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COVID-19's Impact in Long-Term Care Facilities: The Health and Coping Strategies of Older Adults and Their Families

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ABSTRACT

Aim: Describe the stressors that long-term care facility (LTCF) residents and their family members were exposed to during the COVID-19 pandemic, the resources they mobilised to cope with them, and the strategies used by professionals to support them.

Design: A descriptive qualitative design study.

Method: Between March 2021 and February 2022, we carried out semi-structured interviews with 8 LTCF residents, 11 family members, and 6 focus groups made up of healthcare and support staff from 8 LTCFs.

Results: Three themes emerged: (1) residents and family members: separated and suffering, (2) residents and family members: reinventing themselves, and (3) staff: attempts to maintain residents' well-being.

Conclusion: LTCF Residents' and their family members' exposure to the various stressors linked to the COVID-19 pandemic generated suffering. Healthcare and support staff implemented strategies to support them, notably to maintain links between them. Some deep reflection must occur on the concepts of LTCF residents' autonomy and self-determination when implementing protective measures in future pandemic situations.

Implications for the Profession and Patient Care: This study has provided new insights into the nature of the stressors faced by LTCF residents and their families, and the measures implemented by professionals to support them. The role of the families of LTCF residents needs to be better recognised. Our results indicate the importance of involving nurses in discussions on patient autonomy and self-determination when implementing protective measures (in a pandemic situation).

Impact: Exploring the nature of the stressors experienced by LTCF residents and their families enables professionals to tailor strategies to support them. Maintaining residents' self-determination is essential when implementing protective measures. Families involved with residents must be recognised and included in the assessment of stressors and the personalisation and implementation of strategies to support LTCF residents.

Patient or Public Contribution: No Patient or Public Contribution.

1 | Introduction

Until July 2020, the COVID-19 pandemic infected over 15 million people globally, and almost 640,000 of them died (World Health Organization 2020). Since the start of the century, the world has also seen the SRAS (2002–03), H1N1 (2009), and MERS (2012) pandemics (Lum and Tambyah 2020). These infectious epidemics had an impact not only on communities' physical health but also on their psychological health (Sim et al. 2010). The general population, particularly older

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Summary

- What does this paper contribute to the wider global clinical community?
    - The study described family members' essential roles in identifying the stressors experienced by older adults in complex situations and their participation in coping and the provision of care.
    - Practical guidelines should be developed to help introduce new technologies that promote residents' quality of life while limiting their potential negative effects.

adults, was not spared the pandemic's psychological consequences (James et al. 2019; Lee et al. 2006; Sim et al. 2010; Taha et al. 2014). People's fears regarding their health and the health of their relatives represent a significant stressor, but not the only one. There are multiple stressors frequently associated with epidemics, such as disturbances to the routines of normal daily life linked to shut-downs (Sim et al. 2010), mourning and loss (Schwerdtle, De Clerck, and Plummer 2017), or stigmatisation (Matua and Wal 2015). Yet, it is now widely recognised that these stressors do not only have negative impacts. The coping mechanisms put in place to deal with those stressors allow people to evolve and assess the resulting benefits of those mechanisms. Thus, people can find resources and experiment with positive changes (Cheng, Wong, and Tsang 2006; Cheng et al. 2006; Chiang, Chen, and Sue 2007; Mok et al. 2005; Rabelo et al. 2016).

2 | Background

The COVID-19 pandemic pushed long-term care facilities (LTCFs) for older adults to centre stage in the media. Indeed, COVID-19 severely affected residents living in LTCFs in many countries (Gardner, States, and Bagley 2020). Indeed, LTCFs often host the oldest older adults presenting with diminished cognitive and physical capacities and several comorbidities, thus making them particularly vulnerable to COVID-19 (Tana et al. 2023). However, the structure and organisation of LTCFs favour the development of epidemic outbreaks, especially when residents with suspected or proven infections get together at mealtimes or for group recreational activities (Gardner, States, and Bagley 2020).

Switzerland, like many other countries, declared a public health emergency between March and May 2020 to better manage the COVID-19 pandemic. Between March and April 2020, French-speaking Switzerland's LTCFs (known as medical–social establishments or EMS) recorded very significant increases in the numbers of suspected and proven cases of COVID-19. The disease is particularly dangerous for persons over 65 years old, and, indeed, half of the deaths due to COVID-19 recorded in French-speaking Switzerland took place in LTCFs (Fontannaz 2020). Drastic measures were put in place to halt the onrushing potential disaster: all residents diagnosed with a suspected or proven COVID-19 infection were isolated in their room alone, personal movements and activities within LTCFs were designed not to intersect, group activities were kept as small as possible, strict hygiene measures were introduced, and visits were banned (DSAS 2020).

The protective measures against COVID-19 introduced in LTCFs led to negative emotions and feelings and unmet social needs among both residents and their family members (Noten et al. 2022). Some studies highlighted the direct link between the residents' lower levels of well-being and the protective measures put in place, notably because of isolation and the lack of social interactions (Ayalon et al. 2021; Freedman and Nicolle 2020; Kaelen et al. 2021; Santini et al. 2020). The initial lockdown worsened residents' physical, mental, and cognitive well-being and disturbed their links with their families and their communities (Saad et al. 2022). Furthermore, residents and their relatives felt anxiety, sadness, and significant stress during this period (Paananen et al. 2021).

The strategies for coping with stressors employed by disease survivors and individuals from the general population have been studied frequently during the most recent widespread epidemics (Auxéméry and Tarquinio 2020). However, older adult LTCF residents and their family members are populations that have only rarely been studied, despite the former group being highly vulnerable to infectious diseases. The organisational characteristics of these establishments, plus the strict disease containment measures imposed by the pandemic, generated reactions to stressors that the general population only experienced to a far lesser extent, such as social isolation, the fear of being contaminated, or the lack of activity, which leads to idleness. Several studies have investigated stressors' consequences on the physical and psychological health of LTCF residents and their relatives (Schneider et al. 2023). Few studies have examined residents' and family members' perceptions of the stressors they were exposed to and the resources they mobilised to cope with them.

The present study aimed to investigate the stressors experienced by LTCF residents and their family members that were linked to the exceptional preventive measures put in place during the COVID-19 pandemic and to explore the resources that they mobilised or developed to cope with them.

2.1 | Theoretical Framework

In the *Neuman Systems Model* (Neuman and Fawcett 2011), human beings (the client system) are composed of five physiological (the immune system), psychological (e.g., cognition), sociocultural (e.g., support), developmental (e.g., the final stage of life), and spiritual (e.g., the meaning of life) dimensions. The model was chosen as the theoretical framework for our study. According to Neuman and Fawcett (2011), human beings are open systems in constant interaction with intra-personal (one's internal physical and psychological environment), inter-personal (one's proximal external environment), and extra-personal (one's distal external environment) stressors. Neuman defines stressors as 'tension-producing stimuli that have the potential to cause system instability' (Neuman and Fawcett 2011, 22). Depending on patients' perceptions and their capacities to adapt and cope, these stressors can be classified as positive or negative. Neuman and Fawcett (2011) notes that every human being (each system) has resources allowing them to maintain, attain, or reconstruct the stability required for their well-being, which is considered the manifestation of their health. These resources reside in what she termed the flexible line of defence or the lines of resistance. Depending on the situation, the health resources in the flexible line of defence may not be able to protect a human being fully. The client system is thus destabilised, and the individual's health is altered. In the context of the COVID-19 pandemic, this theoretical model was, therefore, quite appropriate to guide our exploration of the stressors experienced by older adult residents in LTCFs and their relatives, how those stressors destabilised them, the coping strategies that they put in place, and the effects of those strategies.

3 | Methods

3.1 | Design

The present study used a descriptive qualitative design (Polit and Beck 2020). The data collected aims to describe the phenomenon and to highlight the themes that reflect the experience reported by participants.

3.2 | Aims

The present study's primary objective was to describe the stressors experienced by LTCF residents and their family members in French-speaking Switzerland during the COVID-19 pandemic. Its secondary objective was to describe the resources that those groups mobilised to cope with those stressors. Finally, we aimed to describe the strategies that healthcare and support staff implemented to support LTCF residents and their family members.

3.3 | The Sample and Participant Recruitment

Our target populations were the older adult residents of LTCF and their family members, as well as the healthcare and support staff in those establishments.

Data were collected in eight LTCFs that were diverse in terms of their size and setting, as shown in Table 1.

TABLE 1 | Long-term care facility (LTCF) characteristics.

LTCF	No of beds	Setting
LTCF 1	53	Rural
LTCF 2	150	Peri-urban
LTCF 3	48	Rural
LTCF 4	122	Urban
LTCF 5	87	Peri-urban
LTCF 6	124	Urban
LTCF 7	63	Rural
LTCF 8	84	Peri-urban

The study inclusion and exclusion criteria defined for participant recruitment are described in Table 2.

We used a purposive sampling method to ensure that the participants selected had a variety of different profiles (Larivière and Corbière 2014). Regarding the older adult LTCF residents, we used several criteria to ensure some participant diversity: men and women of different ages, who had been residents for varying lengths of time in our participating LTCFs. Regarding their family members, the main criterion was being the spouse or child of the older adult, whether in paid employment or not. Finally, healthcare and support staff working in our participating LTCFs included registered nurses, licensed practical nurse(s), certified nursing assistants, animation staff, and members of housekeeping staff.

LTCF head nurses identified residents who meet the study's inclusion criteria and who are able to give informed consent and participate. Managers asked residents for their agreement to meet with a study researcher who would propose that they participate in a study on the impact of COVID-19. If a resident or a family member agreed to participate, the ward manager communicated that information to the research team, who then organised an interview with the older adult. Potential participants were given a period of reflection before having to provide their consent to participate.

The recruitment of LTCF healthcare and support staff took place after presentations on the study made by the main investigator at their places of work. They were also given a period of reflection before having to provide their consent, and interested staff communicated their agreement to participate to their ward managers. The main investigator organised a focus group in each participating establishment in partnership with the ward managers.

3.4 | Data Collection

Data were collected between March 2021 and February 2022. We were among the first researchers to return to Switzerland's LTCFs after the pandemic. With preventive measures still in place, the tense situation in LTCFs remained palpable. The project was completed despite the difficulties linked to our access to participating establishments linked to COVID-19's successive waves in 2021. Nineteen individual face-to-face interviews, lasting 30 min on average, were conducted with residents and family members by a research team member. The interview guide, exploring the stressors experienced in relation to the five variables (psychological, socio-cultural, physiological, developmental, and spiritual), the coping strategies used, and the perceived results, was inspired by the Neuman Systems Model (Neuman and Fawcett 2011). Details of the interview guides can be found in the following Table 3:

Six focus groups involving a total of 36 healthcare and support staff occurred between 4 August 2021 and 23 February 2022. Another interview guide following the same logic as that for residents and their families and inspired by the Neuman Systems Model (Neuman and Fawcett 2011) was used for focus groups (Table 3). To recruit nurses for the focus groups, we left a PowerPoint presentation in each LTCF. Those interested and meeting the

TABLE 2 | Participant selection criteria.

	Inclusion criteria	Exclusion criteria
Resident	• > 65 years old and resident in an LTCF • Having lived during the pandemic in the LTCF • Man or woman • Capable of discernment • Able to speak and understand French	• Presence of an irreversible major neurocognitive disorder
Family member	• Designated by the older adult as their most significant family member[a] • Capable of discernment • Able to speak and understand French	
Healthcare and support staff	• Has worked in the LTCF ward for > 3 months • Has had close links with the older adult and their family member	• Part-time employee • Students

[a] The present study defines 'significant' family member as the person who is regularly present for the older adult, supports them, and is involved and/or interested in their care.

TABLE 3 | Interview guides.

	Questions
Resident and Family Members	• Can you tell me what you find most stressful about the changes generated during this pandemic [psycho-social, physiological, developmental, and spiritual variables]? • What strategies were used to cope with [name the stressor]? • What were the results obtained with [name the strategy]?
Healthcare and support staff	• Can you tell me what stressors experienced by the residents and their family members that you perceived [psycho-social, physiological, developmental, and spiritual variables]? • What strategies were used to help residents and their family members cope with [name the stressor]? • What were the results obtained with [name the strategy]?

inclusion criteria (Table 1) then announced themselves to their unit manager, who forwarded the information to the research team by e-mail. The FGs were organised directly in the establishments and counted as working time. The consent form was signed before the group began. An anonymous information sheet was also filled in to collect socio-demographic data prior to the focus group. The group was led by two researchers, one of whom facilitated the session and the other observed the group.

The questions sought to explore staff perceptions about the stressors experienced by LTCF residents and their families, the coping strategies they observed, and the results obtained. The mean focus group duration was 1 h 30 min, and each was audio recorded.

Researchers also took field notes describing the different LTCFs, the focus groups, and the interviews themselves (e.g. participants' lived emotions and personal reflections) (Fortin and Gagnon 2016; Larivière and Corbière 2014). Furthermore, the researchers also kept a logbook of all the decisions taken throughout the study, particularly during the data analysis stage (Fortin and Gagnon 2022).

3.5 | Data Analysis

Digital audio data from the interviews and FGs were fully transcribed into a Microsoft Word 365 Pro plus file. Data were analysed using MaxQDA qualitative analysis software. Data were analysed thematically by systematically identifying and analyse units of meaning that emerged from participant's discourse (Paillé and Mucchielli 2008) The concepts of Neuman system model (ref) have been used to categorise them into themes and sub-themes. Two research team members, who collected the data, then conducted a thematic analysis. Data were aggregated by these researchers, and a third team member helped to finalise that aggregation. At the end of this stage, themes and sub-themes were identified and presented with verbatims.

3.6 | Validity, Reliability, and Rigour

Several strategies put forward by Larivière and Corbière (2014) were implemented to ensure the study's validity and reliability. Its internal validity was ensured by triangulating data from different sources, such as sociodemographic characteristics, data from the different participants, the logbook, or the field notes. The study's construct validity was ensured by the research team's use of a validated theoretical framework to define its concepts and the rigorous documentation of its different stages in the aforementioned field notes and logbook. Data reliability was ensured by fully audio-recording and faithfully transcribing each interview and FG. Data were analysed by the two principal investigators in planned work sessions with the participation of a third, independent researcher with expertise in qualitative research methodologies to ensure data reliability further. The investigators also rigorously documented the entire data analysis process (e.g., code definition and decisions made). Finally, external validity was improved by using a purposive sampling method that provided a diversity of participants.

3.7 | Ethical Considerations

The Human Research Ethics Committee of the Canton of Vaud approved the study on 14 December 2020 (Project Number: 2020-02397). Participation in the study was always voluntary.

4 | Findings

The mean participating older adult resident's age was 86 years old. All the residents described their relationship with their close family members as excellent. Two residents' (R1, R7) close family members came every day. Table 4 presents residents' characteristics.

The mean close family member age was 69. Half of these close relationships were conjugal (wife/husband) and half were filial (daughter/daughter-in-law). One close relationship involved the resident's legal guardian (FM 11). Most of the participating close family members were women (9/11), and every family member also described their relationship with their resident as excellent. Four of the close family members (FM 4, FM 5, FM 6, and FM 7), all spouses, stated that they came to visit their residents every day. Table 5 presents family members' characteristics.

The majority of FG participants were women (33/36) and healthcare staff (27/36). The support staff were mainly activities assistants (6/36), members of housekeeping staff (3/36), and one cook. Table 6 presents FG participants characteristics.

4.1 | Results

The thematic analysis of the verbatim transcriptions from the FGs and the other participants' interviews enabled the investigators to summarise the data into three principal themes. One of these themes relates to the stressors faced by LCTF residents and their families, two themes highlight the strategies used by residents, their families and professionals providing care. Figure 1 presents the resulting themes.

TABLE 4 | Residents' characteristics.

Resident	Sex	Age	Length of stay	Cognitive disorder
R1	Woman	89	1 year	ND
R2	Woman	89	3 years	Mild
R3	Woman	81	2 years	Mild
R4	Woman	98	1.5 years	ND
R5	Man	78	4 years	ND
R6	Woman	93	4 years	Mild
R7	Woman	79	3 years	ND
R8	Woman	83	8 years	None

Abbreviation: ND, not diagnosed.

The verbatims presented below are annotated to identify the participant according to whether they are a resident of the LTCF (R), a family member (FM), a healthcare or support staff. For the latter, in addition to the identification of the focus group (FG), the profession is specified: nurse (RN), certified nurse assistant (CNA), member of the animation staff (AS), and member of the housekeeper staff (HS).

4.2 | Resident and Close Family Member: Separated and Suffering

The first theme refers to our examination of the stressors experienced by residents and their family members. It highlighted how the pandemic separated or put distance between the partners in the 'resident–family member' dyad. That separation caused suffering on both sides. However, that suffering expressed itself differently depending on whether the participant was inside an LTCF (residents) or outside it (family members).

4.2.1 | The Overall Suffering of Residents

The gravity of the pandemic's physical and psychological consequences, the solitude associated with lockdowns and being confined to one's room, and the general tension existing in LTCFs were all sources of significant suffering for residents.

The residents were conscious of the COVID-19 pandemic's seriousness. They noticed the greater number of deaths in the establishment they were living in, and they had access to news in the media. To begin with, however, residents had found it hard to grasp the scale of what was occurring. 'It was something hard. Me, to start with, I couldn't believe it.' (R5). However, 'By seeing it, and above all hearing about it every day, and at all times, at every moment, nurses talking about COVID-19, through hearing them, it struck home.' (R2). Once the gravity of the situation was understood, 'For me, it had to be something like the plague that our parents talked to us about.' (R2). 'Several residents told me that it was worse than the War, and that struck me, because I told myself that maybe it is worse than war.' (CNA_FG3).

In most interviews, residents evoked growing fears linked to death and a lack of understanding of the virus. For some, it was the fear of dying, despite their old age: 'And I see myself as a youngster, despite being about eighty, over seventy, but...the thing is, you don't want to croak...' (R5).

The measures taken to protect residents involved the closing of LTCFs to visitors and the majority of 'non-essential' staff. Residents were also sometimes confined to their rooms. Those confinements were widely compared to imprisonment, and numerous residents and family members mentioned it. Being shut away cut residents off from routines and traditional celebrations that had previously provided some rhythm to their lives, leading to a loss of social relations with their families. 'We don't know until when it will last, because we can't do Christmas, we can't do Easter, we can't do all the… all the things that were planned.' (R1).

Confinements also generated feelings of solitude among residents, not only linked to the lack of visits and contacts within their LTCF but also to factors associated with a lack of affection, social isolation, feelings of abandonment, boredom, and the overall weight of the situation. Some residents also felt powerless at being unable to support their loved ones. Solitude caused several to withdraw into themselves, to lose drive and desires, to become resigned to the situation, sad, or even to lose hope.

TABLE 5 | Family members' characteristics.

Family members	Sex	Age	Relationship with resident
FM1	Woman	51	Daughter
FM 2	Woman	82	Wife
FM 3	Woman	65	Daughter
FM 4	Woman	77	Wife
FM 5	Woman	78	Wife
FM 6	Man	78	Husband
FM 7	Woman	59	Daughter
FM 8	Woman	77	Wife
FM 9	Woman	56	Daughter-in-law
FM 10	Female	70	Daughter
FM 11	Man	71	Guardian

Staff highlighted how this period of exceptional isolation had psychological and physical consequences on residents: 'We observed losses of weight.' (RN_FG3); 'people with skin problems' (RN_FG5); losses in motor capacities, 'Yes, she doesn't walk anymore, or extremely little.' (FM 1). Residents themselves noted their loss of mobility: 'But I noticed it straight away. I can't go as far anymore.' (R4). One family member confirmed this: 'I realized that he'd gotten a bit weaker because he had a bit more trouble walking.' (FM 8). For another family member, life was coming to an end: 'She's gotten thinner. She was all pale… life… her life was ebbing away.' (FM 4).

Changes in residents' psychological states manifested themselves as worsening cognitive disorders, even forgetting their family member's face: 'He was there, but then he got really confused. He hadn't recognized me, it's true.' (FM 2). Changing psychological states also manifested as disinterest: 'So, I thought that it must be tough for him because he wasn't interested in anything anymore.' (FM 2). Staff had observed this in some residents: 'Some people just let themselves pass away because they couldn't see their children anymore. Life no longer had any meaning. That was the only thing that was keeping them alive.' (AS_FG5).

All the protective measures implemented changed the atmospheres in our participating LTCFs, generating tension. First,

TABLE 6 | Characteristics of the healthcare and support staff participating in focus groups.

Focus group	Sex	Position
FG1	2 men 2 women	2 registered nurses 2 nurses
FG2	8 women	4 nurses 1 member of the animation staff 2 certified nursing assistants 1 housekeeper
FG3	6 women	2 registered nurses 1 licensed practical nurse 1 certified nursing assistant 1 housekeeper 1 member of the animation staff
FG4	6 women	3 registered nurses 1 ward head nurse 1 certified nursing assistant 1 licensed practical nurse
FG5	4 women 1 man	2 registered nurses 1 member of the animation staff 2 housekeepers (including a cook)
FG6	7 women	3 members of the animation staff 1 ward head nurse 3 registered nurses

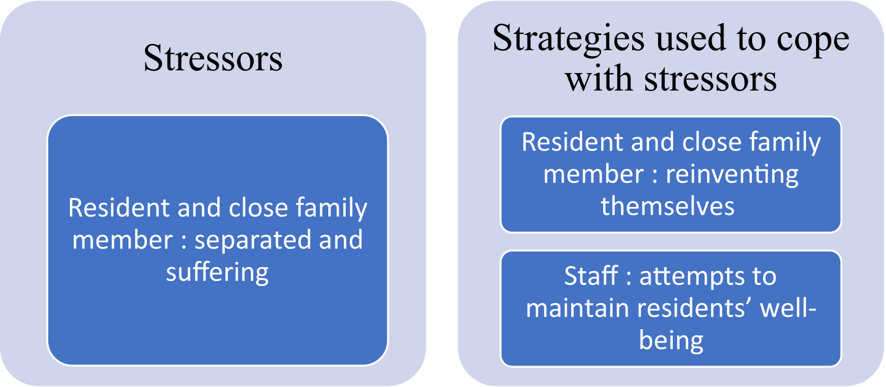

FIGURE 1 | Themes emerging from the analysis.

tensions grew over the most visible changes of visiting restrictions and the impossibility of eating with other residents in the dining hall (FM).

These tensions also provoked irritation, anger, and distrust in the general atmosphere generated by the pandemic, specifically the atmosphere of forced cohabitation within LTCFs. Indeed, staff spoke about the anger felt by certain residents. Even reminding residents about the new instructions they had to follow and the restrictions in place caused inter-personal tensions: 'It was quite complicated to make sure that measures were respected, and it led to conflicts. They held us responsible for political decisions made higher up.' (RN_FG5).

4.2.2 | The Overall Suffering of Family Members

The loss of precious time with residents and the lack of information were sources of overall suffering for family members. That suffering expressed itself as anger, worry, sadness, and resignation. Suddenly, all visits were banned, and family members were kept apart from residents and powerless to play their roles as caregivers: 'Because he is waiting. He's waiting for me. I'm a bit like his reason for living, let's say, even if he's got children.' (FM 2).

> What was very, very difficult during this period, were the physical gestures that you couldn't make anymore, yeah? Taking somebody in your arms, for me, for people like my mother, who doesn't speak anymore… I had the impression that it was something, as they say, vital."
>
> (FM 3)

Although most family members' statements were moderated, others expressed anger: 'Yes, I felt a sense of revolt. I also felt that I expressed that to… to the staff here.' (FM 3). Others were more tempered: 'I can't really say it was anger because I did understand the decisions, of course. I'd say it was more a form of injustice. I found it unjust. Well, firstly for them, but also for us.' (FM 1). That anger was also relayed in the testimony of some members of staff:

> We had families that rebelled against it all, that got angry. They came up to the facility's door. They threatened us with smashing the door in with their vehicle because… we were depriving them of seeing their parents, and then families were in tears in front of the door.
>
> (RN_FG1)

Not being able to see residents generated worry for family members, especially imagining them alone and isolated in their rooms. 'Yes, that was tough. The fact that I couldn't see my mother and not knowing how she was going to evolve – because she has dementia.' (FM 4). These worries were also linked to the fact that family members did not know what was going on inside LTCFs in general; they could no longer form their own conclusions about how residents were feeling, provoking further worries:

> 'Happily, it was very short. It was two, three days, eh? But it was worrisome… I imagined my mother all alone in that room (…) I imagined her all alone in that room, worried, sad. I just couldn't… yeah, it was crazy to think about it.'
>
> (FM 4)

The principal feelings this generated among family members were sadness and resignation. One even asked herself: 'But is she going to survive or not?' (FM 1). While residents said that there was no point living without their loved ones, their family members spoke of the lost time resulting from residents' isolation: 'So, I told myself that maybe I'd lost two and a half months of contact with my mother. COVID stole two months of contact with my mother.' (FM 7). The notion of lost time was also mentioned by a family member who came to visit his wife every day: 'For me, the most stressful thing was not being able to come and visit my wife. […] we'd never lived a day apart.' (FM 6).

Family members also mentioned the lack of information on how the pandemic was managed and restrictions were put in place. This was also reported by staff. What family members wanted from them was news about residents' daily lives and what they were doing. 'I would have liked someone to phone me, to say 'We did this today with your husband, all this and this…' But nothing' (FM5).

4.3 | Resident and Close Family Member: Reinventing Themselves

Family members and residents were confronted by an extraordinary situation. To cope with it, they tried to see the positive side of things and adapt.

4.3.1 | Facing up to an Extraordinary Situation

Inside LTCFs, residents had to face radical changes linked to nurses who suddenly had to dress 'like astronauts' (R8), were 'wandering around like ghosts, like green ghosts. They had green overalls [laughs]' (R2) and had to wear masks. Staff noted, 'It's not easy to be understood with a mask.' (AS_FG3). 'There were times when you were obliged to take it off and move back a little bit to speak, so that the person could understand, because they couldn't understand.' (RN_FG6).

Residents had to adapt to permanent changes in care staff, often part-time staff whom they did not know. On several occasions, residents had to explain how their care was usually given, and this made them feel uncomfortable:

> Well, because they had… For me, there should always be two of them to help me onto the toilet, to get me dressed (…). So, it hasn't been easy. And there were lots of people coming in from the outside. So, I had to explain it to them. Me, who's losing my bearings a bit [laughs].
>
> (R7)

Family members used technological means to maintain communication with residents. Some of them had trouble mastering these new tools, but most of them were appreciated. One family member even spoke of her exchanges with her mother becoming more intense: 'But, no. It went well. She asked me, 'But, how are you here? How can I see you?' Et cetera. So, and then we talked in a different way, maybe even probably a bit more than if we were face to face.' (FM 7). One resident mentioned that 'We used the mobile [telephone]. I had one that my grandchildren had given me. I'd hardly used it. So, I had to get into it.' (R2).

4.3.2 | Seeing the Positive Side

Residents and family members tried to see the situation from a positive angle. Several things helped them, including residents' living conditions and safe environments, the ability to maintain some contact despite the visiting bans, character traits that enabled them to see the positive side of things, and, finally, trust in the establishment and its staff.

LTCF environments and living conditions were resources supporting family members and residents. Nearly all family members spoke about the nice weather that contrasted with the first lockdown but allowed them to keep busy outside when possible. In the LTCFs, indoor areas and outdoor green areas (e.g., patios and gardens) were configured so as to contribute to improving residents' quality of life. 'We're lucky to have a big green park all around the establishment.' (RN_FG1).

The fact that residents continued to be able to have contact with their loved ones, despite the ban on visiting, was an important resource for residents as much as their family members. Even if that contact was judged insufficient, this resource was especially significant for the residents who were used to being visited by their spouses daily.

When participants were asked to describe the resources they had used to get through the pandemic, many responded something similar to, 'I don't know. It's part of having an optimistic character. It's in my genes, that's it.' (R8). For residents, that meant being thankful: 'I tell myself that you have to be thankful that we managed to get through this disease without too many deaths, without too many difficulties, well… So, I'm thankful…' (R1).

Family members evoked their trust in the care given to LTCF residents. They were obliged to trust in the staff and the care given to their relation, even if they sometimes had doubts: 'There were lots of things that I wasn't able to see […]. So, that's where you have to go with trust a bit.' (FM 7).

4.3.3 | Adapting

The sub-theme of adapting was related to the coping strategies mobilised by family members and residents to cope with the extraordinary situation at hand. These were essentially interpersonal resources such as focusing on one's own needs, accepting the reality of the situation, putting things into perspective, trying to remain somewhat detached so as to be able to live on day to day, and finding other things to do.

Some family members and residents tried to focus on themselves using prayer. 'Yes, by praying with all my heart, and by thinking about my family, who were well. I was happy that everybody was in good health, so that helped me.' (R1). They were obliged to accept the situation for what it was, even if that was difficult.

Reasons for accepting the reality of the situation were linked to the fact that everybody was facing the same thing and it was for the good of the residents. That did not stop it from being a very difficult experience to live through: 'My mother-in-law clearly understood this well because she has experienced so many tough things in her life. So she accepted it.' (FM 9).

Another resource mobilised by family members and residents was putting the situation into perspective by comparing it with something even worse. Residents thought back to situations they had lived through and compared them to the present: 'I thought a lot about when I was a boarder in a school in German-speaking Switzerland. But, well, that made me… I kind of almost had the impression of being a girl of that age again.' (R2).

Residents said that they got through this period fairly well because they lived day to day. The fact that they did not think about issues too much and just got on with things helped them to be less affected. The staff also revealed that, 'For some residents, forgetting was a defense mechanism.' (AT_FG6). Living day to day enabled the detachment necessary to, 'Get on with things, laugh, mess about. Messing about is good for you at our age.' (R5).

Family members and residents had to find alternative means of keeping busy during lockdown periods. Family members primarily went outside for walks in the sunshine. Residents, for their part, kept busy as best they could: 'I played Scrabble on my own. And I read a bit. I kept getting the newspaper. [...] Maybe we dared to take some telephone calls.' (R6).

4.4 | Staff: Attempts to Maintain Residents' Well-Being

To reduce the consequences of visiting restrictions and to maintain residents' well-being, staff developed several strategies – successfully in some cases. These strategies aimed to support residents, keep them informed, and reinvent their daily lives.

4.4.1 | Supporting Residents

Staff members put in place strategies to maintain normal life in LTCFs, residents' state of physical and psychological health, and their links with the outside world. Indeed, they realised that isolation had damaging consequences on residents' physical and psychiatric health, that action had to be taken and that active support had to be put in place, as one nurse described.

> We're going to lose them all, but not to the disease [COVID-19]; we're really going to lose them to depression, to sadness, and then they're all going to... they're all going to just slide away.
>
> (RN_FG1).

Staff members allowed residents to express their emotions and welcomed that. But for some residents, that was not enough. Staff were operating in a grey zone of prescribed protective measures, notably in the most severe cases and in end-of-life situations. For example, they were tolerant of certain 'behaviours', for example, letting a couple married for 60 years kiss each other.

Staff also tried to bring life back into their LTCFs, for example, by decorating the establishment's interior, organising a Christmas party, and doing activities such as writing letters to children in the local village school or to neighbours. One ingenious activities assistant made a film in the forest and showed it to each resident in their room. Staff members also tried to improve residents' daily lives and to maintain their autonomy by adapting their care (e.g., spending more time with them in their rooms) and recreational activities (e.g., noisier events and entertainment such as bingo or karaoke).

Despite these efforts, some residents let themselves slip away and died. Care staff had a lot of trouble finding strategies to support residents who were close to the end of their lives and their family members, as one nurse explained.

> It was a really difficult situation [...]. We put in place video links, but (...). We had to change strategy so that the family could come in to say goodbye [...]. A lot of effort was put into families, to help them accompany the dying. But the usual support services (24-hour family presence, the possibility of sleeping in the next room) aren't possible anymore.
>
> (RN_FG6).

4.4.2 | Informing Residents

Staff put in place a number of strategies to inform family members about the different measures put in place in their LTCFs, notably using emails and letters, more rarely using the telephone. They tried to ensure a certain coherence in the information provided and to organise things so that they were not submerged in individual requests by family members. Many LTCFs developed electronic means (dedicated internet pages or telephone applications for families, WhatsApp groups or videoconferencing) of communicating day-to-day information on daily life in their establishments.

These technological aids were mostly appreciated but did not benefit all residents. Indeed, using technological means to ensure videoconferences was impossible for residents with significant neurocognitive disorders who could not recognise their family members on a display screen.

4.4.3 | Communicating Differently

Staff – and participating residents and family members themselves – used several means to keep lines of communication open – largely the 'old-fashioned' methods, like the telephone and letters. But family members could also see their older adult relative if appropriate protective measures were installed. Depending on how their buildings were configured, LTCFs created '*plexiglas visits*' (FM 3) which are desks separated by transparent plastic panels, or '*visitation booths*' (FM 6), which are small outdoor cubicles. Separate offices were also used, as were visits that took place outside or on balconies. These visits were tightly controlled, however, with limits on the number of people allowed, in the locations possible (never in residents' rooms), and in duration (usually 20 min). Finally, using communication technologies was also an opportunity to see one another 'virtually'.

Some family members found seeing residents under these conditions to be trying, as described by this family member who admitted to having cried in the parking lot.

> So, it was extremely difficult. And I had the impression that I was in a prison, and I was coming to visit [...] who was in prison. It was like a prison visitation booth. It's a terrible memory for me, and when I speak about it, I'm still...Yes, it really did shock me.
>
> (FM 9).

5 | Discussion

The present study, carried out after the COVID-19 pandemic's first wave, aimed to describe the stressors experienced by LTCF residents and their family members, together with the resources they were able to mobilise to cope, and the strategies developed by healthcare and support staff to support them. Faced with the pandemic's unique characteristics, it seemed important to put all these different elements into perspective for a deeper understanding of the situation, notably the lived experiences of older adult LTCF residents and their close families.

The COVID-19 pandemic's sudden onset and virulence led Switzerland's health authorities to implement drastic measures to protect the country's vulnerable populations, including older adults living in LTCFs. These include personal protective measures (e.g., masks and overblouses) and strict confinement within establishments, plus prohibitions on and then restriction to visits by residents' family members.

Firstly, the protective measures implemented exposed LTCF residents and their families to various types of stressors which were experienced differently and generated suffering. For residents, new health measures imposed significant changes in routines (e.g., no or fewer shared mealtimes, recreational activities, or traditional celebrations) that led to less social contact, both within establishments (e.g., confinement to rooms, no recreational activities or seeing friends) and from the outside with families (e.g., no visits from family members). These changes were intra-personal, inter-personal, and extra-personal stressors that had real effects on residents' health.

The present study's results emphasised both the physical (e.g., loss of mobility, reduced cognitive skills) and psychological (e.g., fear, feelings of powerlessness, sadness) impacts linked to different stressors, as did findings described by Saad et al. (2022). Indeed, several studies have mentioned similar results, such as upsurges in the symptoms of anxiety and depression linked to separation and social isolation (Ayalon et al. 2021; Crespo-Martín et al. 2022; Huber and Seifert 2022; Kaelen et al. 2021; Noten et al. 2022; Van der Roest et al. 2020), as well as drops in the level of cognitive (Freedman and Nicolle 2020; Santini et al. 2020) and physical (Danilovich et al. 2020; Pérez-Rodríguez et al. 2021) function. Some studies also established direct links between the protective measures implemented and reductions in residents' well-being (health) (Ayalon et al. 2021; Crespo-Martín et al. 2022; Kaelen et al. 2021). The present study also highlighted how changes in some residents' well-being led to them progressively losing interest in life. In similar contexts in France, Nabarrot, Piazza, and Chandon-Piazza (2022) have recently (and controversially) termed this 'sliding away syndrome', describing it as the final, weak act of resistance to death. Contrary to the present work, it is interesting to underline that the other studies available have given very little attention to the impact of sociocultural stressors (e.g., cessation of common mealtimes and recreational activities) within LTCFs.

Whereas the LTCF residents in the present study spoke of a difficult period, their family members and healthcare and support staff described those older adults' lived experiences of suffering. This phenomenon may be linked to the fact that the moment older adults move into an LTCF, they have to adapt to daily routines (Wiersma 2012). Nevertheless, our findings showed that some residents (and family members) would have liked to have had a choice about whether or not to maintain visits by their loved ones. Being conscious that they were in the last phase of their lives, most residents did not want to lose more precious time away from their families (Noten et al. 2022). Indeed, Paque et al. (2018) showed that the loss of self-determination accentuated feelings of solitude among LTCF residents, leading to feelings of despair, depression, and even anger when they had to remain 'locked up' when life outside the establishment was getting back to normal. Restrictions on social contact (e.g., visits, confinement to one's room) meant to protect LTCF residents created tensions about their autonomy and rights to choose for themselves (Vickery et al. 2023). Even during a pandemic, older adults' chronological age should not be the only criterion considered when imposing protective measures, as Ayalon et al. (2021) revealed. It is also important to consider the complexity of health situations and the presence of multiple risk factors when trying to limit the negative impacts of protective measures.

Finally, the present study's findings showed that some residents also fulfilled the role of family caregiver to the person who usually came to visit them. One resident was very worried about her daughter with a disability, who came to visit her every day before the lockdown. Residents can maintain the roles they play for family members outside the establishment. Significant family events and milestones, and the importance of the family unit and the roles that each member plays in it, are essential (Duhamel 2007).

Regarding family members, the present study showed that bans on visiting residents and thus the impossibility of fulfilling their role as a close family caregiver allied with the LTCF were inter-personal stressors that led to significant psychological repercussions. Given the relative time that older adult LTCF residents might have left to live, their family members described the visiting bans as unjust. Noten et al. (2022) wrote about how 'precious time together was taken away'. Veiga-Seijo, Miranda-Duro, and Veiga-Seijo (2022) added that this had an important impact on families' well-being. Family members in our study reported being disconnected from their older adult relative in the LTCF, which generated worry and uncertainty. For residents with neurocognitive disorders, Kusmaul, Miller, and Cheon (2022) showed how an absence of contact and communication between residents and their loved ones led the latter to have negative feelings about being unable to ensure their relation's needs were being correctly met, also because they could not participate in that care. Chu, Yee, and Stamatopoulos (2022) described how family members felt 'locked out' of LTCFs.

Despite the supplementary means of communication made available (e.g., videoconferencing), family members emphasised that they could not take the place of their presence and physical contact with the resident. Smaling et al. (2022) made a similar point, noting that this was all the more problematic when residents have severe neurocognitive disorders. Indeed, the present study showed that family members who regularly visited LTCF residents were also caregivers. They ensured that the resident received the appropriate care, helped to identify the causes of some behaviours, maintained family ties, and participated in care (e.g., being present at mealtimes and keeping the older adult busy or entertained). Ickert, Stefaniuk, and Leask (2021) also showed that family members' support to residents contributed to maintaining their mental health. Studies carried out during the COVID-19 pandemic on the impact of visiting restrictions on family members reminded us how essential their contribution is ensuring residents' quality of care and quality of life and maintaining social links (e.g., holding hands, recalling common memories, establishing links with children and grandchildren) that cannot be reproduced by the care provided by LTCF healthcare and support staff (Hindmarch et al. 2021; Kusmaul, Miller, and Cheon 2022).

Secondly, despite their exposure to stressors, LCTF residents and their family members mobilised strategies to cope with the stressors to which they were exposed related to the five variables. LTCF residents' strategies were mainly linked to accepting the situation and reinterpreting certain elements to see the positive side. These strategies allowed them to overcome their feelings of isolation linked to visiting bans and the cessation of any recreational activities. When dealing with being confined to the LTCF, Crespo-Martín et al. (2022) also found that social support, spirituality, and gratefulness helped. Regarding family members, they had to deal with distance and find strategies enabling them to lower the emotional tensions the situation induced. Indeed, Mitchell et al. (2022) described how family members had to trust in LTCF staff and appreciated their efforts toward maintaining a minimum level of contact.

LTCF staff were unprepared for dealing with the COVID-19 pandemic. As it evolved and guidelines and ordinances were issued by the public health services, staff had to adapt continuously to the changing protective measures against the disease. Healthcare and support staff did their best to ensure residents' quality of life by adapting care and institutional organisation. Giri, Chenn, and Romero-Ortuno (2021) described the implementation of similar strategies in LTCFs. Neuman's model emphasises the importance of exploring stressors as experienced by LTCF residents and their families and their coping strategies. Based on this understanding, professionals could optimised and personalised primary and secondary prevention interventions in partnership with residents and families (Neuman and Fawcett 2011). This is particularly useful in critical situations such as pandemics, as it allows resources to be allocated appropriately.

Staff in the present study implemented strategies to support residents and their family members and to maintain links between them. Those strategies generally involved combining information given to all residents and family members about updated protective measures with specific information on a resident's health. In most LTCFs, this involved designating a contact nurse, as in the study by Veiga-Seijo, Miranda-Duro, and Veiga-Seijo (2022).

At the same time, numerous initiatives were taken to maintain contact between residents and their family members through real-life visits behind plexiglass screens, telephone calls, and letters. Several more technological means of communication were used to reduce residents' feelings of social isolation (e.g., videoconferencing). However, these methods were not successful with every resident, especially those with severe neurocognitive disorders. Indeed, Giri, Chenn, and Romero-Ortuno (2021) wrote of the importance of developing guidelines for introducing such technologies into LTCFs to ensure their optimal use with residents in the future.

Some of the LTCF healthcare and support staff in the present study ‘adapted’ official protective measures to enable the presence of family members, especially in end-of-life situations. Also, the COVID-19 pandemic showed the need for a deep reflection on how LTCFs are designed, organised, and operated, as well as how to adapt public health emergency policy to the populations who live in them (Giri, Chenn, and Romero-Ortuno 2021).

5.1 | Implications for Practice

This study brought significant new knowledge on the stressors experienced by LTCF residents during the COVID-19 pandemic, notably by emphasising that sociocultural and spiritual stressors. Whatever the reason for resident isolation measures, LTCF must ensure that they are justified, documented, meet proportionality requirements and are based on available scientific evidence. Indeed, nurses play essential roles in identifying the stressors experienced by older adults in complex situations and, consequently, the necessary adaptations to the care provided. Furthermore, the study's findings support the important roles of family members. During the pandemic, they were banned from visiting residents who were living through very difficult times – times when they could have been a stimulating and comforting presence. Where there to be a new pandemic, our findings suggest the importance of somehow ensuring the presence of close family members. Nevertheless, it is important to note that even if people are living in LTCF, relatives are an integral part of residents' lives, and at no time should they be prevented from visiting, especially if the resident is at the end of life. Furthermore, innovative nursing and inter-professional interventions should be developed to ensure the health and quality of life of residents and their families. Finally, the present study's results suggest avenues of research for developing partnership strategies within inter-professional teams, especially via the use of new technologies.

5.2 | Limitations

Because of the ongoing health protection measures, the research team was unable to interview residents and their family members during the lockdown – which took place about 6 months later. This is a limitation as participants may have forgotten some important details linked to their experiences of those protection measures, or their memories may have changed over time. Finally, when our participating LTCFs reopened, numerous residents died of COVID-19, and it is impossible to exclude that only the least fragile residents, physically and psychologically, participated in our interviews.

6 | Conclusion

The present study's findings described the consequences of the stringent protective measures implemented during the pandemic and emphasised their effects on long-term care facility (LTCF) residents and their close family members and how they were linked to different types of stressors. Healthcare and support staff implemented interventions that effectively supported residents' physical and psychological health. Indeed, it would be pertinent to identify and analyse the effects of the interventions to be able to propose them to LTCFs when a new pandemic breaks out. Furthermore, staff used digital technologies to help residents and their family members maintain a minimum of contact with each other. Nevertheless, these were not necessarily appropriate for some residents, and they could not compensate for the loss of physical contact experienced. Guidelines should be developed to facilitate the introduction of these technologies into LTCFs and their use by residents and staff.

The fact that LTCF residents and their family members were not consulted before decisions were taken to lock them down – to say nothing of their healthcare and support staff, especially nurses – may be among the reasons that these decisions had such significant repercussions on residents' quality of life. After the pandemic, nurses will have an essential role to play at the policy level to report on the lived experiences of residents and their close family members as well as on the ethical dilemmas they had to cope with. Nurses should also take part in reflections, including at the national and international levels, to learn lessons and draw conclusions about the pandemic and participate in writing recommendations for dealing with the next one. Nurses have the capacity to identify critical situations affecting LTCF residents and to participate in proposing solutions.

Author Contributions

Study design: C.O.B., C.C., M.A. Data collection: M.A. All the authors contributed to data analysis and interpretation, study supervision and writing the manuscript.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data available on request from the authors.

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