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STRESS AND COPING EXPERIENCES OF NURSES AND CARE WORKERS IN A CARE HOME SETTING DURING THE COVID-19 PANDEMIC

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Abstract

Aim: To explore the stress and coping experiences of health care workers (HCWs) in a care home setting during the Covid-19 pandemic.

Methods: A cross-sectional mixed methods study was undertaken using an online survey and virtual one-to-one interviews. The survey consisted of 11 demographic and work characteristics, the 14-item perceived stress scale (PSS) and the 26-item coping self-efficacy scale (CSE). The online survey was distributed via the onlinesurvey.ac.uk platform. The survey aimed to determine levels of stress and coping and identify demographic and work factors influencing these among staff working in care homes The in-depth interviews explored HCWs (carers, nurses, and managers) experiences of stress and coping while working in care homes during the Covid-19 pandemic.

Quantitative data from the survey was entered into the Statistical Package for Social Sciences (SPSS) version 23.13. Mean scores for both the PSS and CSE were calculated, and independent T-tests were carried out to determine any difference between demographics and stress/coping scores. Qualitative data from interview transcriptions were analysed thematically using Braun and Clarke's six step method.

Results: The participants for the online survey (n=52) were predominantly female (90.4%), more than half were over the age of 44 (53.8%) and half of them (50%) had a diploma or higher education. Over a quarter (26.9%) of the participants had their own health issues and half (50%) had caring responsibilities at home. The mean score for the PSS was M=39.75 indicating that participants had high stress levels. Thirteen HCWs participated in one-to-one interviews. The mean score for coping was CSE M=150.6 meaning most participants had medium coping skills. Qualitative data analysis generated four themes contributing to stress; 1. Personal factors, 2. Changed care environment, 3. Amplified scrutiny and 4. Psychological responses, all underpinned by ongoing change and uncertainty. Coping was represented as three main themes 1. Personal factors, 2. Organisational culture and 3. Safety and security which were all underpinned by relational interactions.

Conclusion: This study highlighted that HCWs in care homes have experienced high levels of stress despite having good coping skills. There is a moral obligation to provide psychological support to care home staff in both a reactive and proactive manner. The strong sense of family between HCWs enhanced coping and offers insight into how this could be developed in other health and social care settings.

Introduction

The Covid-19 pandemic has presented unprecedented challenges for the health and social care workforce. These include reallocation of roles and environments, a reduction in the healthcare workforce and anxiety for their patients, as well as their own and their family's well-being.[1] These stressors are additional to wider public ramifications, such as financial insecurity, anxiety manifesting in panic buying, increased home schooling and limited outside exposure (particularly for those who are shielding). Care homes have been one of the largest hotspots for the transmission of the virus that has resulted in a high number of Covid-19 related residents' deaths.[2]Care homes referred to in this report include both residential and nursing homes.

Nurses and carers, referred to collectively in this report as healthcare workers (HCWs), working in care home settings have been particularly impacted due to the high-risk nature of their ageing residents with cognitive impairments and high resident to staff ratios.[3,4] While HCWs in these settings were highly impacted by Covid-19, the UK Government were slow to target interventions in this context, instead focusing initial efforts on acute care settings. Furthermore, a negative media portrayal of care home settings and associated high death rates due to Covid-19 have contributed to additional stress during the pandemic for HCWs in care homes.[4]

While the individual impact of this unparalleled uncertainty has varied, it is apparent this has led to widespread stress and other mental health impacts on HCWs in care home settings.[5] Nurses and carers are known for their ability to adapt and overcome adversity but resilience amongst the HCWs has been challenged by the current pandemic.[6] Given the ongoing impacts of Covid-19, there is a need to develop evidence-based support for staff in the care home sector. To devise effective interventions to support HCWs in this sector it is essential to explore and understand their experiences. Listening and acting on their unique experience will enable tailoring of interventions to support current and future coping, as well as giving care home staff a voice, which was previously unheard.

Background

In Scotland there are approximately 36,600 people living in nursing and residential care homes.[7] Covid-19 disproportionally impacts on people living in care home settings with subsequent high mortality.[8,9] Many care homes were affected by deaths and associated illness in both residents and staff. By 19 June 2020, there had been more than 30,500 excess deaths among care home residents, and by 26 June 2020, there were 268 deaths involving Covid-19 among HCWs.[10] Care home residents are at higher risk of Covid-19 because of their age, co-morbidities, prevalent frailty, cognitive impairment, dependency levels and frequent close contact with other residents, and carers. Early in the pandemic, Covid-19 spread rapidly through care homes despite the efforts of staff.

Historically, the experience of HCWs working in care home settings has been a neglected area in terms of research.[11] However, a current evidence base exploring the impact of the pandemic on HCWs is emerging. The psychological impact of caring for care home residents during the Covid-19 pandemic is significant.[9] A recent systematic review of psychological symptoms among HCWs during the Covid-19 pandemic reported a high prevalence of anxiety (23.2%), depression (22.8%) and insomnia (38.8%).[12] Female HCWs and nurses presented with higher rates of symptoms than their male, medical colleagues.[12] Notably, of the 13 studies they included, 12 were undertaken in China and one in Singapore and it is unclear whether any of the participants worked in a care home setting. Moreover, a recent study draws attention to temporal influences on lived experience. A phenomenological study

exploring the psychological experiences of HCWs caring for Covid-19 patients found that responses changed during different stages of the pandemic.[13] Initially, negative emotions included fatigue, helplessness, fear, and anxiety predominated, however, positive emotions emerged alongside negative emotions over time. Despite the disproportionate impact of Covid-19 on residents and staff in care home settings there is a lack of evidence exploring the impact of working within these contexts during the global pandemic. The pandemic has added significant strain to an already vulnerable workforce, which has historically experienced high levels of turnover, chronic staffing shortages, and high burnout. To protect this workforce against the long-term impact of the pandemic, we must first understand how Covid-19 has affected their stress and coping in their day-to-day work.

Aims

To explore the stress and coping experiences of HCWs in a care home setting during the Covid-19 pandemic.
This study sought to address the following questions:

1. What are the experiences of nurses and care workers working in a care home setting during the Covid-19 pandemic?
    - What demographic and work factors influence their stress and coping?
    - What are the stress levels and factors contributing to their stress?
    - What are the levels of coping and what has helped/hindered their ability to cope?

Study Design

Methods and Materials

A cross sectional mixed methods approach was used to address the study aim. This included an online quantitative survey and virtual one-to-one qualitative interviews. The online survey was distributed to understand levels of stress and coping and identify demographic and work factors influencing these. The survey consisted of 11 demographic and work characteristics, the 14-item perceived stress scale (PSS) (Appendix 1) and the 26-item coping self-efficacy scale CSE (Appendix 2). The PSS is a valid, reliable, and brief measure of a person's appraisal of their stress and has been used widely in health research.[14,15] The CSE scale is also a valid and reliable measure that provides a measure of a person's perceived ability to cope effectively with life challenges which has been used to predict positive work outcomes, specifically, job satisfaction and job performance.[16]An open ended interview guide was designed to explore experiences of stress and coping (Appendix 3).

Ethical Considerations

Ethics approval was obtained from the University of Highlands and Islands Research Ethics Committee (Ref: ETH2021-1110). Participants received the invitation for the online survey through their workplace. Informed consent was obtained prior to survey administration and

one-to one interviews Given that the subject of experiences of stress and coping during the Covid-19 pandemic might engender distress participants were signposted to a mental health helpline as required via the Balhousie Benefits Scheme and national helplines such as Breathing Space andThe National Wellbeing Hub for People Working in Health and Social Care https://www.promis.scot/

Participants and Sample Size

All HCWs working in a care home setting between January and May 2021 (all employees of the Balhousie Care Group) were invited to participate. All carers and nurses working within the Balhousie Care Group were invited to complete the online survey and indicate their willingness to take part in a virtual interview. 52 HCWs completed the online survey and 13 HCWs participated in the in-depth interviews, conducted via Microsoft Teams.

Recruitment and Data Collection

All study information was housed in a secure webpage. The web link, containing information about the study was shared initially via the Balhousie inhouse newsletter. Interested participants were able to access the survey and any further information about the study via a web link. To aid recruitment a QR code was created, and a short promotional film produced and displayed on digital hand sanitisers. Participants were required to read the online Participant Information Sheet (PIS) and complete the online consent form prior to accessing the survey and respond anonymously which took approximately 10 minutes to complete. Survey respondents wishing to participate in an interview were directed to a separate web link where they could leave their contact details (email or telephone) for researchers to get in touch. This enabled the initial survey to remain anonymous. A researcher telephoned the participants who consented to be contacted. Online consent was obtained prior to conducting the interviews. One-to-one interviews were conducted using a semi-structured interview guide informed by the research questions.

Data Analysis

Quantitative data from questionnaires were entered into the Statistical Package for Social Sciences (SPSS) version 23.[17] Descriptive statistics were calculated for sample characteristics. Interview recordings were transcribed verbatim using software, which adheres to the General Data Protection Regulations (GDPR) and data sharing requirements. Qualitative data from questionnaires and verbatim transcripts were analysed thematically.[18]

SharePoint was used to manage and store the data. First, thirteen transcripts were independently read by each member of the research team and data initially coded ((MB, CC, RM, LM, AM). The research team met to compare emergent codes and constructed preliminary coding frameworks which were applied to all interview transcripts. During the next stage of analysis, the research team held a series of meetings to identify themes depicting the stress and coping experiences of participants. Subsequent analysis generated final themes for the study as reported below.

Results

Survey Data

Table 1 shows frequencies and percentages of the participants characteristics. Most of the participants were female (90.4%) across a range of ages. Nurses who participated were also managers; therefore, if we combine both nurse and manager categories (9.6 and 34.6 respectively) then approximately 44% were managers and 56% were carers (32.7% carers and 23.1% senior carers). Over a quarter (26.9%) of participants had their own health issues, with 19% reporting mental health issues. Additionally, 50% of participants also had caring responsibilities at home.

Table 1: Descriptive statistics of sample n=52

Variable	Response Range	Frequency	Percent
Age	25-44 years 45-64 years 65+ years	24 22 1	46.2 42.3 1.9
Gender	Female Male Prefer not to say	47 4 1	90.4 7.7 1.9
Job Title	Carer Senior Carer Nurse Manager	17 12 5 18	32.7 23.1 9.6 34.6
Own Health	Long term condition Disability MH None	7 1 10 38	13.5 1.9 19.2 73.1

Figure 1: Perceived stress scale (PSS)

Low Stress	0 – 18
Moderate Stress	19 – 37
High Stress	38 – 56

For stress (PSS) the participants' mean score was M=39.75, which shows that most of the participants had high stress scores. The coping scale (CSE) scores range from 0 to 260. A lower score means lower coping. The mean score for coping was M=150.6 which means

that most participants had moderate levels of coping. Both scales exhibited high internal consistency as shown by Cronbach's alpha (PSS α=.899) and (CSE α=.963), which tells us that the tools were consistently measuring the constructs of interest. We did independent T-test to determine if a difference existed between demographics and stress/coping scores. We looked at five different demographics in relation to stress and resilience (age <44yrs vs 45yrs; education for those with a diploma and below compared to those with a degree or above; own health concerns versus no health concerns; caring responsibilities versus no care responsibilities and job title). We did not find significant difference in most instances apart from own health versus no health concerns. Participants with no health concerns had an average coping score of 0.11 points (95% CI, 0.79 to 0.82) higher than the group with their own health concerns. This means having no health issues contributed to higher levels of coping.

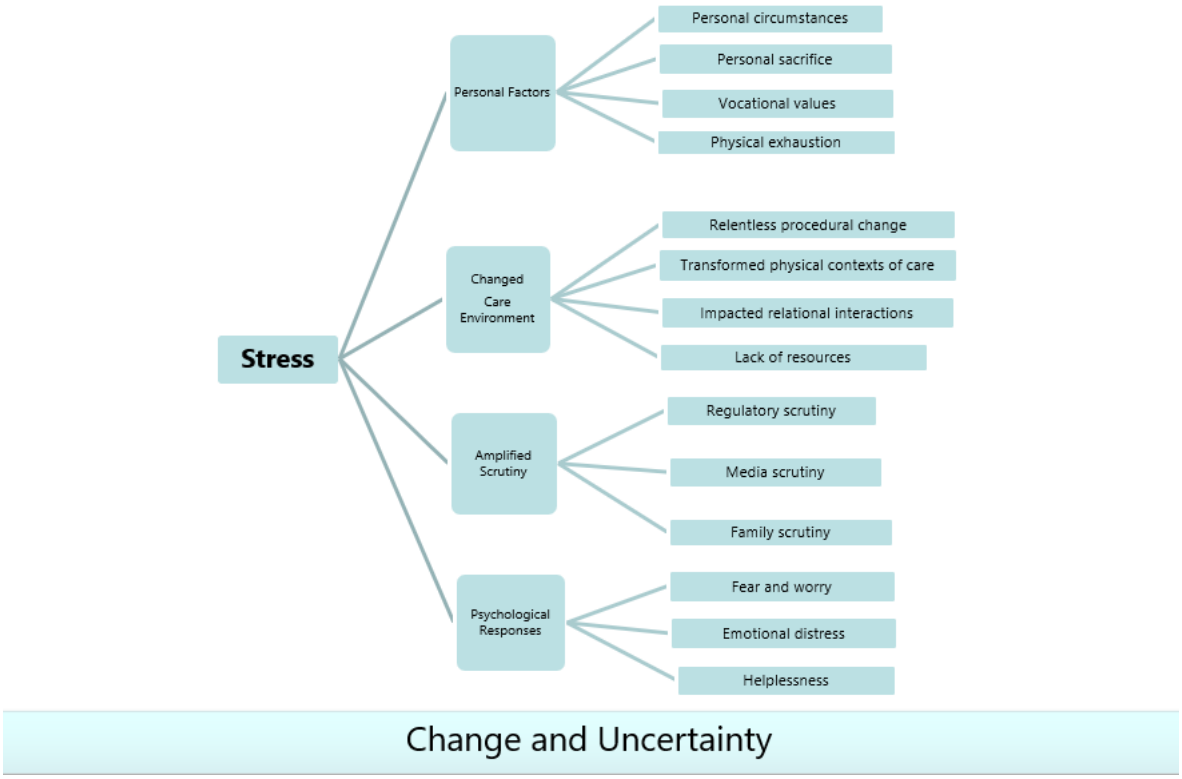
Qualitative Findings

Participants characteristics for those who participated in the qualitative interviews were mostly female (81.8%). They were in the age group 25-44 (63.6%) and 45-64 (36.4%). Nurses who participated in the interviews were also managers; therefore, if we combine both nurse and manager categories (7.6 and 53.8 respectively) then approximately 61% were managers and 39% were carers (24% carers and 15% senior carers). 30% had mental health issues and 77% of participants also had caring responsibilities at home. Participants openly shared their experiences of working in a care home during the Covid-19 pandemic enabling understanding of both their experience of stress and coping to be shaped and reported below.

What created stress?

Analysis of the data generated four themes depicting what created stress 1. Personal Factors 2. Changed care environment 3. Amplified scrutiny and 4. Psychological responses. All four themes were underpinned by ongoing change and uncertainty consequent on living and working during the COVID-19 pandemic. A schematic illustrating the themes, subthemes and the underpinning influence of change and uncertainty is illustrated below (Fig 1)

Figure 1: Visual Schemata of HCWs' Stress Experience



PERSONAL FACTORS

Findings showed that working through the pandemic, participants experienced high stress levels which were influenced by personal circumstances, characteristics, and physical impacts. These were impacted by continual changes and uncertainty in both the workplace and everyday living during the pandemic.

Personal Circumstances

Participants described the restrictions imposed by the pandemic and the competing demands in their personal lives as everyday citizens as a source of stress. This included their parenting roles with responsibility for home schooling and dealing with the impact of the lockdown restrictions on society and everyday life.

> *"It has been quite rotten, to be honest. One thing after another. Eh. Well, just having the way the kids home schooled all through the pandemic. I've got three, my son he left school. He couldn't access anything. So, it was it a nightmare." P5*

At times this left individuals feeling isolated, overwhelmed, subsequently contributing to their stress.

"I feel like I've just locked myself in; I'm either in my house or I have to go to the shop, which I limit that and then I just go to my work. P6

Personal Sacrifice

Participants spoke of their commitment to work through the pandemic and how this affected them personally. Some participants made significant personal sacrifices to enable them to continue working in the care home setting. Some depicted lost precious time with family trying to mitigate the risk to their loved ones and residents which provoked stress

"I lost seven months with my daughter so I could keep me safe, them safe and my residents safe. I'll never get those seven months back." P9

"I never seen my kids or him (partner) for eight weeks, in person, which was extremely difficult. I was in the house on my own, and I hated every minute of it." P7

"My mum has no immune system, so I moved my mum into my house with my children and I moved into hers. Because obviously I was going to be mixing with other people. at work and things. So that was really difficult because I felt quite alone then." P5

Vocational values

Personal sacrifices appeared to be driven by their beliefs and values. Despite individual values and vocation providing a sense of purpose and drive to keep working during the pandemic, these also contributed to HCWs' experience of stress. The admirable action of putting residents needs before their own came at a personal cost which contributed to their stress.

"I had said to myself from day one, I would never not go and care for my residents. That's just not me. I wouldn't. I wouldn't put myself before them...I've been in this job for 10 years, and I'm not going to let some virus take away what my life is really, I've put my life into this job." P6.

"We're all at risk but we've still got a job to do. And these residents are the most important people in all of this, we have to protect them." P7

"When you sign up for a job as we do, then you always know that you're going to sometimes have to compromise yourself and your own families. And you know, you're going to miss birthdays and Christmases and things like that." P2

Physical Exhaustion

It was evident that several participants were dealing with exhaustion as they had worked tirelessly throughout the pandemic.

"I have worked shifts in homes where there's been COVID. And it's incredibly tiring, incredibly tiring." P8

"My work actually had the virus, it was in there for about eight weeks, and it was just, I mean, we were all like, exhausted, we were like, the staff were dropping like flies, we were losing residents that still had a fair amount of life left in them and it was just, it was awful. I worked a lot more hours than I normally would because of staff sickness and stuff like that. So, I was pretty much run to the ground." P6

For some, the impact of tiredness appeared to push stress into distress.

"I'm normally quite good at, like as a nurse However, due to this COVID pandemic has been, I mean, it's pushed to the limits at times." P7

"It's running on empty now, you know I'll get family members, you know, saying you look exhausted. And you think Well, yeah, that's because I am, that's because you're not quite yourself, you're not sounding yourself or because I feel like I've got the weight of the world on my shoulder sometimes." P2

CHANGED CARE ENVIRONMENT

Covid-19 provoked constant change transforming the care home environment beyond recognition and conceptualised through four subthemes of 1. relentless procedural change; 2. transformed physical contexts of care 3. impacted relational interactions and 4.lack of resources. It was clear from participants that the organisation took pride in providing a homely environment and it was distressing for staff to operate within a more clinical and sterile environment due to infection control procedures. Changes required in the physical care home environment and limited resources influenced the relational aspects of care giving which HCWs found stressful.

Relentless procedural change

The constant changes to guidelines, protocols and policies from government and other agencies in response to emerging evidence caused anxiety and apprehension, leading to stress. The constant changes limited time and ability to adjust and make sense of the new ways of working, ultimately creating stress and anxiety for HCWs.

> *"It was hard going, because we were getting a lot of changes thrown at us, we were having to wait on government announcements before our head office would decide what was happening, that type of thing. The first three weeks were very much, you know, every hour, everything was changing." P1*

> *"And when our protocol has changed, and that has been that has been really difficult and well not difficult. I've just been, it just causes anxiety, you know, when we're changing a way that we've worked for a short time." P7*

On occasions there was conflicting information between different organisations within the sector.

> *"I think that things change so quickly that you never really understand where you are. Never really quite understand what… they mean. I mean, even today, I've been to a meeting with infection control from the local area, and they're talking about current regulations of care home residents going out in cars, and our guidelines, our company completely contradict what they're saying." P13*

Transformed physical contexts of care

It was clear from participants that the organisation took pride in providing a homely environment [pre - pandemic] and it was distressing for staff to operate within a more clinical and sterile environment due to infection control procedures.

"...like the whole home was stripped, stripped bare so that we can clean and, like get it all fresh and got up to the point where we changed everything...You know, getting rid of all that the home basically went from like a nice cosy home to like a clinical and clinical home" P6

HCWs clearly empathised with the impact of these changes on themselves and the residents.

"It is against the grain of all we are. We are person centred care sort of thing, so it makes it hard." P5

While implementing infection control procedures such as the need to wear PPE was recognised as important for both resident and staff safety, HCWs struggled with its impacts. HCWs voiced concerns about perceived negative impacts on communication practices and the depersonalisation of care believing it generated fear in some residents, especially those with cognitive issues.

"Staff look different because they've got masks. So, our means of communication had changed. And their lives had changed. And they didn't understand why. And it was really, really, difficult. And for the rest of the residents." P12

"They (residents) don't understand. They're so frightened of us walking in with full PPE all the time. You know, there's no there's no personalisation anymore. It's just it's very clinical." P5

The responsibility of enforcing restrictions to maintain social distancing within the home was challenging especially for the residents with dementia.

"Maintaining social distancing has been probably the most challenging area of it with the residents." P7

"How do you isolate residents with dementia, when they can't understand what is happening, what's going on? They're ill. So therefore, they're even more confused." P12

Impacted relational interactions

Relational interactions and care were adversely affected as a direct consequence of the infection control procedures. This was experienced by staff as they had to deal with the impact of the restrictions on residents and their families. Families not being able to see their loved ones in such worrying circumstances created further feelings of stress and distress in HCWs.

> *"It has been very difficult as far as that's concerned. Zoom and Skype just aren't the same for them. I can appreciate that. It's very difficult. I totally understand. This is the most precious cargo that family have, and they've not seen them for months, it's awful. P4*

> *"The relatives and just not knowing. I think that's just been the worst." P5*

> *"But yeah, really feel for the relatives, I really feel for them. It's just, it's not been good, you know, and not being able to see them. So, I think that's been the hardest thing of all." P1*

> *"I remember when we first closed doors to relatives, and it was, it was really heart-breaking, you know, some of the conversations we've been having." P7*

> *"How can you not get attached where you're working and caring for these people? It's very difficult. I'd say that. I have went home a few times in tears. And you know, that's part of the job, but because you do become very close to them, especially during this time when they're not going to see their own family members and stuff. Your all they've got really, that can be quite difficult." P9*

The adverse impact of new infection control procedures on relational interactions was notable during the provision of palliative and end-of-life care and depicted as challenging and highly distressing to HCWs. Delivering care to the dying in accordance with specific guidelines and procedures felt remote and distant at times, rather than being person centred. These disconnects between ethical values in relational care appeared to extend stress into moral distress and trauma for HCWs.

"And it was just horrific, because, you know, you were having to phone families and tell them that, you know, their mum was, it wasn't looking good, you know, and at that time they weren't allowed in to visit." P2

"The bit I found traumatic was that we had people who had passed away that weren't COVID positive, but families weren't allowed in. Sitting with someone with all your PPE (Personal Protective Equipment) on it just feels horrible. When undertakers came in there was nothing personal about it at all. You know putting a mask on someone that is already dead, it was horrible." P5

Lack of resources

Lack of resource had a huge impact on HCWs' ability to cope with the increased demands of additional tasks and care needs. This in part was due to reduced staffing levels as a direct effect of Covid-19 on staff sickness, self- isolation and shielding. Staff felt they were unable to give their usual quality of care due to reduced resource and this subsequently created stress.

We were working with a skeleton staff just because of you know, people isolating, and schools, no childcare, different things. And so there has been hard times for them." P7

"It's been very stressful. Obviously, you're not allowed to use agency staff. At the very start of the pandemic things were changing on a daily basis. Even now you're still facing issues with being short staffed, we're still getting tested". P5

Again, lack of staff resource intensified HCWs' distress when providing care to dying residents

"It was probably the most traumatic day I've had throughout COVID, managing so many deaths in such a short period of time with a staff team that is not what we usually would have." P8

Moreover, the prioritisation of resource to the NHS was keenly felt by participants.

"So, where everybody flocked, again, to the NHS to support and volunteer. And, you know, the nurse banks flourished. We were again in the dark going, hello, can somebody come and help us?" P13

AMPLIFIED SCRUTINY

A fundamental challenge that HCWs faced due to the pandemic was multi-facetted amplified external scrutiny from a wide range of external sources, including 1. regulatory bodies, 2. the media and 3. residents' families. Amplified scrutiny was driven and intensified by the enforced and relentless changes to the changed contexts of care depicted above.

Regulatory scrutiny

Many organisations were involved in inspecting and auditing care homes regarding compliance with policies and procedures. Whilst the need for scrutiny was recognised and in part welcomed, this appeared fragmented placing additional stress on staff. It was felt that the regulatory bodies were not taking the competing demands and wider context of the care home setting into consideration. The scrutiny by regulators with the care homes was seen as unrealistic and punitive as opposed to being supportive.

> *"I think the scrutiny part and I get that like of course, we have to be scrutinised, and we are transparent, but again, it's just an added pressure." P2*

> *"I think sometimes, sometimes when people are already working in extremely challenging situations to come in with a big stick, and say, you know, say something like your bins in the wrong place." P8*

> *" The scrutiny has been unbelievable. So public health, Scotland are coming in saying one thing, the partnerships are coming in, the care inspector is coming in, the NHS is coming in, so leadership has actually been about juggling all these people coming in making almost unreasonable and unrealistic demands that sometimes people sometimes forgetting these are residents' homes." P12*

> *"We've been living and breathing this, we've not had COVID and here's her (inspector) picking me up, because I've got version two of the same poster instead of version three, you know, it's just, it's just ridiculous." P2*

The constant and rapid changes of rules and regulation also exacerbated the fear of litigation experienced by HCWs to be very real and distressing.

"And I think just because everyone's on tenterhooks as well, last year you know about litigation or, you know, the procurator fiscals (similar to Coroner in England) going to be investigating all the deaths in the care homes and, you know, even that just sends shivers down your spine!" P2

"If you have somebody who dies from COVID in a care home the police come and do an investigation for the procurator fiscal, staff are stressed by it" P12

Media scrutiny

A further external source of pressure that was highlighted repeatedly by participants was the effect of the media. Participants felt care homes were constantly derided in contrast with the elevation of the NHS. This caused feelings of distress and devaluation. Stories from the media were also picked up by residents and their families causing further fear and anxiety.

"The focus of the nation quite genuinely, and correctly, to an extent has been on the NHS. But actually, in the background, social care has been really hammered and struggled and there hasn't been, it's always tacked on as yeah, the NHS and .... oh, social care. Yes, clap, clap, clap." P12

"It actually made me feel quite down because it was like the NHS was getting praised but we were getting slated. We're working under worse conditions and it's not our fault that at the start a lot of things were unclear." P5

The negative media portrayal of the care home environment not only impacted on HCW staff but caused distress for the families of residents. Families' fears were unable to be managed as they were unable to visit and see evidence to the contrary. Families distress adversely impacted on staff stress.

"The effect that media has had on the workforce…it's all about the NHS and how they're fantastic, you know, nation hero service and all this kind of, and they very much felt disregarded, because all you would read in the paper is how terrible care homes are, don't put your loved one in a care home, you know, all that kind of thing." P8

"You're reading about the number of deaths and the terrible staff and the lack of PPE. How would you feel? so the stress levels where shocking and relatives really distressed because they've read the headlines…Going care homes are terrible. They can't come in and they can't see. And it was just horrific." P12

Family scrutiny

Participants felt a strong sense of care and duty towards resident's families due to the empathy felt for them in relation to visiting restrictions. Conflicting information from different sources of media was often confusing. Staff had to relay this information and enforce official regulations which caused further distress to residents and their families. Some family members responded in negative ways to staff which added to the HCWs stress.

> *"So, it's like, we would only be allowed to have one person to come in at that point of the end of their care or the end of that life. So that was just, it wasn't nice, it wasn't fair to see, I certainly wouldn't have liked to be in that position. They were just wanting to see their family, they are just as worried as we are with regards to how they were going to be looked after, staffed you know, we totally understood that, but it was a lot of extra pressure that we didn't really need at the time." P6*

> *"But I had to field phone calls from two families in particular that terrorise me with every little thing they have read or seen on the television...'well I read this in the Daily Mail today." P2*

The difference between restrictions across the UK also caused confusion. The organisation took a more cautious approach to re-opening which likely limited the spread of Covid-19 within the care homes. However, HCWs did find explaining the regulations and enforcing them to relatives was challenging and caused conflict at times. Some of the stress was further impacted with the continual change and uncertainty around restrictions.

> *"We did open up and then the lockdown, so we had to close up again. And then we started off with window visits. And like us as a company, obviously we follow guidelines, but then the company set their own rules. And then it's and then the family say, look, I heard on the TV, blah, blah, blah. And so, you explain its a guideline, the rule is, it's not kind of set-in stone. And then obviously the mix up because obviously sometimes the Scottish Government is different to the English what's going on it became, we are slightly behind them in opening up and things and so explaining it all to them, but no we're doing it this way." P10*

> *"And they (relatives) were, some who were quite nasty about it, to be perfectly honest. We were trying to do garden visits as best we could. Why can't we touch them? Because, you know, if you touch them and you've got it, it was before all the testing was getting done, it was really hard. And then I think we got two, we had a room set up and we got to two inside visits and then we went into lockdown again." P5*

PSYCHOLOGICAL RESPONSES

The pervasive uncertainty of the Covid-19 pandemic was evident and created fear and worry, emotional distress and, at times, a sense of helplessness. These responses whilst evident as a source of stress were also experienced because of stress.

Fear and Worry

The uncertainty of working with a novel virus, the threat to their own health, colleagues, residents and families and the public, caused ongoing feelings of fear and worry amongst HCWs.

> *"Obviously, is it's extremely worrying, and you know, it's a global pandemic, you know, so everybody's been affected by it." P1*
>
> *"I forget the very beginning that could be described as dramatic because it was so scary. We didn't know about this virus, you know, you know, even the authorities, nobody knew, you know, how it was going to hit." P2*
>
> *"To start with I was feeling scared because nobody knew anything." P5*
>
> *"It's that fear of, you know, a lot of the staff have spent a year in fear." P8*

Fear was particularly apparent for those in leadership positions with responsibility for keeping others safe:

> *"I think it's the unknown and trying to, you know, trying to reassure others when we might not know the answer, especially at the early stages, and it's particularly challenging, and it's upsetting." P8*
>
> *"It's a huge responsibility as a manager, you know, keeping everybody safe and well, not just your residents, you know, your staff and their families. And, you know, you've got workers that are pregnant, and, you know, what, workers with a cancer diagnosis and, you know, so you've got all the usual strains and stresses of the job, which are really difficult even under normal circumstances. It's Yeah, it's one of these jobs that are very, very difficult and I think but that's a lot added on." P2*

Staff were also deeply concerned for the well-being of their own family members, as well as residents and their relatives

"It's worrying for families I mean, you know, I've got, you know, my own family, Grandparents that are still alive, but I've also got my own staff, my residents as well to think about, and obviously their families so it is a worrying time." P1

"At times I was wondering what am I gonna do if it comes into this home one, how am I gonna care for everybody, how are we gonna care for everybody, you know, how are we gonna support families?" P2

Emotional distress

Working in the care home environment through the pandemic caused feelings of emotional distress due to inherent uncertainty posed by the pandemic, the extremely pressurised work environment and the high risks faced daily.

"I think they really need to look at the people that have had to work through all this and the hours and all the uncertainty we have worked through it has taken a toll. And I think once things go back to normal, we've all had a lot of people off with stress and anxiety. Because, at the moment, we're all, well personally I'm running on empty." P5

The enduring nature of the anxiety extended into periods of overwhelming distress for some staff with physical impacts such as insomnia evident

"It's been overwhelming at times, it's been stressful, it's been frightening at times. I think a lot of us, have been maybe there's been lots of times I've been in this office crying, you know, shut the door, and just, I need to cry, I have to just cry." P2

"At times I couldn't sleep like, you know, it was just like I said, every time I shut my eyes, I was seeing stuff, seeing the images and the buzzers, you were hearing them in your sleep. And it was just, it was hard. But it's a lot better now." P6

Some participants had not realised the enormity of the impact until they were discussing the things that had contributed to their stress during the research interview, with some becoming tearful during the interview.

"Oh, my goodness, so it has been stressful. And actually, I don't think I realised till I was talking to you how it does impact. It's with us all the time." P12

Helplessness

Feelings of helplessness as a direct result of the traumatic experiences of daily challenges, relentless stress compounded by uncertainty caused by the pandemic were evident in participant's responses. Where there were continuous stressful experiences with little or no control then some HCWs experienced a sense of helplessness.

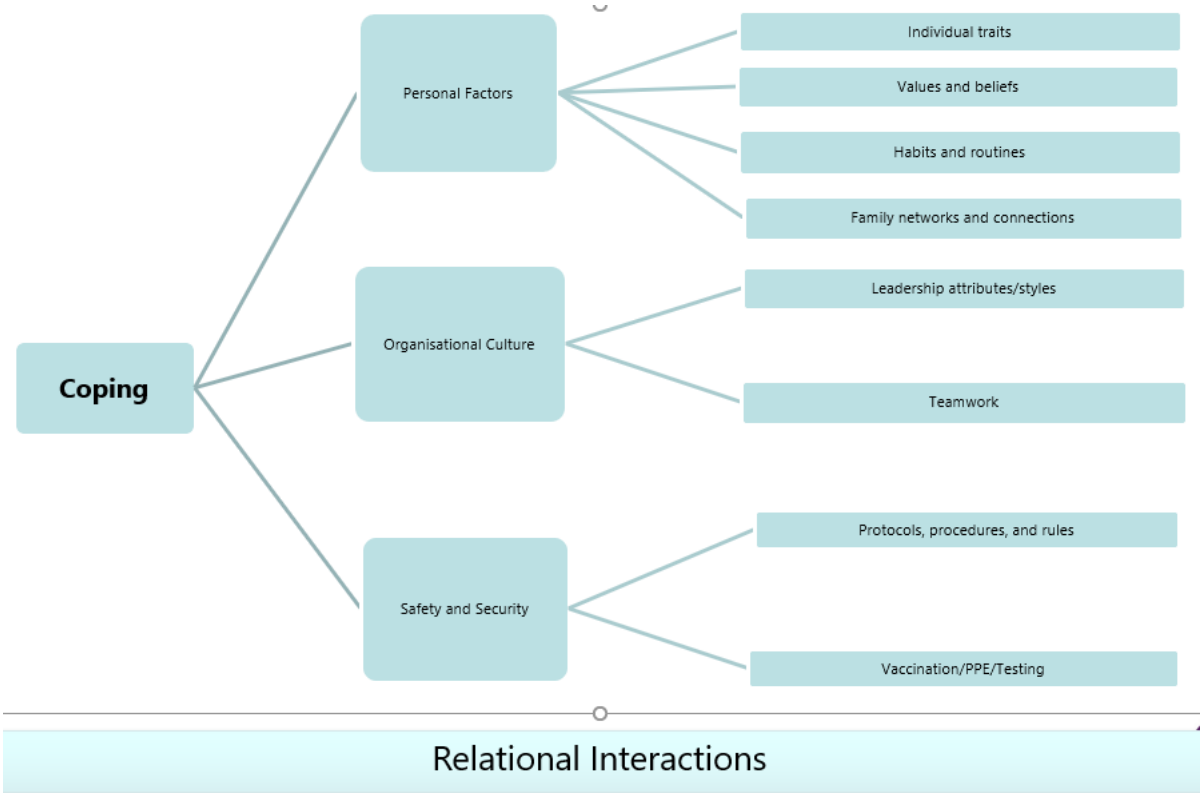
> *"Yeah. I mean, the workload just, I mean, in a normal day, our jobs are quite hard as it is like we're having to, you know, make sure that we're giving the best care possible. And it got to a point where people would only receive just basic, basic care, and you know, that's not us, that's just, it was so upsetting to feel that you're wanting to do more, but you just you could only do the best you could you know, we were going home at night. I wasn't sleeping. I mean, it was it was awful." P6*

> *"It has been difficult to keep everybody going at times, especially when me myself feel like bursting and crying myself. You know, when I, me, myself, I feel…. what, what does the world look like going forward? What does life look like going forward? But those guys are looking to me to be the strong one and a leader. And that's a lot of pressure. When you're feeling a bit fragile yourself." P2*

What enabled coping?

Every participant we interviewed, expressed positive comments about their experiences of coping whilst working in a care home during the Covid-19 pandemic. We present an analysis of the factors which enabled them to cope with an underpinning theme of relational interactions. The relationships within their family networks, between each other as co-workers and with managers and leaders within the organisation provided core stability and support to enable coping. While habits and routines, individual traits and values and beliefs were identified as important coping influencers, these were often expressed through relational interactions. Figure 2 provides a visual representation of the themes and subthemes of coping. There were three main themes of 1. Personal factors, 2. organisational culture and 3. safety and security which were all underpinned by relational interactions. The following sections provide data to support each theme and subtheme within these categories.

Figure 2: Visual Schemata of HCW's experience of coping



PERSONAL FACTORS

Participants reported a range of personal factors that influenced coping as discussed below:

Individual traits

Participants shared experiences of their coping styles which were linked to their individual personality traits, such as extraversion and conscientiousness. Participants also expressed experiences which incorporated problem focused and emotional coping. Problem focused coping involved people responding to stressful situations by taking action to resolve the problem, whereas emotion focused coping involved altering the emotional response (feelings) to the stressful situation.

> *"I'm a talker so I'm not too bad. Talking and getting everything out, rather than bottling everything up." P5*

> *"I found myself sneaking off to the toilet to have a wee cry, just to get the emotions out and feel better myself and I never took work home with me, I just left it there, we got on with it and then I went home." P2*

Participants shared experiences of dispositional optimism and hope as a mechanism for coping. Those who appraised the situation positively, or at least with a reduced threat (people can survive Covid-19), highlighted the following as enabling their coping.

> *"I just think every day is a new day sort of thing." P1*

> *"So, your attitude is a big thing?" Interviewer "I think so. We've got to be positive rather than negative." P4*

Humour was also seen as a strength of character to buffer stress and was frequently referred to in participants' experiences. Humour amongst colleagues and residents also reinforced connections with peers and helped participants and others feel good.

> *"You've got to have a laugh. Honestly you have just got to have a laugh. It's a very serious job, taking care of people but playing bingo, karaoke, dominoes you know, you just need to be able to have a laugh and a sing song and get Alexa on. And that's how I've coped. Yesterday we had a laugh, and it was brilliant." P9*

> *"... it's just being there for each other, supporting each other. Still trying to have a laugh and a joke and make things fun, not all work orientated and serious. So having fun and a laugh." P10*

> *"Just being able to still smile and have a laugh with each other that's really helped everyone." P11*

Values and beliefs

Coping appeared to be influenced by participants' values and beliefs about their ability to get on with their everyday living and working. There was a real sense of pragmatic resilience thus, the need to adapt to the current situation in a practical way. Values and beliefs were also explained as being positively influenced by relational interactions.

> *"Well, I just had to get up, I just had to get on with it and pull up my big girl pants. And if it wasn't for being able to see my daughter on Facetime and stuff like that,*

that made it a little bit easier, I don't think it would have been the same had these not been available to me." P9

"It is what it is you know, and we just have to tackle it head on." P1

"I thought at first that I might have that feeling, you know, I don't want to go in there (speaking about work). But I didn't I just took it on the chin and just got on with it really." P6

There was also recognition that preoccupying thoughts by 'getting on with it 'may not be the best strategy for long term coping. There was an awareness that once given space for reflection to process there may be a delayed adverse psychological response.

"So, it's like just keep going, keep going, keep going. And then when it's all over we'll sit, and we'll think, and we'll reflect, and we'll come to terms with all this because I think once the floodgates of this is opened it's going to be hard for some people. P2

Inherent within participants' values and beliefs was a strong sense of altruism and duty to their residents and job. HCWs described transforming their own stressful thoughts and feelings by helping others and reminding themselves of their primary purpose. In many instances, residents' and their family's needs were prioritised above HCWs' own wellbeing.

"I had said to myself from day one, I would never not go and care for my residents. That's just not me. I wouldn't. I wouldn't put myself before them...I've been in this job for 10 years, and I'm not going to let some virus take away what my life is really, I've put my life into this job." P6.

"I think as a nurse it's just in you to be like, I need to be at my work, and I need to be available if anybody needs me sort of thing. So, I think that's what's kept me going, I 've got a duty of care to my residents and my staff…It's not, it's not a 9-5 job, it's something we dedicate our lives to." P7

These altruistic values were linked to a sense of purpose. A strong sense of purpose appeared to give meaning to participant's lives and the challenges of living and working during the Covid-19 pandemic, which helped mitigate against stress. The importance of

their work and the significance of the care they provided to residents was exemplified during the pandemic.

> *"I think I've felt really proud that, you know that I'm a key worker and that my role in this, in my community, in my world is really important." P2.*

> *"I'm glad I was still working though you know, that's been a bonus I feel. As much as it's been stressful at times…. giving you a purpose too." P9*

> *"I know it's your job normally, but it feels more rewarding, does that make sense? ...As if it's had extra purpose, obviously you were helping them, every day as normal but that extra load of protecting them and getting them through this." P10*

Habits and routines

Participants described regular activities that provided structure, certainty, and escapism from the stressful experiences during unprecedented change and uncertainty imposed by the pandemic. Habits and routines mostly included being outdoors and creating opportunities for social interactions within the pandemic restrictions:

> *"Clearing my head, I'd take the dogs, I've got two great big Labradors and I just go away up into the countryside just to clear the air." P5*

> *"I formed an outside bubble with another friend, and we go out probably three or four times a week and walk outside." P12*

Family networks and connections

Participants often described families [spouses, children, parents, in laws] being a crucial source of support and a major influencer to help them cope.

> *"I've got my husband and my two kids…. I've got them for support. And my mum as well, she knows what I'm going through, I've got a good family network around me."* P1

> *"My husband he's very good at supporting me in everything I do. I have a good family network."* P4

"Well, I still have both of my children at home, so that's been great. As much as they are grown up at 20 and 23. But they both still live at home, so I've got them at home which is fantastic, and they've been a great help." P10

Some participants shared stories of physically relocating to live with or be in closer proximity to family members. This increased a sense of connectedness and safety.

"So, I went to be closer to my mum. So, I've had a lot more support since I moved back here, I'd say, than I did in the first six months." P3

"I currently stay with my mum and younger brother just now; I'm spending this lockdown with them. So, I'm not on my own, so that's been good...most of the time I do have a close network out with work." P6

ORGANISATIONAL CULTURE

Leadership attributes/styles

The culture of working in a care home at Balhousie was described as democratic. The open and accessible leadership from immediate line managers to the Chief Executive enabled staff to feel supported throughout the pandemic. The following theme describes the leadership attributes and styles evidenced in the data with a strong connection to relational interactions at all levels. Participant expressed perceptions and experiences of transformational leadership where leaders influenced and motivated staff by reminding them of their purpose. The reciprocal, supportive and respectful relationships between staff and line managers helped HCWs cope with the challenges of the pandemic.

"They knew I was doing it for them and all the residents, and that sort of thing, so, you know, I had a lot of support from them, which was great. And likewise, I was giving them the support, you know, through it all sort of thing. P1

"Going through a lot of the polices that's changed with staff in layman's terms. Yes, you know, ensuring they're wearing their PPE, I know it's uncomfortable. The reason why, giving the rationale behind instead of saying just do this." P5

"I'm not short on giving them the praise when they do something right, you know, now, I will always go and, you know, say to them…well done, today was a hard shift, you know, and, you know, sort of thing, but yeah, they're nothing short of amazing, because they've done a brilliant job." P1

There was an awareness of the connection between keeping staff motivated and a high quality of residents' care.

"I just, I want to keep my guy's spirits high, because ... you know, if their spirits are high, my residents' spirits are high." P1

Participants expressed experiences aligned to authentic leadership due to managers leading by example and being compassionate with staff as they could resonate and empathise with their situation. Demonstrating this compassion formed strong connections between staff and managers as reciprocal trust created certainty during times of rapid and constant change.

"Um…letting them cry when they need to cry, when they were scared when people started testing positive and just guiding them when we were short of staff, as to what was key duties, what wasn't key duties." P5

"You have obviously got to lead by example, you know. And the thing is, don't ask anybody to do something you're not going to do yourself. You know that sort of thing as well." P1

"You know, basically, I try to adopt an approach where they follow me, like we all get through the day together as a team. It's not like, I'm the Senior and you do this, and you do that, I just don't think that works well. So, it's like, I help as much as I can, and I just show them that I'm here." P6

"And it's, you have to look like you absolutely know what you're doing. So that they can think, right. Okay, there's a steady ship, they're gonna be able to help." P12

This certainty aided staff to cope during the pandemic.

"That's all it is…stability, once they start to realise that they are actually safe, and they are safe to make mistakes, and they're not going to get thrown under the bus. And we all want

the same things. And they'll be fine. I can see that each day, they just relax a bit more." P13

This supportive culture expanded beyond local managers to leaders of the organisation.

"You need to give them support, and all the rest of the as a group itself have been extremely supportive of, not just me as manager, but to the staff in that as well, in making sure they've got the tools that they need, then, you know, giving them the training, and things like that, and that's come right from our chairman." P1

"*I feel well supported by the company. And I feel safe at work."* P7

"The main thing through all of this has been supporting our workforce as our teams, through what has been an incredibly challenging year." P8

Teamwork

The perceptions of authentic leadership, and the urgent call to action created by the Covid-19 pandemic, reinforced a strong sense of teamwork and comradery which helped HCWs cope with the continued changes to workplace practices and environment. Experiences expressed within this theme included team cohesiveness and cooperation, social support (including virtual socialising) and a strong sense of family.

> *"It's not all been bad if that makes sense, you know, and it allowed us to sort of become a stronger team."* P7
>
> "*Having each other, just helping each other, and I don't think any of us would cope if we didn't have each other to keep each other going. It really has probably been one of the main things that has kept us putting one foot forward every day, it's just having the support of your colleagues and we're all in this together and we're all feeling the same and facing the same*." P2

Participants explained that many HCWs had 'stepped up' in response to the pandemic. Mutual positive regard for team members increased cohesiveness

> "*So, I felt I had to step up and be there and stuff like that. But I've actually enjoyed it. Being in that role and being that supportive person for my team*." P6

"As I say everybody's willing to step up, everybody's willing to you know, I've had a couple of deaths, my brothers had a heart attack and things like that, if I've needed time off or to swap shifts everybody's willing to step up. It's been good, really good support." P4

This stepping up included step going 'above and beyond' their roles and responsibilities which created a sense of pride amongst the team.

"*My team are just fabulous. Absolutely fabulous and yeah, they're nothing short of heroes really and what they do every day they go above and beyond, above and beyond*." P2

"Aye they're amazing... When there's a problem, we all just try it we get together we see what the problem is and we try our best to rectify it and get it dealt with, so that it's not carrying on throughout the whole shift. We pulled together as a team, and we have done amazingly well." P5

"It's a ...it's a war in a lot of ways you know, we have to stick together, then you know keep moving forward and I think for us we have definitely demonstrated that, it does make you feel proud." P2

The underpinning thread of positive relational interactions occurred frequently and was incorporated throughout the organisational culture theme. The relationship of team members extended beyond the workplace and created a sense of family. Participants felt that there was a strong sense of loyalty to each other and of the necessity to support each other through daily and life challenges. This included talking about their feelings and sharing experiences of family life, which and was an important aspect to increase participants perceptions of coping.

"I think together you know; we were really supporting each other through. We've all faced real challenges, you know, some have had COVID, some you know are unable to go and support their homes because they've got a long-term health condition. You know some haven't seen parents, haven't been able to get married." P8

"Yeah, we all keep in contact with each other all the time, it's like we're this little family as we say now." P6

All work colleagues, everyone, we've all come together and it's almost like they've become your family, we're a very close-knit family in the home." P9

"Fantastic absolutely, everyone's pulled together and been there for each other. I would say it brought us all a lot closer obviously what we've been through and, as a whole, I would say it brought the whole team a lot closer together, kind of more of a family." P10.

Participants seemed to capitalise on virtual socialising within and out with the work environment to stay connected during the pandemic.

"*We've been doing virtual games nights and things like that.*" P7

"We've got social media pages where we can post photos and things like if we've done anything within the home and get a thank you and just those words of support have been great as well." P5

"And also, I know that, you know, if there's anything, anybody has a problem with or if I had a problem, then we can open up in our group chat." P4

This sense of family was also evident in relation to how HCWs considered residents. At times, participants viewed themselves as 'surrogate' family in the absence of visitors. This commitment to caring for residents as family also connected with their sense of purpose and vocation.

"Trying to keep residents aware of what's going on without scaring them, trying to comfort them because they couldn't see family members, trying to cope, things like that. I go round the residents every day and speak to them all. We've obviously taken on the role of family members in the home, trying to comfort them and entertain them and try to keep them upbeat." P9

"There's lots of things going on with the COVID but the main one is keeping their (residents) spirits high, you know, trying to keep them as positive as we can." P1

SAFETY AND SECURITY

Protocols, procedures, and rules

The data in this theme includes participants' descriptions of how personal and work based polices provided a framework to help them cope with the uncertainty created throughout the Covid-19 pandemic. Adhering to the rules provided reassurance and confirmation that HCWs were delivering the best possible care safely. The use of PPE, testing and vaccination helped reduce staff's perceptions of the perceived threat of Covid and offered some sense of security. As the pandemic continued staff began to adapt to the new ways of working.

> *"It's important to understand that I've done everything online, apart from going to work and filling the car with diesel, we don't leave the house very often, to ensure that we're keeping safe."* P6

> *"We're at a stage where we know what's procedure so if any changes come through now, they are few and far between because this is the norm now, this is it?"* P1

Vaccination, Personal Protective Equipment (PPE) and testing

The use of PPE, testing and vaccination helped reduce staff's perceptions of the perceived threat of Covid and offered some sense of security.

> *"We get our weekly tests and everything which is reassuring. I'd rather have that and be working and get the test and know that I am clear." P3*

> *"If we could only get number two (COVID vaccination) that would certainly help with peace of mind." P4.*

> *"I think as a country to have gone from a disease that is basically new that we didn't know about…. to where half the population is vaccinated in 12 months. In some ways it's made me feel safer." P13*

Additional resource also provided a layer of safety and security. Some care homes were able to recruit a Covid-19 Coordinator to help manage many of the additional administrative tasks created by the pandemic. This helped care home managers cope with the additional administrative burden.

"I do have two COVID co-ordinators in post which has been so useful and has took a lot of pressure off myself and the administrator." P7

"COVID testing and stuff like that, supporting them or if they have to self-isolate for any reason, like track and trace messages. I can always help them in the right direction as to how to go about getting a test out with work applying for one with the NHS or whatever." (COVID Co-ordinator) P11

Discussion

This study explored the stress and coping experiences of HCWs working in Balhousie care homes during the Covid-19 pandemic. HCWs reported high levels of stress due to the uncertainty of the pandemic and the subsequent challenges faced in a care home setting. A key source of stress was the changes to the care home environment which were necessary to reduce the transmission of Covid-19 creating a clinical as opposed to a homely environment. HCWs described care as depersonalised due to the wearing of PPE and other infection reducing behaviours. The challenges of maintaining a therapeutic relationship were exacerbated for residents who lacked capacity to understand the necessity of the measures. A study exploring the impact of Covid-19 on healthcare workers providing end of life care in a hospital context also reported that the use of PPE restricted the ability of HCWs to communicate and retain empathic human interaction.[19] When care delivery is at odds with HCWs values and beliefs it can result in moral injury, with subsequent stress, anxiety, depression, and even post-traumatic stress disorder.[5] Moral injury is said to be present when there is a perceived betrayal of what is morally right in a high stakes situation.[20] The experiences of HCWs in this study suggest they may have experienced moral injury as a result of the disconnect between Covid-19 reducing behaviours and their professional caring values.

The Balhousie Care Group made a difficult decision to restrict end-of-life visiting. This decision was made after much deliberation with clinical and operational staff and likely helped minimised the spread of Covid-19 in their care homes. This impacted on staff stress and distress as they enforced visiting restrictions even when this rule clashed with their values and beliefs about caring, such as relatives being unable to be present when residents were dying. The emotional labour of such ethical dissonance has been associated with HCWs burnout.[21] Restricted visiting had adverse impacts on residents and staff in this study. Consistent with this finding, a survey of care home managers in England reported that 84% of residents had low mood with 98% attributing this to deprived visiting.75% of managers also reported a negative impact of visiting rules on HCWs mental health and wellbeing.[22]

HCWs communication with residents' families was made difficult due to the need to enforce the legislative and policy changes associated with the pandemic. Relatives were mostly supportive of the lockdown measures but the information they picked up from the media, was not always correct particularly in relation to access and visiting. At times this was exacerbated further by geographical differences and, also the times Balhousie took a more

cautious approach to visiting and re-opening. Once measures were explained to relatives this appeared to alleviate relatives' anxieties, however the burden still lay with HCWs to undertake that communication and resolve conflict by providing the correct information and underlying rationale. The care home environment is unique as staff can work with residents and their families for months and years at a time, and the added familiarity can add to the emotional cost of care.[23]Families are also often involved in supporting the daily care and emotional needs of residents. One study found that visitor bans to care homes had a severe impact on residents' mood and behaviour and in turn increased staff workload, stress, and burnout.[24]Infection control guidance also meant care partners which routinely provided support to care homes, including general practitioners and community based multidisciplinary teams, were required to maintain only essential visits with care homes. This meant there was an increased workload due to changes in the way that support services that care home staff routinely relied on for advice and guidance were delivered. Enforcing regulations caused a dilemma and had a profound emotional impact on HCWs as although policies were not their decisions, they felt responsible for the implementation.[23]

The continual changing of policies was another aspect that caused increased stress among HCWs in this study. HCWs described multiple changes to infection control regimes and care policies which was confusing and incoherent at times. Recommendations around infection control, testing, workforce mobility and hospital transfers in care homes was constantly changing in the early stages of the pandemic. Staff were often having to navigate the complex and rapidly changing guidance and conditions to make important care delivery decisions. Devi *et al* further explains that while local and central government were changing their policies to promote patient safety it often resulted in duplication of effort for an already overstretched workforce and as a result risked jeopardising resident care.[25] The stress of scrutiny was further compounded in this study from multiple external agencies who were checking that the correct policies and procedures were being followed particularly in relation to infection control. Such inspections were perceived as uncoordinated, fragmented and from multiple agencies including the Care Inspectorate, local authorities, and the NHS. HCWs often felt the points for judgement were not considered in relation to the care home context and were often seen as trivial in comparison to their daily challenges.

The daily death toll from care homes being continually featured in the media may have been one of the reasons that political agendas were ensuring care homes were subject to intense scrutuiny.[26] Policy makers also felt that this scrutiny was essential to ensure care was regulated and safe promoting accountability and justice.[27]However there are lessons to be learnt as to what the most effective manner for undertaking these inspections might be and this study has shown that there is a need to reduce duplication and an awareness that constant scrutiny increases HCWs stress affecting their ability to do their job efficiently. One solution proposed is a more co-ordinated approach and that care home management should have the opportunity to work in partnership on formal guidance and have sufficient warning to implement any changes required.[27]

Staff resource contributed to stress with HCWs working more hours to cover gaps caused by sickness and self-isolating. Lack of staffing in nursing homes is recognised as a global issue, which makes providing basic care challenging, and has further complicated caring for residents with Covid-19 symptoms.[11]Participants in this study said that understaffing also made it difficult for staff to adhere to protocols and enforce physical distancing amongst residents. Research from other pandemics highlights frontline HCWs are at risk of experiencing severe stress which can be influenced by both personal and physical

factors.[5,13]The associated increased workload of looking after residents with Covid-19 resulted in HCWs going above and beyond, often working long hours. This was especially true given the shortage of staff due to illness, shielding and self-isolation. HCWs described feelings of exhaustion and tiredness especially as there is still a sense of uncertainty and threat over subsequent waves of the pandemic. Other studies have found that caring for patients with Covid-19 is associated with a higher level of stress, anxiety, burnout, and work exhaustion amongst HCWs.[20]

HCWs in this study reported being unable to see their friends and family, and at times chose to live apart for a period to protect their loved ones and the residents from contracting the virus. This led to feelings of isolation and loneliness at times and led to extended periods apart from their families. There was also a sentiment expressed about the time lost with their nearest and dearest as not being able to be recaptured and missing out on significant life events. Similar findings have been reported elsewhere with one study stating that more than 70% of care home managers reported that they had concerns about staff morale and mental health and well-being describing a fearful and overworked workforce who felt the pressure of responsibility to protect residents from contracting the virus at all costs.[27] HCWs often struggle with work-life balance, the issue of dual loyalty in caring for their families and patients has been realised in an unprecedented way during this pandemic.[19]Enormous stress has been placed on HCWs and their families as they fulfil their roles and responsibilities. Other recent pandemic studies with HCWs have shown that an excessive load in terms of working hours, lack of personal protective equipment, uncertainty about personal safety and that of their families and concerns about patient mortality are factors that can trigger psychological distress.[2,25]

HCWs in this study displayed a strong sense of duty and self-sacrifice and were prepared to go the extra mile' to make sure their residents were cared for. Although at times they experienced feelings of fear and anxiety they were so committed to their role, and they were determined to keep working throughout the pandemic. However, this could also have a detrimental effect as HCWs who neglect to self-care are at an increased risk of burnout. The challenges of balancing home commitments with work, irregular hours, higher workloads, and unfamiliar clinical roles increases the risk of emotional strain and physical exhaustion.[28]Furthermore Ouslanderand and Grabowski warn that HCWs are facing a 'perfect storm' as they work through the pandemic continually risking their own and their families lives every day to care for the sick and most vulnerable in society.[29]

Psychological effects experienced by HCWs include anxiety and severe stress which may lead to distress and can be associated long term impacts.[1,5,13] Many HCWs have been committed to saving lives and minimising transmission of the virus in care home settings working while being exposed to a high risk of contracting the disease. Working in this extremely pressurised environment has led to feelings of distress and anxiety because, in some cases, they have had to work through challenging circumstances daily over a sustained period with no end in sight. As a result of this some HCWs have reported experiencing burnout, and described the physical, mental, and the emotional burden of taking on heavier caseloads and learning new policies and procedures.[12,29]Mitchinson*et al* explains that burnout is a real risk associated with the highly distressing events associated with Covid-19 and is likely to be exacerbated as a result of the pandemic.[19]HCWs in this study were frequently exposed to situations of emotional overload posed by the pandemic so it is understandable that staff have become overwhelmed with the competing demands. This was especially true if residents got ill or died due to Covid-19 causing HCWs to

experience significant grief and distress. One notable feature that participants repeatedly expressed was that they had not yet reflected fully on their experiences of working through the pandemic, as their current aim was to keep doing their job and deliver care. It is likely that the psychological impact on HCWs will only be fully realised later when they feel ready and have time to process their experiences.

The moderate scores reported by HCWs for coping whilst experiencing high levels of stress are an indicator of the high levels of resilience within this study population. Despite the relentless nature of working in a care home during the pandemic most managed to "keep going" and maintain psychological functioning. Resilience in healthcare workers is a protective mechanism against the development of post- traumatic stress disorder.[30]Participants in this study expressed that optimism, self-care routines, and a sense of humour aided their ability to cope. An optimistic outlook and self-care habits have been recognised as important contributors of resilience.[31]Humour has been identified as a coping strategy during the Covid-19 pandemic, with those reporting the use of humour as experiencing less anxiety.[32-33]Throughout the data there was evidence of both problem focused and emotion focused coping. Problem focused coping involves people responding to stressful situations by tacking action to resolve the problem i.e., working extra hours when the care home is short staffed, whereas emotion focused coping involves altering the emotional response (feelings) to the stressful situation i.e., using humour.[34]A survey of stressful events amongst the US public during Covid-19 also noted that both problem and emotion-based coping were utilised.[35]

Relational interactions were foundational to all coping themes and sub themes within this study. This included HCWs' family members as well as close relationships with those in the workplace. Participants in this study explained how close family relationships had helped them cope whilst working in a care home during the pandemic. This also extended to keeping in touch with friends and family through phone calls, social media or virtually, especially when individuals were isolating or shielding. It is known that individuals with a secure family base are able stretch further in terms of resilience. Recent research has shown HCWs working through the pandemic who are in long term relationships and those with children have reduced rates of stress, anxiety and depression.[36] Families, to varying degrees, provide social support and this has been correlated with lower rates of burnout.[37] It has been acknowledged that requirements for social distancing due to the pandemic have made it challenging for HCWs to spend time with their loved ones but it is important that staff are encouraged to maintain social connections through digital means and video calls.[38]

HCWs in this study were glad to be able to come into work and care for others which gave them meaning and a strong sense of purpose. Other studies have found that a shared purpose and a sense of duty have helped HCWs cope with working through the pandemic.[39] Furthermore the key worker status aided motivation and added a sense of pride to HCWs roles. HCWs in care homes saw the key worker status as a huge recognition as they are often a de-valued workforce, and the pandemic has highlighted the importance of their role in society.[40]Values and beliefs played a significant role in HCWs adopting emotion focused

Participants spoke of a strong sense of family felt between HCWs and their teams. A study by Maben *et al*[41]found that a sense of family between nurses improved patient experience and staff well-being. This was evident in the ways they looked out for one another and supported each other through times of crisis, often keeping in touch with each other out with working hours through social media. Ornell *et al* recommends that virtual

communication can be used within teams to establish a climate of reciprocity and empathic cooperation allowing individuals to express their feelings and concerns and thereby reduce the risk of burnout.[42]Prior research has shown that crisis situations can stimulate peoples willingness to work together to achieve shared goals.[43]There appeared to be a genuine care and concern for each other appreciating the wider issues and needs in colleagues personal lives. This was evidenced in a clothing grant for one member of staff and support for attending healthcare appointments. Mayo explains that demonstrating kindness by going beyond job expectations to help and backup others has been found to enhance and promote effective teamwork.[44]

Leadership within care homes throughout Covid-19 has been particularly challenging due to the growing administrative burden and having to navigate frequently changing guidance from policy makers.[4,21]Participants expressed that they felt that the organisation provided strong leadership by implementing timely strategies to mitigate the spread of Covid-19 and providing a safe place to work. Communication from leaders was also highlighted as a strength both at a strategic level and locally by individual home managers. It is known that timely effective communication between healthcare managers and staff has been found to help staff to accept changes in clinical procedures and resource utilisation.[45]Changes to daily practice, some of which were difficult, were made more palatable when they clearly served a shared purpose such as keeping the residents and staff safe. HCWs felt more motivated to comply with new practices when managers invested time in explaining why changes were necessary and provided staff with opportunities to discuss these changes. Several participants spoke about feeling safe to voice their ideas or concerns and shared that their manager was visible and approachable. A study of HCWs found that providing a space to share feelings and experiences with colleagues and being able to express negative emotions greatly reduces stress and exhaustion levels.[4]

A number of those in management positions demonstrated authentic leadership styles which supported HCWs ability to cope. Authentic leadership is recognised as fostering a sense of community, encouraging staff to be kind to themselves and providing emotional space to strengthen the team and help regulate difficult feelings.[46]This was evident in this study as there were multiple examples of leaders providing emotional support. Havaei*et al* highlight that managers have faced a challenging task in demonstrating effective leadership through the pandemic, whilst managing the safety and well-being of staff and residents.[47]Transformational leadership is also critical in crisis situations, and care home managers in this study demonstrated this by maintaining regular lines of communication with staff and keeping them informed of policy changes and safety protocols.

Limitations

The most important limitation of this study is the sample size, particularly in relation to the survey data. The survey results may have been different had more HCWs participated, known as non-response bias. Despite multiple recruitment strategies the number of survey participants remained low. Several strategies were deployed to aid recruitment including the creation of a short video clip to state the purpose of the study and integrating QRS codes into digital hand sanitiser screens within the care homes. The representativeness of the sample is also an important consideration. While all participants worked for Balhousie many worked in different care homes within the organisation. Although the experiences described

here are not representative of other care home organisations the findings are similar to other study results. The sample in this study had a proportionately higher number of nurses to health care workers and this is not representative of the Balhousie workforce. Had there have been more carers and less nurses interviewed the data and subsequent findings may have been different. However, there appeared little differences in the experiences of stress and coping between carers and nurses, except many of the latter in managerial roles expressed an increased their sense of responsibility. Despite these limitations, to our knowledge this is the first study carried in Care Homes in Scotland to explore the stress and coping experiences of staff working in a care home during Covid-19 and the results provide an insightful view of their experiences.

Recommendations

- HCWs would benefit from a 'safe space' and time to reflect on their pandemic experiences.
- A values-based approach to support would likely be beneficial given the challenges of ethical dilemmas experienced by HCWs during the Covid-19 pandemic.
- Covid-19 specific guidance should be tailored wherever possible to the care home setting, taking cognisance of residents with reduced cognitive function.
- Inspections should be coordinated, supportive and avoid a 'tick box' mentality.
- Resource is necessary to keep resident's family informed and supported during ongoing pandemics.
- The view of HCWs in care homes requires a cultural shift to acknowledge their unique and high-quality contribution to care.
- Identifying and sharing coping strategies between HCWs may be useful.
- Developing and exemplifying the strong sense of family would be useful for other HCWs.
- Further research is needed to identify evidence-based support interventions
- Codesigning interventions to support current and future coping with care home staff

Conclusion

HCWs in care homes have experienced high levels of stress during the Covid-19 pandemic. There is a risk that this stress extends into distress and other psychological health problems. There is a moral obligation to provide psychological support to care home staff both in a reactive and proactive manner.

This study identified important factors which contributed to HCWs stress and what helped them cope while working in a care home setting during the pandemic. This study provides an opportunity to acknowledge and act on these findings to reduce further physical and mental health impact on staff and commend their efforts and commitment during this crisis.

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APPENDIX 1: The Perceived Stress Scale (PSS 14)

The questions in this scale ask you about your feelings and thoughts during THE LAST MONTH. In each case, you will be asked to indicate your response by placing an "X'" over the circle representing HOW OFTEN you felt or thought a certain way. Although some of the questions are similar, there are differences between them, and you should treat each one as a separate question. The best approach is to answer fairly quickly. That is don't try to count up the number of times you felt a particular way, but rather indicate the alternative that seems like a reasonable estimate.

For each question choose from the following alternatives:

0 - never 1 - almost never 2 - sometimes 3 - fairly often 4 - very often

1. In the last month, how often have you been upset because of something that happened unexpectedly? ___
2. In the last month, how often have you felt that you were unable to control the important things in your life? ___
3. In the last month, how often have you felt nervous and "stressed"? ___
4. In the last month, how often have you dealt successfully with day-to-day problems and annoyances? ___
5. In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life? ___
6. In the last month, how often have you felt confident about your ability to handle your personal problems? ___
7. In the last month, how often have you felt things were going your way? ___
8. In the last month, how often have you found that you could not cope with all the things that you had to do? ___
9. In the last month, how often have you been able to control the irritations in your life? ___
10. In the last month, how often have you felt that you were on top of things? ___
11. In the last month, how often have you been angered because of things that happened that were outside your control? ___
12. In the last month, how often have you found yourself thinking about things that you have toaccomplish? ___
13. In the last month, how often have you been able to control the way you spend your time? ___
14. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? ___

APPENDIX 2: Coping Self-Efficacy Scale (CSE)

When things are not going well for you, or when you're having problems, how confident or certain are you that you can do the following:

1. Keep from getting down in the dumps.
2. Talk positively to yourself.
3. Sort out what can and cannot be changed.
4. Get emotional support from friends and family.
5. Find solutions to your most difficult problems.
6. Break an upsetting problem down into smaller parts.
7. Leave options open when things get stressful.
8. Make a plan of action and follow it when confronted with a problem.
9. Develop new hobbies or recreations.
10. Take your mind off unpleasant thoughts.
11. Look for something good in a negative situation.
12. Keep from feeling sad.
13. See things from the other person's point of view during a heated argument.
14. Try other solutions to your problems if your first solutions don't work.
15. Stop yourself from being upset by unpleasant thoughts.
16. Make new friends.
17. Get friends to help you with the things you need.
18. Do something positive for yourself when you are feeling discouraged.
19. Make unpleasant thoughts go away.
20. Think about one part of the problem at a time.
21. Visualize a pleasant activity or place.
22. Keep yourself from feeling lonely.
23. Pray or meditate.
24. Get emotional support from community organizations or resources.
25. Stand your ground and fight for what you want.
26. Resist the impulse to act hastily when under pressure.

Use problem-focused coping (6 items, α = .91), stop unpleasant emotions and thoughts (4 items, α = .91), and get support from friends and family (3 items, α = .80). Chesney et al, 2006

Cannot do all=0, 1,2,3,4,5= Moderately Certain can do,6,7,8,9,10= at certain can do

APPENDIX 3: Interview Guide

Introduction:

Many thanks for agreeing to participate in an interview as part of the Care Home Staff Experiences.
Researcher introduces themselves.
The purpose of the interview is to explore your experiences of working in a care/nursing home, during the Covid-19 pandemic, with a particular focus on stress and coping.

If you are happy to proceed, I am now going to record the interview.

Read Following Statement:

This is participant number (*insert participant unique number*) on (*insert date and time of interview*).

Facilitation Experiences:

What are your thoughts about the current covid-19 pandemic?
Can you tell me about your experiences of working in a care/nursing home during the covid-19 pandemic?
How did you feel working during the pandemic?
Can you tell me specifically what your job role involves?
Does your job involve elements of leadership?
Are there aspects of your job which allow you to work independently?
How would you describe the team in which you work?
Can you tell me about what social support you have?
Were you exposed to events at work or home that you would describe as traumatic?
How would you describe leadership at work?
What has worked well for you and your colleagues to cope during the covid-19 pandemic?
What has hindered coping or created stress for you and your colleagues during the covid-19 pandemic?
Is there anything else you want to share with us about you experience of working in a care/nursing home during the covid-19 pandemic?

Do you have any questions for me?

Thank the participant for their time and willingness to participate in the project.

Stop the recording.