Sustaining a Workforce: Reflections on Work from Home and Community Care Nurses Transitioning out of the COVID-19 Pandemic

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Abstract

Introduction: The COVID-19 pandemic has had an unprecedented impact on nurses' well-being and desire to practice; however, the experience of Canadian home and community care nurses remains less well understood. As the health human resources crisis in this sector persists, understanding these nurses' experiences may be vital in creating more effective retention strategies.

Objective: The aim of this study was to explore how the COVID-19 pandemic shaped the working experiences, motivations, and attitudes of home and community care nurses in the Greater Toronto Area.

Methods: Using an exploratory, descriptive, qualitative approach, 16 home and community care nurses participated in semistructured interviews. Data were analyzed using collaborative thematic analysis. Participants shared their reflections on work by detailing their experiences prepandemic, during crisis, transitioning out of crisis, and regarding pandemic recovery.

Results: During the COVID-19 pandemic inadequate staffing resources during and beyond the crisis period disrupted many desirable facets of work for home and community care nurses such as stable, balanced, and flexible work conditions, and exacerbated the unfavorable aspects such as isolation and inconsistent support. Many nurses were reevaluating their careers: for some, this meant stronger professional attachment and for others, it meant intentions to leave. Improved sector preparedness, wages, and workplace support were identified as strategies to sustain this workforce beyond the pandemic.

Conclusion: Home care organizations must consider ways to address the root cause of concerns expressed by nurses who wish to practice in a supportive environment that is sufficiently staffed and sensitive to workload expectations.

Keywords

community nursing, occupational stress < mental health, COVID-19, home care, health human resources

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Introduction

The global impact of the COVID-19 pandemic on healthcare workers has been profound and is likely to be felt for many years to come. Pandemic conditions highlighted many challenges within the Canadian healthcare system while exacerbating others, as healthcare workers on the forefront of the pandemic have reported an array of work-related difficulties and pressures (Akoo et al., 2023; Berkhout et al., 2021; Brophy et al., 2021; Connelly et al., 2022; Grady et al., 2022; Hopwood & MacEachen, 2022; Maunder et al., 2021; Ménard et al., 2023; Nizzer et al., 2023; Stelnicki et al., 2020). These challenges are not unique to Canada, as evidence from around the globe details the ways in which healthcare workers have had to rapidly adapt to changing work environments and heavier workloads, while concurrently managing increased occupational stress stemming from anxiety around infection transmission, illness, and overall safety at work (Beattie et al., 2023; Billings et al., 2020; Blanco-Donoso et al., 2022; Brady et al., 2021; Cengiz et al., 2021; Harris et al., 2023; Nelson et al., 2021; Wanninayake et al., 2023). For nurses, changing workplace conditions comprised of constantly evolving protocols, staffing shortages, isolation, and changes in care delivery have negatively impacted their occupational stress and ability to cope effectively (Beattie et al., 2023; Berkhout et al., 2021; Nelson et al., 2021; Stelnicki et al., 2020). In Canada, these challenges have led many nurses to feel greater dissatisfaction with their employment, burnout, and desire to leave their jobs (Akoo et al., 2023; Connelly et al., 2022; Grady et al., 2022; Maunder et al., 2021; Ménard et al., 2023; Statistics Canada, 2022a). These data have come primarily from institutional settings, and the voice of Canadian home care nurses throughout the COVID-19 pandemic remains absent in the emerging evidence base. This is of particular concern as the home care sector is experiencing an unprecedented health human resources crisis that worsened over this pandemic (Gurnham et al., 2023; Maunder et al., 2021). Home and community care play a vital role in effective health system functioning, and the lack of capacity in the sector has concerning implications on the ability to support patient flow and ensure that care is delivered in the most appropriate setting (Gurnham et al., 2023).

Review of Literature

Home and community care nurses support clients by delivering vital home health care to Canadians of all ages with complex, chronic, and palliative needs so that they can live independently at home for as long as possible (Home Care Ontario/Ontario Home Care Association [HCO], 2011). Nursing scope of practice in home and community care can extend beyond performing clinical tasks to include holistic person-centered assessments, client-teaching, therapeutic relationships, and liaising with other professionals in the client's circle of care (HCO, 2011). The nature of home care work is intimate and independent in comparison to institutional care settings where nurses work closely with their colleagues. The provision of home care occurs in private residences which are unique practice environments with variables that impact work experience such as travel, increased difficulty accessing required supplies, time constraints, and expanded responsibilities, without on-site support (Armstrong-Stassen & Cameron, 2005; Denton et al., 2002; Tourangeau et al., 2014; Tourangeau et al., 2017). These working conditions are also underscored by other home care sector concerns around limits on in-person collegial or supervisory support in managing challenging interactions with clients and caregivers, and exposure to environmental safety hazards in some client homes (Denton et al., 2002; Happell et al., 2013; Tourangeau et al., 2017). Furthermore, lower wages received for nursing work in home and community care compared to other healthcare sectors have contributed to negative perceptions of value and growing intentions to leave this workforce (Armstrong-Stassen & Cameron, 2005; Tourangeau et al., 2014; Tourangeau et al., 2017). On the other hand, those who remain in this sector do so because they value the greater autonomy they experience, the relationships they foster, and the purpose felt from their work (Armstrong-Stassen & Cameron, 2005; Denton et al., 2002; Gebhard et al., 2022; LoGiudice & Bartos, 2021; Nizzer et al., 2023).

The Canadian Province of Ontario is expected to face a home care workforce shortage of 33,000 nurses and personal support workers by the years 2027-2028 (Gurnham et al., 2023). Since the onset of the pandemic, the Province has seen a twofold rise in healthcare job openings (Gurnham et al., 2023) with a similar rise in job openings on a pan-Canadian level (Statistics Canada, 2022a, 2022b). Of those not considering retirement, nearly a quarter of nurses intend to leave or change employers in the upcoming three years due to feeling burnout and job stress (Statistics Canada, 2022a). Similarly, the Registered Nurses Association of Ontario [RNAO] (2021) reported that approximately 12.6% of the nursing workforce was considering leaving their profession entirely postpandemic and predicted that the Province could expect to lose 20% of early-career nurses, who have reported the greatest challenges coping with the heightened demands of pandemic work conditions (Maunder et al., 2021).

Retention of qualified staff remains challenging in the home and community care sector, where high rates of turnover and absences over the pandemic have resulted in an increase in nursing referral rejection rates from 5% prepandemic to 30% by August 2021 (Home Care Ontario [HCO], 2021, September 29). As nurses leave this sector, remaining workers feel the burden of higher caseloads and pressures to service as many in-need clients as possible (Tourangeau et al., 2017). Consequently, as the demand for home care is expected to increase and workforce instability persists, it will be difficult for the sector to meet these supply needs, putting hundreds of clients at risk of not receiving the quality care they require (Tourangeau et al., 2017). Thus, it is imperative to understand the experiences of the

home care nursing workforce throughout the COVID-19 pandemic, especially as these may be negatively affecting their attitudes toward their work and motivations to continue practicing. A better understanding of the interplay of workplace factors and organizational commitment unique to home and community care nursing can also inform organizational strategies to improve recruitment and retention in the sector beyond the pandemic. This research will seek to address this knowledge gap by exploring how the COVID-19 pandemic has shaped the working experiences, motivations, and attitudes toward the work of nurses in the Canadian home and community care sector.

Methods

Study Design and Setting

An exploratory qualitative descriptive approach (Sandelowski, 2001; Sullivan-Bolyai & Bova, 2021) utilizing semistructured interviews was chosen to address the study objective. The study was set at one large, unionized home care service provider organization located in the Greater Toronto Area of Ontario, which employs nurses who provide care in clients' homes or in community clinic settings. All study materials, data protection, and consenting procedures received institutional research ethics approval from the University of Toronto Health Sciences Research Ethics Board REB Protocol #43368. All participants provided verbal informed consent before participation and all interviews were conducted remotely as a COVID-19-related precaution to minimize safety risks between researchers and participants. The reporting of this research follows the guidelines in the consolidated criteria for reporting qualitative research checklist (COREQ) (Tong et al., 2007).

Participants and Sampling

Participants were recruited through purposive sampling across all regions in the Greater Toronto Area in which the organization provided home care nursing services between September and November 2022. Participant inclusion criteria were (1) holding an active registered practical nurse (RPN) or registered nurse (RN) designation in Ontario; and (2) working as a home and community nurse during the COVID-19 pandemic (March 2020 onward) to ensure that a breadth of experiences during and immediately following the pandemic crisis period could be captured. A study information letter explaining the purpose and goals of the study was shared widely across nursing teams through emails and weekly organization-wide e-newsletters. In line with previous qualitative research, 15 interviews were anticipated to be sufficient to achieve informational richness in the dataset to address the study objective (Braun & Clarke, 2019; Hunter et al., 2019), however, the study team was prepared to continue enrollment until all interested prospective participants had an opportunity to participate. Twenty-one interested participants contacted the study team to receive more information and screen for eligibility; however, five participants did not respond to follow-up email communication for study participation. The remaining 16 participants were enrolled in the study.

Data Collection

Sixteen interviews were conducted by the first author and a research associate both trained in qualitative interviewing and as clinical social workers at the Masters level; interviewers did not hold any preexisting relationship with participants. In-depth interviews were conducted remotely via telephone between October and November 2022. This period was a point of transition from crisis toward recovery within the healthcare sector; pandemic-related public health restrictions such as social distancing and public masking had been downgraded or removed (Ontario Ministry of Health, 2022), while universal precautions remained in place for all healthcare workers across sectors. An interview guide (S1) was utilized to facilitate narrative dialogue with open-ended questions developed based on a literature review and the researchers' previous study exploring the experiences of home care workers during the COVID-19 pandemic (Nizzer et al., 2023). First, participants were asked for basic demographic information including age, gender identity, ethnicity, role, and tenure before moving onto reflexive questions that probed career motivations, working experiences over the pandemic, attitudes toward their work, and the future of home and community nursing (e.g., *Could you share with me what it is like to work as a home care nurse during the COVID-19 pandemic? What you find motivating about your work and what you do? Can you describe challenges you faced or are facing working during the pandemic? How has your relationship to nursing changed or evolved over the pandemic?*). Additional probes were used to encourage participants to expand on their responses as needed.

Interviews were audio-recorded for accuracy and participants received an honorarium in the form of a $40 digital gift card to recognize their time spent in the study.

Data Analysis

Descriptive statistics were applied to demographic data to enable reporting of sample characteristics. All interviews were professionally transcribed verbatim; before analysis, transcripts were deidentified and reviewed for quality assurance by the researcher who conducted the interview. Thematic analysis was guided by the DEPICT (Dynamic reading, Engaged codebook development, Participatory coding, Inclusive reviewing, Collaborative analyzing, and Translation) model for collaborative qualitative analysis (Flicker & Nixon, 2015) led by the first author and supported by two research assistants who did not have any

preconceptions about the study population. Using this model, analysis was completed over six sequential stages with frequent group meetings to achieve collaborative decision making. Each analyst kept a reflexive journal and group meetings at each stage involved discussions whereby team members reflected on the data and potential biases in interpretations due to researchers' positionality (Braun & Clarke, 2021). The first stage of analysis involved independently reading all transcripts and inductively isolating concepts or patterns. The second stage involved a group meeting to discuss concepts and patterns, and to collaboratively identify relationships to create a preliminary coding scheme; a pilot codebook was developed to organize categories and subcategories with descriptors to be used in the coding process. In the third stage, the preliminary coding scheme was piloted on six transcripts by the three analysts working independently; refinements were made to the codebook after consensus was achieved from the group discussion. The resulting final codebook was utilized to code each transcript line-by-line. Next, data in each code was re-reviewed and compiled into descriptive summaries with example quotes highlighted for group analytical review. From these summaries, broad themes were developed, and a final series of group discussions were held with the full study team until consensus was reached and themes were finalized. Trustworthiness of reporting was established through prolonged engagement with the data and engaging in reflexive group discussions. The dependability of the research findings was improved through a rigorous research process supported by a dynamic work plan and a clearly documented and traceable audit trail was maintained throughout data collection and analysis (Lincoln & Guba, 1985).

Table 1. Participant Demographics and Work History ($N = 16$).

Characteristic	Sample
Age (years)	
Mean (SD)	46 (13)
Range	25–67
Gender identity, *n* (%)	
Woman	15 (94%)
Man	1 (6%)
Racial identity, *n* (%)	
Black	3 (19%)
Southeast Asian	4 (25%)
South Asian	4 (25%)
White	3 (19%)
Additional racial identities not listed above	2 (13%)
Nursing designation, *n* (%)	
RPN	6 (38%)
RN	10 (63%)
Years as a nurse	
Mean (SD)	15 (11)
Range	2–45
Years in home and community care	
Mean (SD)	11 (12)
Range	2–45
Number of employers (current), *n* (%)	
One	12 (75%)
Two	4 (25%)

Results

Sixteen interviews were conducted, each lasting between 25 and 80 mins. Participant self-reported demographics are summarized in Table 1. Our sample is reflective of the present home care nursing workforce (Tomblin Murphy et al., 2022); with an average age of 46 years and the majority (94%) identifying as women representing visible minority groups. While tenure as a nurse averaged 15 years, three participants identified as early-career nurses (<5yrs). To provide an in-depth exploration into how home and community care nurses' motivations, experiences, and attitudes toward their work were impacted by the COVID-19 pandemic, four overarching themes with corresponding subthemes were constructed from participant narratives (Table 2): (1) motivations to work in home and community care, (2) adjusting to pandemic working conditions, (3) self-preservation after crisis, and (4) sustaining a workforce.

Theme 1: Motivations to Work in Home and Community Care

The first theme establishes nurses' motivations behind their decisions to work in the home and community care sector before the onset of the pandemic and the desirable conditions that aligned with their personal and professional needs.

Conditions in Home and Community Care. Nurses in this study shared diverse personal factors that led them to choose the home and community setting to practice nursing, with schedule stability and a flexible pace inherent in the provision of home care as the main reasons shared. Here, participants ($n = 12$) drew contrasts with their experience of work in acute care as "*overwhelming and chaotic*" to further explain their decisions. These personal factors were congruent with their lifestyle and family obligations, with the flexibility in their schedules allowing them to attend urgent personal commitments as outlined by one nurse:

> "The flexibility was good for me. In long-term care, having a family, it was hard to just adhere to just the basic shifts, 9 to 5 type of shifts, in acute care or long-term care. But in the community, it is very flexible." (Nurse 3)

Other motivations that contributed to the decision to practice in home and community care related to appreciating a work environment that was conducive to practicing the principles of person and family-centered care; an important facet of nursing expressed by all participants. Participants ($n = 10$) desired to provide holistic care that considers the entire family unit, to have the ability to follow up on treatment, and to have the opportunity to witness quality-of-life progress over time.

Table 2. Experiences of Home and Community Care Nurses' Transitioning out of the COVID-19 Pandemic.

Themes	Subthemes	Exemplifying Participation Quotes
Motivation to work in home and community care	Conditions in home and community care	"I just like the more, kind of, stable pace. It is a bit more stable. It's not too frantic or too overwhelming. I'm going in and, for the most part, it's the same routine and the same thing. I like that and I don't like that." "I also like how flexible the home care side is. And it allows for a better work-life balance for sure."
	Motivated by intrinsic rewards	"I come sit with them and I help them with their problem. The thing is they feel like they are waiting for a friend, right, to share their problem and their feelings. That's the part I like most in the community. They are really happy." "I'm able to hear the different stories and — be an advocate for them because few of them do [not] have access to certain resources, and, for myself, I'm a vehicle for people who– you know, who cannot access the resources and people who doesn't know how to. And sometimes, they don't have anybody to help them."
Adjusting to pandemic working conditions		"It was fluctuating. So, when I say that, I mean at times it was very stressful, very hard to deal with all the new rules and stuff like that, just to make sure that you're doing things the correct way to not get yourself sick and get your family and your patients sick."
	Feeling overworked and undervalued	"They just– they're like, 'Oh, just work, work, work, work.' Nobody calls. Nobody checked in." "…we did feel very isolated, like very left alone."
Self-preservation after crisis	Restorative self-care	"I have colleagues that I work with that are close to me. So they're a good support." "My therapy is gardening [laughs]. Yeah. I'm busy with my family as well so that's a distraction."
	Intentions to stay or leave nursing	"I thought about it [leaving], for sure. I continue to think about it. I have a backup plan in the event one day I just lose it because– and everyone, all the senior nurses that I know that are left, they're all ready to leave." "I'm actually planning to go back to teaching because that was something that I was doing previously." "I was thinking, 'Should I just leave this and just go to another place and look for a whole different job?' Because you would think with the work that we do as nurses, we would be appreciated more, or we would be paid more. But they pay you like nothing."
Sustaining a workforce	Home care sector preparedness	"This is an overwhelming job to learn. Any new nurse that I've taken out to orientate them to the job, they probably get two or three days of orientation, then they're on their own"
	Improved wages and benefits	"I think it's [wages] a huge factor. Because in terms of hours, if you were in a hospital setting, you're sometimes guaranteed hours." "I would say the wages part is one of the biggest factors [for leaving]."

Participants agreed that the unique practice conditions in this sector allowed them to provide continuity of care, cultivate therapeutic relationships, and engage in advocacy.

> You're with the family for such a long time. Oh, it's not about all the machines that we operate. It's not about all the medications that we give. (Nurse 9)

Motivated by Intrinsic Rewards. Participants ($n = 12$) considered their work meaningful and received intrinsic rewards through witnessing the positive clinical and relational impacts of their work on the lives of their medically fragile clients who range from infants to seniors. They considered the long-term relationships they cultivated with clients and caregivers as a cornerstone of their work, embraced being a support system to the whole family unit, and believed that their impact extended to support and provide respite for otherwise overwhelmed caregivers. Nurses felt valued by their clients, which increased their motivation and commitment to practice.

> I think what I find motivating is just kind of the impact that I have on the families and–, the impact I have on [the client], and how it really helps them. I know it may seem kind of small, but to them, it's a big deal. (Nurse 1)

Theme 2: Adjusting to Pandemic Working Conditions

New demands introduced by the COVID-19 pandemic crisis required all nurses to rapidly adjust the way they worked. Increased physical and mental workload demands included adhering to constantly changing guidelines and increased infection prevention procedures required at each client visit. Wearing several pieces of facial protective equipment (FPE) was an additional challenge expressed by participants ($n = 13$) as it caused physical discomfort and interfered with their ability to deliver care and hindered their ability to engage with their clients:

> When it was summer, it's hot already. I work in a home that has no AC, so having all that equipment [FPE] on and then fogging up on you and you're doing wound care or anything with a catheter in terms of flushing and the NG tube. I wasn't being able to see it properly because I would have my glasses, the goggles, and the mask. (Nurse 2)

Early in the pandemic, it was important to frequently communicate changing protocols to clients and caregivers. These changes added confusion and stress that was compounded by global uncertainty and panic around how the virus spread. This led some participants ($n = 4$) to second guess their clinical judgment and adopt intense sanitization practices beyond those recommended by public or organizational guidelines, as one nurse describes:

> We sanitized the area that we touch, even while wearing gloves, the gloves we wear can't be on us longer than an hour. And then we're always constantly changing. So, say, if I would touch the alarm clock, and then I want to touch [my client], I would have to sanitize and then change my gloves. And then the alarm clock, I would have to sanitize. (Nurse 6)

Anxiety and uncertainty also remained high in the home, straining nurse-client relationships as participants ($n = 8$) tried to navigate transmission risks present in the care environment. Trying to comply with public health directives to maintain physical distance (two meters apart) was difficult in the confined spaces of some residences which made physical distancing impractical, particularly when many members of the household were present:

> It's very hard for clients and the families to keep distance to the nurse-they tried their best to keep distance to me, but I can see it's hard for them because I have to use the kitchen because I prepare medication, feeds or I have to grab something. So I'm moving from the [client's] bedroom to the kitchen. And sometimes, I will cross the living room. (Nurse 10)

Feeling Overworked and Undervalued. As the crisis progressed, participants ($n = 11$) expressed greater experiences of exhaustion and stress that superseded early anxieties related to uncertainty about the virus. These feelings were brought on by widespread staffing shortages, resulting from resignations or quarantine periods, which led participants to feel burdened and unable to take a break. As staff absences rose, nurses who remained noticed their workplace boundaries erode, with their days spent fielding calls asking them to accept new referrals and/or provide coverage, despite having no break themselves. They worked longer hours and were repeatedly asked to work outside of their established availability. These conditions increased the difficulty of taking time off and finding coverage. In some areas where nurses practiced, subcontractor agency nurses were deployed in response to staffing needs – for one nurse, the combination of working with newly hired nurses and subcontracted employees rather than more experienced colleagues contributed to their workload burden and growing tension in the workplace.

> The staffing shortage is so hard because we don't want to take time off. And when we do, we're terrified that everything's going to get screwed up. (Nurse 7)

Several participants ($n = 6$) expanded on the impact this period had on their ability to maintain work-life balance, as they were driven by a feeling of duty to report to work despite the conditions contributing to increased stress. It was difficult for them to feel comfortable limiting their workloads to maintain their balance and well-being, knowing that care needs for many clients in the community were not being met as one nurse explains:

> I feel that they [Employer] are calling me because they don't have anybody to send. And at the end of the road, the person there who is not getting the service is a client. Those vulnerable clients who do not have care at home, and they are forced to go back to the hospital to get that care. It's such a big burden for the family to do that, bringing someone vulnerable to an infectious environment and anything can happen. It does sadden me to not say "okay" to go, and all the time they [Employer] call me, I try my level best to go because client care is the most important thing for nurses. (Nurse 5)

When participants shared concerns about their high workloads with their leadership, some ($n = 5$) felt their experiences and need for relief were not validated:

> Even during team meetings, we'll get excuses and reasons, but never validation, ever, […] maybe we can't do 40. Maybe we can only do 30 visits. There was no talk about that. There was no one saying during a team meeting, "Just do what you can do." (Nurse 7)

Furthermore, participants ($n = 5$) expressed feeling disheartened by shifting public attitudes toward nurses as the pandemic progressed. While nurses were first considered "*heroes*," they later perceived dwindling appreciation of their efforts in responding to staffing shortages and amidst public-sector nursing wage freezes for nurses employed in hospital settings. While these wage freezes did not directly apply to employees of home care organizations, the message communicated by this provincial government legislation (Bill 124) during the COVID-19 pandemic contributed to them feeling undervalued as professionals:

> It's not a big factor of why I went into nursing, and I've never been a political person, but that Bill 124 [...] was a slap in the face like you would not believe. I think that was a big contribution to why there's a nursing shortage. (Nurse 14)

Theme 3: Self-Preservation After Crisis

As the period of crisis lessened, all participants ($n = 16$) highlighted the ways they preserved their mental health and well-being in response to the challenges they experienced in their workplace. They shared strategies they implemented to recuperate while also reflecting on their relationship to their nursing career.

Restorative Self-Care. While all participants recognized the widespread experience of burnout especially among their peers, they did not express themselves to be in a current state of burnout, instead describing themselves as being in an active state of recuperation from the intense experience of working under pandemic conditions. Self-care strategies primarily focused on restoring their social support networks, something that they had not felt to be feasible or safe during a crisis. Given that the restrictions that had previously limited social connectedness were gradually lifted, participants prioritized spending time with their family and friends. They were hopeful that public health restrictions would not return and looked forward to reconnecting with other aspects of their lives that had previously brought them joy. Neither professional mental health services nor employee assistance programs were utilized by study participants, who preferred instead to self-manage through engaging in hobbies such as singing, gardening, and exercise to decompress from work.

> I just try to find different ways to destress when I'm not at work, try to do different hobbies, just try to do the things that take my mind off work and stress. So those are the biggest things, going to the gym, playing sports, being with my family and friends. Those are the biggest things that help me. (Nurse 4)

Relatedly, workplace social support was another strategy utilized to combat isolation by nurses ($n = 11$). In the context of pandemic restrictions, the already independent and geographically dispersed nature of home care work felt isolating. When in-person gatherings were reintroduced in the workplace, nurses sought out colleagues whenever possible. Those who reached out to their nursing peers at work or in other settings for support felt their feelings and experiences validated, as one participant highlights:

> I just talk to my peers because they are obviously on the ground in the field, so they see this day in and day out. I mean, community nursing is very isolating because you don't work in a hospital where you see colleagues every day, so it can be a little difficult [...] So I'm just trying to kind of find people who maybe see the whole thing the same way you do, and just talk with them so you don't think you're crazy [laughs]. (Nurse 1)

Others ($n = 4$) felt compelled to restore their workplace boundaries by reducing their workload as a much-needed strategy to recoup their energy to work without compromising their well-being:

> So the only thing is to reduce the workload. Plus, I have to make sure that I have to sleep enough. I don't want my work to be affected [...] if I need to rest, I have to rest, and if I'm sick, I have to call in sick. So that's how we survive the pandemic and the workload. (Nurse 13)

Intentions to Stay or Leave Nursing. Participants had split feelings on their attachment to their job and commitment to their practice as they emerged from their pandemic crisis experiences; half of the participants had intentions to leave ($n = 8$) while the other half ($n = 8$) shared feeling recommitted to their nursing career. Those who shared intentions to leave frontline nursing felt their professional fulfillment had been depleted by unmanageable workloads and other sector conditions. Participants who shared these feelings, including early-career nurses, reiterated feeling unvalued linking this to feeling unheard, overworked, and inadequately compensated. The strategy of reducing availability and referrals was commonly shared by nurses who felt demoralized by the stress caused by high workloads and inadequate staffing resources, as described by one nurse:

> I haven't decided, but I'm considering doing this more on a casual basis, like two or three days a week. But I'm not going to carry my own caseload, so it's going to be much less hectic. Because it's incredibly frustrating to try and stay on top of all of these things all the time when it seems like nobody else really cares. (Nurse 14)

Early-career nurses ($n = 3$) particularly expressed dissatisfaction with financial compensation, causing them to consider other career opportunities that could supplement their income. They contemplated leaving home and community care nursing for other healthcare settings that offered higher levels of compensation, and for different industries, as one participant outlines:

> It's actually impacted my outlook on this field when it comes to me being in it for the long-term. So I've had some thoughts about, is this the right field that I want to be in for my whole life, if I want to switch out from this field? I've been kind of thinking of a couple of fields. One of them were trades, maybe somewhere in business or tech or policing. Those are the main things that have come across my mind. (Nurse 4)

Working without conventional on-site support was an additional sector-specific challenge influencing early-career nurses' intention to leave. They found it especially difficult to adapt to working independently, without immediate access to their colleagues, during the pandemic. Participants compared their current work setting with their experience in hospital settings to emphasize this difference; in hospitals, they could rely on a whole team for coverage and/or consultation at the same site. Furthermore, independent work with limited access to collegial support is further complicated when a novice nurse is caring for a client with complex medical needs who may also display responsive behaviors, or working with anxious caregivers who may impede the ability of nurses to focus on their care plan. The early-career nurses would have benefited in these instances from receiving rapid support and guidance to help them build practice confidence.

> Sometimes my client is very unstable. It would be nice to have a fellow nurse to help you out, to call somebody. But because in community you're by yourself, so you think for yourself, you do everything on your own, I think that's one of the challenges that sometimes makes me really anxious. Because I would like to have support or to have reassurance that I'm doing the right thing because this client literally goes from A to Z. You can turn around and my client would be blue. (Nurse 6)

By contrast, participants who had intentions to stay in their role expressed renewed commitment to nursing practice and personal accomplishment at having worked during a public health crisis, particularly amid resource challenges.

> I see that we are more needed in the community and with the aging population. I realized how important nurses are and what would happen if we are not there. (Nurse 13)

For these nurses, their driving motivations to work, including job satisfaction and intrinsic rewards of community-based nursing, remained unaltered by their pandemic experiences. They also noted extended support from their workplace support network throughout the pandemic.

> I would say that [my supervisor] is such a wonderful, wonderful nurse herself, and she does go above and beyond her way to visit some of the clients who really need care over the weekend when we are not able to. That's a great support. (Nurse 5)

Theme 4: Sustaining a Workforce

Participants ($n = 14$) expressed their worries about the future of home care nursing with staffing shortages at the center of their concerns. Participants identified retention-promoting solutions at the organizational and system levels that they believed would contribute to sustaining the home care nursing workforce through pandemic recovery and ahead of future public health crises.

Home Care Sector Preparedness. Nurses ($n = 8$) resoundingly shared dissatisfaction with support to prepare nurses to practice in the home and community care sector, with emphasis on improving orientation and workplace social support for new hires and graduates. Comprehensive onboarding including more extensive orientation was suggested as a practical retention enhancement strategy at the organizational level to ensure that new hires felt more comfortable and supported to work independently in the field as one nurse explains:

> They're not given near the support they need, the staff, the new nurses. Like visiting nursing is nothing like being in a hospital, zero, nothing like it at all. There are so many different things that you're just expected to know or expected to figure out on your own time. And you might be even still struggling with your own skills as a new nurse. (Nurse 7)

Participants identified that high attrition of new nurses wasted the effort required to orient and mentor them, increasing experienced nurses' workload. Participants outlined the complexity, emotional labor, and administrative duties inherent in home and community care and believed that a more extensive onboarding and mentorship period would support new nurses to adjust to practicing under these conditions and would be beneficial both to new hires and to their more experienced colleagues.

> I think it's important to sustain the nurses in the workforce because if they have a lot of stress going into the home independently right after they are hired, that's going to encourage them to leave because it's a highly stressful environment to work and I think they need to be ready to work. (Nurse 5)

Improved Wages and Benefits. Harmonized wages across healthcare sectors were perceived as an urgent priority need for participants ($n = 12$) and an important factor in nurses leaving their roles, as described in the following quote:

> Why are nurses leaving? Because the nursing job is very hard. It's draining, physically draining and mental too. And they don't increase wages. Prices for everything is increasing every six months. But for [home care] nurses, I don't remember the last time when it [the wages] was increased…Other businesses get more money than the nurses. Why would I just wear myself [down] for that amount? A lot of people think like that. (Nurse 11)

Expanded benefits that aligned with other health sectors were additional incentives participants desired to improve their quality-of-life and income stability. Low wages contributed to feeling underappreciated; for participants in this study, enhanced extrinsic rewards could have offset the occupational stress they felt. Importantly, this would reduce the financial reasons for considering a change of career or for supplementing income by having multiple employers, which was perceived by some participants as necessary to meet the realities of growing inflation concerns.

Discussion

This study provides insight into how the COVID-19 pandemic impacted home and community care nurses' perceptions of work and commitment to practice through reflections on their motivations and experiences before, during, and after the crisis period. To the research team's knowledge, this is the first study to report on Canadian home and community care nurses' perceptions of and reflections on their pandemic experiences.

Consistent with findings globally and in other healthcare sectors, nurses in this study worked under extraordinary pressures throughout the pandemic to shoulder the burden of mitigating the impacts of workforce shortages on patients (Akoo et al., 2023; Ménard et al., 2023; Nelson et al., 2021). While workforce shortages have been a persistent issue across the Canadian home care sector (Denton et al., 2002; Tourangeau et al., 2014; Tourangeau et al., 2017), the health human resources crisis has worsened as nurses leave their careers due to burnout caused by high workloads and other unfavorable workplace conditions (HCO, 2021; Statistics Canada, 2022a). Conditions such as high workloads and inconsistent workplace support all contribute to psychological challenges among healthcare workers which extend to their relationship to their work, feeling valued, and intentions to leave (Akoo et al., 2023; de Vries et al., 2023; Janssen & Abbott, 2023; Martin et al., 2023; Tourangeau et al., 2014; Tourangeau et al., 2017). For nurses in this study, inadequate staffing resources disrupted many desirable facets of work in the home and community care sector such as stable, balanced, and flexible work conditions, while exacerbating the unfavorable aspects such as isolation and, for nurses less well connected to their peers and supervisor, difficulty accessing support. For example, they described frequent calls from their employer asking them to increase their caseload and work outside of their availability, preventing nurses from receiving a 'mental break' from work. They also developed conflicting feelings between their professional duty to work and managing their own health and well-being. This finding aligns with other reports that described the psychological strain on healthcare workers from increased workloads and pressure to service many more patients than previously amid workforce shortages during the COVID-19 pandemic (Aiken et al., 2023; Akoo et al., 2023; Billings et al., 2020; Brophy et al., 2021; Connelly et al., 2022; Ménard et al., 2023).

As pandemic conditions lessened, it is unsurprising that a key self-preservation strategy implemented by participants was to restore workplace boundaries. Self-preservation through detachment and compartmentalization of work has been reported by Connelly and colleagues (2022) as a positive coping strategy used by nurses to counteract the stressful work conditions the pandemic had created and replenish their resiliency. Alternatively, detachment from work can also signal a desire to leave their nursing role as job satisfaction and motivation decrease (Singh et al., 2016), as exemplified by participants with intentions to leave who deliberately reduced their availability and acceptance of client referrals. This practice of detachment may indicate burnout (Galanis et al., 2021; Ménard et al., 2023) and a concerning trend among nurses and other healthcare workers who are "*quiet quitting*"—remaining at their workplaces but significantly withdrawing their efforts (Boy & Surmeli, 2023; Zuzelo, 2023). Recent reporting on this phenomenon has understood it to be a response to negative workplace conditions exacerbated by the pandemic and could present long-term consequences for healthcare quality (Boy & Surmeli, 2023).

Ménard and colleagues (2023) have similarly reported nurses' turnover intentions due to frequent experiences of feeling undervalued and abandoned by their government or leadership, who were perceived to be prioritizing high work volumes over staff well-being. For nurses in this study, feeling unvalued at work was further compounded by controversial government legislature that froze public-sector wages for hospital-based nurses. While this legislation did not apply to the employment contracts of home care nurses, it was taken as a signal of the downturn in the societal value of nurses (Harris et al., 2023). Among those considering leaving their profession are early-career nurses who struggled to adapt simultaneously to home care sector conditions and pandemic conditions, while coping with the financial insecurity associated with a fee-for-service employment model.

Despite increased occupational stress, some home care nurses also experienced concurrent feelings of heightened purpose and self-efficacy that amplified their sense of professional identity and accomplishment, mitigating some of the harmful effects that stress at work can have at the individual level (Blanco-Donoso et al., 2022; de Vries et al., 2023; Gebhard et al., 2022; Janssen & Abbott, 2023). Individual-level factors such as inherent personality traits, duty, and history (Beattie et al., 2023; de Vries et al., 2023) can all have an influence on an individual's ability to process and cope with stressful events, as described by participants who felt a renewed sense of pride in their role as nurses.

Workplace social support can also contribute to an individual's ability to cope with work stress (Beattie et al., 2023; Connelly et al., 2022; de Vries et al., 2023; Godfrey & Scott, 2021; Grady et al., 2022; Janssen & Abbott, 2023; Nelson et al., 2021). An absence of workplace social support was particularly impactful for those experiencing a decline in their organizational commitment, where a perception of insufficient leadership support contributed to their

dissatisfaction with their work experience (Akoo et al., 2023; Blanco-Donoso et al., 2022; de Vries et al., 2023; Nelson et al., 2021; Wanninayake et al., 2023). Relational connections and outreach facilitated by leaders to lessen the feelings of isolation and improve practice confidence could help those who are new to the sector or consider themselves to be early-career nurses. Equally, tenured nurses in this study expressed their desire for more vocal recognition and validation for their efforts from their leaders.

As the healthcare system moves toward recovery from the loss of nurses and other staff throughout the COVID-19 pandemic, there is an opportunity for organizations to implement sustainable retention solutions that consider how work impacts emotional health, and subsequently job satisfaction and organizational commitment (Armstrong-Stassen & Cameron, 2005; Janssen & Abbott, 2023; Nizzer et al., 2023; Singh et al., 2016). Workplace resources and well-being interventions such as physical relaxation, mindfulness, and resiliency training have been found to be feasible measures that can alleviate feelings of job stress (Connelly et al., 2022; Janssen & Abbott, 2023; Nelson et al., 2021; Zhang et al., 2021); however, these interventions fall short of confronting the root causes of concerns voiced by nurses in this study and healthcare workers globally (Aiken et al., 2023; Akoo et al., 2023). This has been most notably described in a recent article by authors Aiken and colleagues (2023), which reports a growing disinterest among physicians and nursing professionals in receiving wellness and resiliency programs which put the onus on clinicians to improve their ability to adapt, rather than on workplaces to address occupational conditions including unpleasant work environments and unmanageable workloads, that precipitate resignations. Growing disinterest in mental health programs may also be present among nurses in this study, who did not utilize the self-directed resources or professional mental health supports available through their workplace.

Implications for Practice

The past three years since the start of the COVID-19 pandemic have had a remarkable impact on home care workers and led nurses to leave the profession at an alarming rate (RNAO, 2021; Statistics Canada, 2022a; Tomblin-Murphy et al., 2022). Relying solely on the resiliency of home care nurses is not sufficient to combat the crushing levels of occupational stress that they have experienced. Structural changes to reduce sector pain points are needed to support this workforce. Organizations can begin to implement practical retention-promoting strategies such as enhanced orientation and mentorship to ease entry to practice, support for the maintenance of work-life boundaries, and improved workplace social support. Additionally, some systems-level changes, including investments into the home and community care sector to establish wage parity with other healthcare sectors, are necessary to rebuild and sustain this workforce to meet future public health needs.

Strengths and Limitations

This research expands the limited evidence base regarding pandemic impacts on nurses working in the home and community care sector. The generalizability of these findings is limited by the fact that all participants were employed at a single home care organization, in a primarily urban locale. Purposive sampling is likely to have engaged nurses with the strongest feelings and experiences related to the research question and may have excluded nurses who were experiencing burnout and could not accommodate the additional request to participate in a research study.

Evidence to date on COVID-19-related impacts on healthcare professionals has largely focused on those working in acute care settings with job features and retention solutions that are different from community-based healthcare settings. The findings in this study demonstrate how the impacts of the pandemic differed in home and community care and for nurses at different career stages. We offer two suggestions for future research to build upon this work: (1) consider regional experiences as community nursing is not homogeneous, and (2) further exploration of job features that influence the work commitment of early-career nurses in the home and community care sector. There is also a significant need for research and practice change reports that evaluate the implementation in home and community settings of recommended strategies for addressing the root causes of nurses' occupational stressors.

Conclusion

Home and community care nurses were challenged daily throughout the COVID-19 pandemic and burdened by staffing shortages that created heavy workload demands with little reprieve. These workload pressures contributed to negative perceptions of work and feelings of under-appreciation by the public and their employer, despite their best efforts to deliver essential care. Many who previously enjoyed their nursing role are reevaluating their relationship to their careers; for some, this meant stronger professional attachment and for others, it meant intentions to leave. As the Canadian home care sector continues to be challenged by labor supply shortages, rebuilding and retaining this workforce will require organizational-level and system-level interventions that address the root cause of concerns expressed by nurses who wish to practice in a supportive environment, with sufficient staffing, that is sensitive to workload expectations.

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Author Contributions

Sonia Nizzer: Conceptualization, methodology, investigation, formal analysis, writing—original draft, project administration.

Simran Baliga: Methodology, formal analysis, writing—review and editing. Sandra M. McKay: Conceptualization, supervision, writing—review and editing. D. Linn Holness: Funding acquisition, supervision, writing—review and editing. Emily C. King: conceptualization, supervision, writing—review and editing, funding acquisition.

Declaration of Conflicting Interests

S Nizzer, EC King, and SM McKay are researchers employed by the organization at which the research was conducted.

Ethical Approval

Before study procedures, all study procedures and materials received ethical approval from the University of Toronto Health Sciences Research Ethics Board REB Protocol #43368. Informed consent was obtained from all participants before data collection.

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Supplemental Material

Supplemental material for this article is available online.

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