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RESEARCH ARTICLE

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Working in a Dutch nursing home during the COVID-19 pandemic: Experiences and lessons learned

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Abstract

Aims: To gain insight into how direct care staff in Dutch nursing homes experienced work during the COVID-19 pandemic.

Design: A qualitative study consisting of semi-structured, face-to-face focus groups was conducted using "the active dialogue approach".

Methods: Participants ($n = 29$) were care staff from four care teams at Dutch nursing homes. Teams were selected based on the number of COVID-19 infections amongst residents. Data were analysed with conventional content analysis.

Results: Themes emerging from the data were the loss of (daily) working structure, interference between work and private life for direct care staff, the importance of social support by the team and a leader, and the effects on relationship-centred care of the measures. Results offer concrete implications for similar situations in the future: psychological support on-site; autonomy in daily work of care staff; an active role of a manger on the work floor and the importance of relationship-centred care.

KEYWORDS

dementia, long-term care, management, nursing staff, relationship-centred care

1 | INTRODUCTION

Older people living in nursing homes seem to be at particular high risk of severe courses of COVID-19 and seem to suffer from an increased related mortality (Dichter et al., 2020). First, estimations from European countries suggest that between 19% and 72% of all people who died from COVID-19 lived in a nursing home (Comas-Herrera et al., 2020; Verbeek et al., 2020). At this moment, the COVID-19 pandemic is still ongoing. To prevent and reduce the number of infections, nursing homes have taken very restrictive measures that have changed the way of living and working in nursing homes. Examples are bans on visitors and volunteers, isolation of residents, reduced contact time between residents and direct care staff, as well as restrictions or bans of medical and allied health professionals (Schols et al., 2020). Nevertheless, as of 27 October 2020, estimations of electronic resident files indicate that 15,987 residents in Dutch nursing homes (had) suffer(ed) from (suspected) COVID-19, of which 2,219 residents have died and 3,154 have recovered (Verenso, 2020). In addition, direct care staff members who spend much time with infected residents, often without wearing personal protective equipment (PPE), have also become ill or have died. In the Netherlands (until October 2020), 18% (total number 34,376) of the persons infected with COVID-19 and 1.8% (total number 14) of COVID-19 fatalities were reported to be care staff (RIVM, 2020).

In March 2020, the World Health Organisation (WHO) recommended that healthcare workers should not only wear PPE but should also be properly trained in how to put it on, remove it and dispose of it (WHO., 2020). At the beginning of the pandemic, there was a critical shortage of PPE for front-line healthcare workers due to several reasons, such as problems within the global supply chain

(Ranney et al., 2020). The shortage led to the use of lower-grade equipment or even the reuse of equipment, which put care staff at higher risk for getting infected (McGarry et al., 2020).

2 | BACKGROUND

The long-term consequences for those who live and work in nursing homes are yet to be unveiled, and few studies on primary data exist. Anecdotal knowledge about current nursing home care provision suggests that direct care staff had to find a balance between restrictive infection control measures and the delivery of person- or relationship-centred care to maintain residents' social participation and well-being (Dichter et al., 2020). In 2020, care provision in nursing homes is ideally relationship-centred, which implies that the needs of the resident, the family and the needs of the care staff are taken into account (Nolan et al., 2004; van Stenis et al., 2017). The applied measures to prevent CODVID-19 infections violated the principles of relationship-centred care, as they put safety above individual needs. This not only had consequences for the residents who experienced loneliness and social isolation but also for care staff who wanted to provide personal and individual care to the residents (Gordon et al., 2020). The dilemma of safety versus quality of life which care staff experiences in nursing homes has been reported before (Preshaw et al., 2016). Additionally, immense psychological burdens due to a mix of workplace stressors and personal fears affect care staff's well-being (Tan, Yu, et al., 2020).

As staff in direct care had little time to prepare for the pandemic and had to adapt to changes in their way of working quickly, the long-term mental and physical impact on staff is expected to be huge. More than ever, long-term care organizations are being forced to invest in the health and well-being of their employees. It is well-known that direct care staff are in the "line of fire" and play a key role in facing the pandemic (Rosa et al., 2020). First indications from hospital settings highlight the impact of the pandemic on the employment and the mental health of the direct care staff and the quality of care (Halcomb et al., 2020; Spoorthy et al., 2020). To enable staff to stay healthy, keep them at work and support their well-being, organizational and governmental support (e.g. a clear testing policy, sufficient PPE and employment conditions) seem indispensable. To guarantee the sustainable employment of direct care staff, it is important to have an understanding of the work-related issues which they face during the COVID-19 pandemic.

The aim of this study was to provide insight into how staff members experienced work during the pandemic.

3 | METHODS

3.1 | Study design

In June 2020, a qualitative study was conducted in which data were collected by means of focus groups using "the active dialogue approach".

3.2 | Participants and research context

Participants were employees from four different teams located at three nursing homes that are part of a Dutch long-term care organization. All team members were verbally invited by their team manager to participate. Participation was voluntary and was held during their working hours.

Nursing homes in the Netherlands provide long-term residential care for people with dementia and/or severe physical disabilities and short-term skilled care for rehabilitation or subacute conditions (Backhaus et al., 2018). The educational level of direct care staff varies. Most care is provided by certified nurse assistants (CNAs), with 2–3 years of education. These CNAs are comparable to licenced practical or licenced vocational nurses in the United States (Verkaik et al., 2011). In addition, there are also nurse assistants or nurse aides, as well as some uneducated staff members. Often, the lowest percentage of care is provided by vocationally trained or baccalaureate-educated registered nurses (Buljac-Samardzic et al., 2016). Unique to the Netherlands, nursing home medical specialists provide medical care for nursing home residents. These medical specialists as well as all associated health professionals (e.g. physiotherapists, psychologists, occupational therapists) are employed by the nursing home.

During the lockdown period in the Netherlands, nursing homes applied several measures to prevent COVID-19 infections (Verbeek et al., 2020). Examples are as follows: visitors were not allowed access, direct care staff was not allowed to switch between wards and residents were not allowed to leave their ward, infected residents were isolated in their own room (except for residents with dementia), group activities were disallowed if the 1.5 m distance rule could not be kept and new residents were isolated until they were free of any symptoms.

Teams were selected by using a purposeful sampling method (Suri, 2011). Based on the number of COVID-19 infections among residents, the healthcare organization selected four teams. In the ward shared by two teams, no residents were infected, while in the other two wards many residents got infected and died. In Table 1, the participants of each team are described.

3.3 | Data collection

Data were collected by means of four semi-structured face-to-face focus groups in June 2020. A topic list based on the principles of the active dialogue technique developed by ZozorgIk was used to structure the focus groups (Table 2). This technique focuses on participants sharing experiences within a dialogue. The underlying philosophy of the active dialogue approach is appreciative inquiry. Within appreciative inquiry, people are engaged to produce effective and positive change (Cooperrider & Srivastva, 1987). Questions asked during the dialogue were equal for all participants and the participants were able to determine the main content of the discussion.

Two independent professionals (first author and an external team coach) organized the focus groups that lasted on average 120 min and

TABLE 1 Team characteristics

Team	CODIV–19 infections	Participants
Team A	No infections	Four certified nurse assistants
		One baccalaureate-educated registered nurse
		One manager
Team B	COVID- 19 infections	Four certified nurse assistants
		One vocationally trained registered nurse
		One occupational therapist
		One manager
Team C	COVID- 19 infections	Two certified nurse assistants
		One baccalaureate-educated registered nurse
		One vocationally trained registered nurse
		One nurse assistant
		One activity staff member
		Job title not reported
Team D	No infections	Four certified nurse assistants
		Three vocationally trained registered nurses
		One manager

TABLE 2 Guiding questions

1.Introduce yourself: who are you and which photo did you pick and why?
2.What have been your personal experiences during the COVID–19 pandemic?
3.Which event touched you the most?
4.Looking back at the past months, what do you wish for the future?
a.Is there something you would like to keep for the future?
b.Did you learn something new (for instance a new way of working or an innovative idea)?

took place at the nursing home location. The team coach led the discussion, and the researcher took detailed notes and verified that all topics were covered. After the session, the notes were sent to the participants for a member check (Thomas, 2017). Additional remarks of respondents were included in the notes. Detailed notes were preferred over audiotapes to ensure a safe atmosphere for the participants.

To start the dialogue, a photo elicitation technique (Harper, 2002) was applied in which participants had to select one or two photos (out of 50) that best reflected their experience during the COVID-19 pandemic. Examples were photos of a beach, a rollercoaster, a mule, a sunflower, an orange fruit, a candle or a soccer team. The idea behind using photo elicitation in interviews is that the participants are likely to respond differently when using images instead of only words. When triggered to combine images and words, respondents are more likely to unveil their true views and beliefs (Harper, 2002; Sion et al., 2020).

3.4 | Data analysis

Data analysis was based on the detailed notes gathered in all four focus groups. In the analysis, respondents' explanations of why they chose specific photos were analysed. Conventional content analysis was used to acquire a descriptive presentation of the qualitative data (Hsieh & Shannon, 2005). This is a systematic approach to code and categorize qualitative data to determine trends and patterns (Grbich, 2012; Mayring, 2004). Content analysis is reported to be well suited to analyse multifaceted phenomena in nursing (Elo & Kyngäs, 2008; Vaismoradi et al., 2011).

By reading the notes multiple times, the authors gained a deeper understanding of the data. The first author identified key concepts by means of open coding. These codes consisted of a few words or short sentences. The emerging concepts were summarized in a code tree and the codes were then integrated into central topics. The code tree and the central topics were discussed within the research team. Differences were resolved and adjusted throughout the whole process of data analysis. The data were analysed with MAXQDA version 20.0.8 software (MAXQDA., 2020).

3.5 | Rigour

Different strategies were applied to enhance study rigour. Due to purposive sampling, the views of staff members of teams that differed with regard to the number of COVID-19 infections among residents could be compared (Barbour, 2001).

Space triangulation (i.e. data collection among teams working in different sites to test for cross-site consistency) led to richer insights into the research topic (Polit & Beck, 2008). Verification by participants was reached through a member check. The coding process and clustering of data were cross-checked within the research team, leading to a refinement of the coding frame (Barbour, 2001). The COREQ (COnsolidated criteria for Reporting Qualitative research) Checklist was used (Tong et al., (2007).

3.6 | ETHICAL CONSIDERATIONS

According to Dutch law, approval from an ethics committee was not needed, as no residents were involved (http://www.ccmo.nl/en/your-research-does-it-fall-under-the-wmo). Verbal and written consent for participation were obtained before the focus groups took place. At the start of each focus group, the researchers emphasized that participation was voluntary and that all answers would be treated with strict confidentiality. Respondents received an information letter and were able to withdraw at any time. All respondents signed the informed consent; there were no withdrawals. No audiotapes were made and all data were analysed anonymously.

4 | RESULTS

In total, 29 care staff from four different teams located in three nursing homes participated in the focus groups (Table 3).

The results of the photo elicitation highlighted the variety of experiences during the COVID-19 lockdown. The chosen photos showed that each team experienced the lockdown in a different way depending upon the situation on the ward. Participants from wards without infections mainly selected photos that expressed positive feelings, such as hope, closeness and taking care of each other. For example, one participant selected a photo of a beach because the past weeks felt like a vacation, her way of working did not change and, in her ward, it was quiet, "while in the rest of the world it was the opposite". Participants working on wards with COVID-19 infections experienced the opposite. They mainly selected negatively associated photos, such as the photo of a mule (as the pressure at work got higher and higher and the participant felt like a "fully packed mule").

From the conventional content analysis, four major themes emerged that dealt with how participants experienced work during the pandemic and how their way of working had changed (Table 4): loss of (daily) structure, work and private life interference, social support and relationship-centred care.

4.1 | Loss of (daily) structure

Regarding the loss of daily structure and routines, participants mentioned that there was an overall reduction in administrative tasks and an increase or decrease in the level of stress, depending on whether there were infected residents on the ward. During the lockdown, a majority of administrative (often mandatory) tasks were no longer necessary or allowed, for instance team meetings or training. All participants reported that they perceived that they had more time for one-on-one activities with the residents (e.g. more attention to personal hygiene or individual conversations). They suggested for the future to minimize the number of administrative tasks in order to reserve more time to spend with the residents and for primary care delivery tasks. Furthermore, participants proposed organizing short, informal evaluation moments instead of mandatory large-scale team meetings. During the lockdown, the short evaluation moments were considered effective and an improvement in the quality of work.

Participants who worked on wards without infected residents experienced a quiet and peaceful atmosphere. They felt that the peaceful atmosphere on their ward was in contrast to the hectic COVID-19 related events outside the nursing home. In addition, they reported to have more time to spend with the residents. Some participants mentioned that residents with dementia were less agitated, which resulted, according to them, in lower administration of psychotropic drug use.

Participants working on wards with infected residents experienced a stressful period. The loss of daily structure, ambiguous communication about new measures and additional tasks, such as wearing protective equipment and top-down decision-making, contributed to a stressful work atmosphere. The new measures and restrictions caused a loss of structure and daily routines. On top of that, the frequency of new measures and communication (for instance via e-mail) about the application of these measures caused insecurity and uncertainty. One participant expressed that the measures and guidelines changed so quickly that this caused confusion among the care staff. Communication about new measures and guidelines took place via e-mail, without the opportunity to ask particular questions, which caused insecurity.

> *"Everybody* [of the team] *gets the same e-mail* [with instructions] *and it* [the rules and measures] *is still unclear."* (Participant of team C)

Participants also expressed that in order to integrate new measures and guidelines in the most fitting way into their daily work processes, they wanted to be part of the decision-making process. According to them, new measures and guidelines would then be less disturbing. They felt this would make the application of new measures and guidelines more efficient and comprehensible for direct care staff.

4.2 | Work and private life interference

Regarding work and private life interference, participants reported that a fear of infection, social isolation and loneliness, and an increase in stress were factors that had a significant impact on their personal and working lives. All participants mentioned that they had taken home stress from work. Additionally, they reported that they had even fewer social contacts than others in society due to their awareness of the possibility of bringing the virus into the nursing home. Participants reported that they were afraid of getting infected or of infecting others, such as relatives or residents.

> *"My husband was looking at me, and I saw in his eyes that he blamed me for making him sick—he wouldn't say*

TABLE 3 Participants' characteristics ($n = 29$)[†]

Demographic characteristics	
Age in years (mean/range;)	44 (22–63)
Gender: female (*n*; %; $n = 29$)	24 (83%)
Experience as informal care staff in a nursing home (*n*, %)	9 (33%)
Occupational characteristics	
Years of experience in current position (mean/range)	17 (1–45)
Direct care professionals (n):	24
Nurse assistant (*n*)	1
Certified nurse assistant (*n*)	14
Vocationally trained registered nurse (*n*)	5
Baccalaureate-educated registered nurse (*n*)	2
Activity staff (*n*)	1
Occupational therapist (*n*)	1
Nursing home managers (n):	3

[†]Two participants did not provide information on demographic or occupational characteristics.

TABLE 4 Identified themes related to staff's care experiences during the lockdown

Theme	Subtheme
Loss of (daily) structure	Degree of experienced stress
	Administrative tasks
	Top-down decision-making
Work and private live interference	Fear for infection
	Social contacts
	Taking home stress from work
Social support	Teamwork within wards
	Collaboration between different teams
	Social support from a leader
	Psychological support
Relationship centred care	Effect of measures
	Loneliness of the clients
	Providing High quality of care
	Collaboration with the family

it, but I saw it." [Participant with a husband who had COVID-19] (Participant of team C)

The fear of infection caused participants to avoid even more social contacts compared with others which made them feel lonely. Not being able to meet with relatives, such as grandchildren, caused loneliness and social isolation. One participant reported she was so terrified that she locked herself up in her home.

Specifically, participants working on wards with infected residents reported they were not able to leave the stress behind when returning home. Some participants had so much difficulty relaxing in their free time that it caused exhaustion.

"After the last one died, we thought 'now we can finally sleep again'." (Participant of team C)

4.3 | Social support

Regarding the topic of social support, participants mentioned improved teamwork within teams, a decline in collaboration between teams, lack of support from leaders and insufficient aftercare.

All participants mentioned that the teamwork within teams improved notably. The lockdown strengthened mutual trust and team members supported each other "more than usual". The existence of a common goal ("to be there for lonely residents") tied the team members together even more.

"Penguins are animals with a positive attitude, but with difficulties to walk and that is how I experienced the past weeks. The team had a good attitude, but a lot of challenges to deal with." (participant of team D)

Participants also highlighted the importance of good communication, evaluation and giving feedback within the team and mentioned that these aspects improved greatly. They wished to keep up the spirit of teamwork and to implement more frequent and less formal evaluation moments to provide feedback to each other.

"Due to COVID-19, it was even more important to communicate with each other, and this therefore improved. It was kind of mandatory to listen to tips from others; to survive as a team it was necessary to have evaluation moments." (Participant of team D)

In contrast to the improved teamwork within teams, collaboration between different teams declined. Teams experiencing higher work

pressure missed the support of other teams and teams working on wards with infected residents felt abandoned by other teams.

> *"The pressure at work got higher and I felt like a fully packed mule the past weeks. We got more and more tasks and received no help from other colleagues of other wards."* (Participant of team C)

Additionally, two of the four teams reported a lack of social support from leaders in the crisis situation and a lack of suitable "aftercare". Here, participants distinguished between their team leader and higher management. The (physical) absence of a manager, in charge of implementing and deciding on new measures, caused the feeling of being alone in the crisis situation for participants. The team leaders, in general, supported their teams sufficiently, but participants desired more (personal) attention and appreciation from the higher management.

> "*They* [the higher management] *had to be present at the ward, wearing personal protective equipment*." (Participant of team C)

Participants were given the opportunity to schedule an online or telephone consult with an internal psychologist for support during the pandemic. According to them, a "remote psychologist" (the organization provided a psychologist – employed at the organization – on call for direct care staff for which appointments had to be scheduled) was insufficient. Undertaking the step to call for an appointment was considered a barrier to making use of the consult. Participants expressed the need for on-site psychological support to ask for help in the moment. Furthermore, they highlighted the need for someone they could talk to about their feelings. According to them, timely support on demand instead of an appointment scheduled for a week later was important.

4.4 | Relationship-centred care

Regarding the topic of relationship-centred care, the following points were reported: the impact of the applied measures, loneliness of the residents and collaboration with the residents' families.

Participants expressed their concerns regarding the applied measures, in particular the ban of visitors. They implied that this increased loneliness and restricted decision-making for residents. According to the participants, the applied measures were focused on safety and did not take into account the importance of relationship-centred care. Residents had no opportunities to express their personal wishes and needs, for instance if they chose to see their family members instead of choosing safety. All relationships outside the nursing home and sometimes even inside the nursing homes were cut off. For participants, this felt like a restriction in offering the best quality of care. In order to provide the best quality of care, participants felt they sometimes needed to violate the rules:

> *"If we had followed all the rules, we would have been very inhuman—then we would have suffered from our behaviour."* (Participant of team B)

In cases where residents died, participants especially felt the restrictions due to the COVID-19 measures. Only a limited number of visitors were allowed to see a resident on their last day of life, forcing care staff members to choose which family members were allowed to say their final goodbyes. In addition, direct care staff themselves and other residents were not able to say their final goodbyes to the residents in the usual way. They indicated that when a resident died, they missed the process of closure and that was the most radical event during the lockdown for them. They highlighted the importance of the process of closure for themselves, other residents and the family members.

> *"Three people were immediately put in a coffin without a chance for the family to say goodbye."* (Participant of team C)

Due to the imposed measures, residents had no (physical) contact with their family and only restricted physical contact with their care providers. This caused loneliness among the residents. The experienced loneliness of the residents also greatly impacted the direct care staff. Staff perceived that loneliness worsened symptoms and increased the illness of some residents (e.g. decline in mental abilities). In general, the absence of physical contact with the direct care staff and family members was indicated as a cause of decline in mental abilities, especially for residents with dementia. Participants highlighted that they tried to offer the "best quality of care", while working under exceptional circumstances and seeing the residents suffering from either coronavirus disease and/or loneliness.

> "*We didn't just commit 100% of ourselves, but 200% for the residents—this shines a bright light onto the past period*." (Participant of team A)

> "Due to Covid-19, I did not only see loneliness but also closeness. The nurses took good care of the residents." (Participant of team A)

During the lockdown, family members who were not allowed to visit the nursing homes expressed their appreciation by sending the care staff gifts and cards. Participants appreciated the positive feedback and expressed their wish to strengthen the interaction with family members. According to the participants, a positive outcome was the quick adoption of new ways to involve family members (e.g. video calls).

5 | DISCUSSION

This study aimed to gain insight into how direct care staff in Dutch nursing homes experienced working during the COVID-19 pandemic.

All staff experienced a conflict between their role as a healthcare professional and a person in private life. Relationship-centred care played a crucial role, as staff members did their best to provide individual care and personal attention for residents, but this sometimes conflicted with rules and regulations of infection prevention. All participants mentioned that teamwork within teams improved notably. Findings showed that experiences differed for teams due to the presence or absence of COVID-19 infections on the wards. The loss of daily structure, combined with ambiguous communication about new measures, additional tasks such as wearing protective equipment and top-down decision-making contributed to a stressful work atmosphere. Staff without infections perceived more autonomy and felt they had more personal time with residents due to less administrative tasks.

Findings showed that care staff experienced a conflict between their professional roles and private lives. These conflicts appeared to be an additional burden and potentially contributed to a loss of a balanced life in a study among nurses working with COVID-19 patients in a clinical setting (Tan, Abhiram, et al., 2020). In our study, care staff felt particularly afraid of infection and felt stressed. Severe mental health issues, such as stress, anxiety, anger and insomnia resulting from the loss of a balanced life, have been reported earlier for care staff working with COVID-19 patients (Kang et al., 2020; Lai et al., 2020).

Care staff members working on wards without COVID-19 infections experienced more autonomy due to fewer administrative tasks and therefore enjoyed working more than usual. They described their daily work as more "peaceful" and enjoyed being able to spend more (one-on-one) time with the residents. Autonomy, defined as the choice between alternate actions (Freidson, 2001), has been associated with higher overall job satisfaction for care staff in clinical practice (Pron, 2013). In addition, being able to provide person-centred care by knowing the patient well has shown to promote care staff acting more autonomously in their daily work (Skår, 2010). Knowledge about the patient and the relationship with patients seem important to develop professional autonomy (Mantzoukas & Watkinson, 2007; Skår, 2010).

The possibility to get to know the patient seems to give the nurses in this study invaluable knowledge and a greater opportunity to act autonomously and create holistic care both towards an individual patient and groups of patients.

As a consequence of the unusual circumstances, teams reported a better teamwork within teams, but less collaboration between teams. Results of a German study reported that teamwork was a good motivator for care staff to continue working during a crisis (Begerow and Gaidys, 2020). Our findings highlight the importance of good functioning teams. Short and unofficial evaluation moments within teams to reflect on the current situation and to solve problems supported teams in their work during the pandemic.

Participants stressed their wish for support and clinical leadership. With respect to their manager, they expected the manager to be physically available, make decisions, "feel" what it means to work during the pandemic and appreciate their work. Moreover, direct care staff emphasized that they need support "at the moment when a critical situation arises". "Remote" psychological support was considered insufficient. McGilton et al. (2020) recommended for the nursing home setting in a pandemic, among others, more 1:1 engagement between supervisors and staff, with an emphasis on appreciation of the work being done, to develop a leadership group that is available 24 hr a day to support staff and to ensure that at least one manager is physically present to address questions. Tan, Abhiram, et al., (2020) concluded, based on a qualitative study involving nurses in Wuhan, that it is necessary to strengthen the availability of personalized psychological interventions for front-line nurses. An editorial by Williamson et al., (2020) highlights the need for "readily accessible psychological support" for care staff. They blame waiting lists as a reason why care staff do not seek psychological support at all.

The perceived loneliness of residents was a trigger for direct care staff to deliver more personalized care, such as individual conversations and one-on-one activities. While earlier research has already indicated that for direct care staff preventing residents' loneliness is as important as personal hygiene (Simard & Volicer, 2020), they now felt hampered by the restrictive measures and did their best to deliver person-centred care during the lockdown. An earlier study reported that care staff experienced a discrepancy between following rules and offering the best quality of care during the COVID-19 pandemic (Begerow & Gaidys, 2020). In addition, care staff highlighted that collaboration with the residents' families is important in times of a pandemic. Taking into account the needs of the resident who lives in the nursing home, the family who visits and the care professional who works in the nursing home belongs to the concept of relationship-centred care (McCormack & McCance, 2006; McCormack et al., 2012). In past years the concept of relationship-centred care has become a central concept in the long-term care sector (Beach et al., 2006). Several benefits of relationship-centred care have been reported: higher quality of life for the residents, more successful clinical interventions, higher satisfaction for care staff and residents and lower mortality (Massey et al., 2006; Rider, 2011; Williams et al., 2000). Therefore, it seems especially important to keep up relationship-centred care during a pandemic, as it benefits all stakeholders in the nursing home setting.

Several methodological considerations need to be addressed. Focus groups were held with four teams from one healthcare organization in the south of the Netherlands; therefore, this study might not be representative of other teams in the Netherlands. Due to the sample size, it is hard to assess whether data saturation has reached. In order to achieve data saturation, a member check took place in which participants had no additional comments on the data. Purposeful sampling, was used to select extreme cases to enrich the data. Teams were, however, chosen by the healthcare organization, so it is unknown if any selection bias, in the sense of intentionally not inviting specific teams, has occurred. The discussion leader invited all participants to report their opinions by directly asking them. Nevertheless, their participation during the following group

discussions differed. Furthermore, the presence of the team manager in three of the four focus groups might have led to socially desirable answers from the participants. In one focus group no team manager was present and participants seemed to be more negative about the management and leadership style.

At the moment, it is still unclear how long the COVID-19 pandemic will continue. Based on our results, it is recommended that the interests of all parties within the nursing home setting should be considered. To ensure a healthy work environment and care quality, it is recommended to evaluate these on a regular basis.

For direct care staff, straightforward communication and autonomy in their way of working and implementing on-site psychological support in crisis situations is recommended. Managers with decision-making authority should be actively involved on the work floor and offer care staff the opportunity to work as autonomously as possible. Residents' personal needs and wishes should be considered in decision-making processes. Family members should be involved instead of locked out, and collaboration should be strengthened by considering their needs. Our results highlight the importance of a continuous evaluation of the working situation for care staff during a pandemic.

Further research should investigate practical ways for sustainable employment and empowerment of direct care staff in nursing homes. Barriers to and facilitators of job satisfaction and stress levels in a pandemic should be investigated. Additionally, the methods and the effectiveness of psychological and managerial support, especially in crisis situations, should be investigated.

6 | CONCLUSION

To date, this is one of the first studies that has collected experiences of direct care staff working in nursing homes in the Netherlands during the COVID-19 lockdown. Nursing home care staff experienced a turbulent period from which a lot can be learned for similar situations in the future: psychological support should be on-site, care staff appreciate autonomy in their daily work, the active role of a manger on the work floor is important and relationship-centred care becomes even more relevant and should not be hampered by guidelines or measures. It is therefore important to find a balance.

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CONFLICTS OF INTEREST

The authors declare no conflicts of interest. The funders had no role in the design of the study, in the collection, analyses, or interpretation of data, in the writing of the manuscript, or in the decision to publish the results.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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