staff. Gillham found (Gillham et al. 2018) that staff were already sympathetic and sensitive to cross-cultural issues and that staff required clear, uncomplicated educational resources to equip them with the skills needed to address problematic cultural situations. However, a systematic review showed that workers' awareness of cultural diversity varies in care for older people, and that their knowledge of each other's cultural backgrounds is limited (Chen et al. 2020). As language and culture are closely linked, first-line managers may also need to implement some cross-cultural education together with language skills training to create an inclusive workplace (Debesay et al. 2022). Knowledge of what languages and cultures are represented in the working group is an asset for first-line managers, as the number of foreign-born residents is increasing. The present results revealed that residents who do not share their native language with any staff member may be socially isolated. First-line managers need to acknowledge the language competence among employees and use their competence more consciously, as it may prevent isolation for residents and agitation with staff on the part of residents with dementia (Cooper et al. 2018).

The present findings demonstrate the stressful working conditions many care staff experienced during the pandemic, for example, taking care of critically ill residents and handling deaths without clear information on how to do these tasks as previously reported (The National Board of Health and Welfare 2020; van Tol et al. 2021; Zhao et al. 2021). Furthermore, the participants had to continue working knowing they were risking their health, and they feared they would transmit the Covid-19 infection to residents or their family members. Nevertheless, care staff felt proud when they were able to prevent the transmission of Covid-19 infections at the NH. These results are interesting, as they indicate that, even in times of despair, feelings of pride can motivate care staff to continue working during critical situations. These findings should be recognised and are highly valuable for first-line managers at NHs, who need to provide support to healthcare staff in stressful working situations. Although care staff in the present study had received some

support to promote their mental well-being, it was not effective for everyone. The use of mental health promotion strategies has been reported to reduce stress and anxiety among nurses during the pandemic outbreak (Pinho et al. 2021), and NH institutions should acknowledge their responsibility for providing such support (Cabarkapa et al. 2020) henceforth. After the pandemic, first-line managers need to ensure good working conditions to maintain care staff's mental health and well-being (Rahim et al. 2022).

6.1 | Strengths and Limitations

Interviews were conducted by phone or videocalls, and some words were therefore difficult to hear. However, this did not affect overall understanding, and one strength was that participants could choose to do the interview by phone or videocalls (Archibald et al. 2019). Another strength was that the participants represented 13 languages and four professions, although most of them worked as associate nurses. One limitation was that only one male participant was included, although more females than males work in care for older people in Sweden. The present qualitative study aimed to seek a deeper understanding of care staff members' experiences; thus, not to generalise the findings. However, the findings may well be transferrable to similar contexts (Patton 2015).

7 | Conclusions

The present study contributes new knowledge on how care staff in nursing homes managed to work during the pandemic, sometimes with a lack of information and difficulties communicating with colleagues whose Swedish language skills were inadequate. Based on the present results, we conclude that care staff handled these situations by accepting the impaired communication, although it led to frustration and was time-consuming. Clear information helped care staff prepare themselves and develop routines to use in critical situations. However, some suffered negative mental health effects from working with critically ill residents and taking care of the deceased. This indicates that employers did not provide sufficient support for care workers, and strategies are needed to maintain care workers' mental health and well-being.

Author Contributions

E.E. and K.H. planned and designed the study. E.E. conducted the interviews and led the data analysis with regular input from K.H. All authors reviewed and approved the manuscript prior to submission.

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Ethics Statement

The Swedish Ethical Review Authority approved the study (Reg. no. 2020-03636 and 2020-07193).

Consent

The authors have nothing to report.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The interview data set generated and analysed during the current study is not publicly available due to promises of participant confidentiality. However, the data could be available upon reasonable request from the corresponding author.

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