Rapid #: -24691809

CROSS REF ID: **256195267500043336**

LENDER: **OHS (Oregon Health and Science University) :: OHSU Library**

BORROWER: **UAU (University of Calgary) :: Taylor Family Digital Library**

TYPE:	Article CC:CCG
JOURNAL TITLE:	Gerontology
USER JOURNAL TITLE:	Gerontology
ARTICLE TITLE:	Experiences of care providers working in long-term care during the COVID-19 pandemic
ARTICLE AUTHOR:	Nicholas, David Bruce
VOLUME:	
ISSUE:	
MONTH:	
YEAR:	2025-04-14
PAGES:	1 - 16
ISSN:	1423-0003
OCLC #:	

Processed by RapidX: 6/3/2025 11:08:11 AM

Gerontology

Behavioral Science Section

Gerontology
DOI: 10.1159/000545782

Received: June 27, 2024
Accepted: March 31, 2025
Published online: April 14, 2025

Experiences of Care Providers Working in Long-Term Care during the COVID-19 Pandemic

David B. Nicholas[a] Rosslynn Zulla[a] Jennifer Hewson[b] Navjot Virk[c] Jenna Naylor[d]

[a]Faculty of Social Work, University of Calgary, Central and Northern Alberta Region, Edmonton, AB, Canada; [b]Faculty of Social Work, University of Calgary, Calgary, AB, Canada; [c]Faculty of Nursing, University of Calgary, Calgary, AB, Canada; [d]The Brenda Strafford Foundation, Calgary, AB, Canada

Keywords
Long-term care · Providers · Older adults · COVID-19 · Psychosocial impacts

Abstract

Introduction: In this qualitative study, care providers from long-term care homes were interviewed to explore how they experienced, coped with, and adapted to care shifts during the COVID-19 pandemic. ***Methods:*** Thirteen multidisciplinary care providers and 24 supervisory and administrative staff participated in either a focus group or individual interview between July 2021 and February 2022. Participants were front-line care providers in 5 urban long-term care homes in western Canada. ***Results:*** Care providers described negative impacts on residents and family members related to service delivery, restricted visiting, and quarantining protocols. They also identified negative impacts they experienced as care providers including fear and uncertainty, exhaustion, concerns about care provision, lower morale, and job self-efficacy. Buffers to stress comprised working as an integrated team and organizational support. Opportunities for growth and development and being adaptive were also described. Recommendations focused on organizational pandemic readiness and the importance of holistic care. ***Conclusion:*** These findings highlight the need to proactively ensure a supportive infrastructure, wellness-promoting work culture, and a sustainable resource plan to help care providers pivot and adapt in a pandemic.

Plain Language Summary

The COVID-19 pandemic drastically impacted processes of care and the well-being of residents in long-term care facilities. Related to these shifts, this paper addresses the experiences of long-term care providers during the pandemic. In this study, 13 front-line and 24 supervisory and administrative long-term care staff participated in either a group or individual interview between July 2021 and February 2022. Findings from these interviews revealed profound impacts on care providers including deleterious physical and mental health impacts. However, care providers also demonstrated resilience, and relied on individual and community assets to buffer the negative impacts. These findings highlight the need to be proactive in providing infrastructure that promotes well-being and a sustainable plan to help care providers pivot and adapt in a pandemic.

karger@karger.com
www.karger.com/ger

Correspondence to:
David B. Nicholas, nicholas@ucalgary.ca

Karger

Introduction

With the emergence of the COVID-19 pandemic, multiple drastic service changes in long-term care created cascading negative psychosocial impacts on care providers. Over the past 3 years, studies have documented that long-term care personnel experienced substantial stress, anxiety, depression, insomnia, and burnout [1, 2], largely due to increased workloads [1, 2], staff shortages [2], insufficient personal protective equipment (PPE) and preparedness planning [3], lack of time to review public health protocols [3], and strains on quality care to residents and their families [3, 4]. Negative psychosocial impacts such as trauma and anxiety emerged due to fear of potentially contracting COVID-19 [1, 4, 5] and risk of spreading the virus to residents and staff members [1, 4]. This concern was amplified if long-term care providers were worried about COVID-19 infection risk due to their own age or coexisting health condition [6], and/or feared they might infect members of their own families [6, 7]. Other impacts such as moral distress were reported by long-term care staff who witnessed residents' decline, distress, and/or death [1, 6, 8]. However, Brady and colleagues [9] argued that negative psychosocial impacts may be attributed not only to stressors emerging from the pandemic, but also from prior service delivery gaps such as organizational issues and inadequate levels of staffing.

Ongoing and Contextual Stressors

Studies have documented that ongoing changes in public health protocols created a demanding workplace that was further challenged by a decreased number of workers due to COVID-19-related impacts (e.g., staff not working due to having acquired COVID-19, staff unable to work in more than one long-term care home, staff choosing to leave the profession [3, 10, 11]) and/or historic or longstanding staffing gaps (e.g., an insufficient number of staff, lack of a hiring pool equipped to work in long-term care [3]). Intensified and stressful work environments were associated with organizational factors such as insufficient resources for ongoing screening [3], gaps in strategies to attain PPE on a continuing basis [3, 12, 13], lack of timely and accurate information from managers and/or public health authorities [3, 14], and implementation strategies that were not sufficiently tailored to existing physical spaces (e.g., lack of resources or expertise to ensure safe and socially engaging communal spaces [11]). Lastly, stressors emerged due to, among multiple reasons, negative public and media coverage, including messaging focused on many strains, restricted visitation, and multiple deaths in long-term care settings, particularly in the early period of the pandemic. Such challenges lowered morale among residents and care providers [10, 12].

Adaptation to Workplace Stress

The ongoing stressors experienced by long-term care providers resulted in mixed experiences. The literature documents that long-term care providers used multiple strategies to cope with stressors such as positive thinking, humor, attentiveness to the moment, relaxation, exercise, stress leave, and accessing mental health supports [4, 8, 14]. An individual and/or collective sense of pride or a sense of satisfaction and dedication to their work further mitigated the effects of stress [1, 8, 13]. Other strategies or factors to mitigate stress were practicing infection control strategies (e.g., washing hands, social distancing [4]), and gaining accurate and timely information [15]. Peer support was noted to buffer stress as care providers relied on their peers for emotional support and guidance [7, 8, 14]. Collaboration between organizations was reported as a resource to address organizational needs such as staffing challenges [10] and PPE issues [16]. Engagement with external public health groups assisted in managing outbreaks and disseminating public health information [16].

Long-term care providers also identified negative or challenging coping responses. These included increased alcohol intake, stress leaves, isolation, struggle in being unable to change work-related situations, and feeling "stuck" [4].

Despite the emergence of studies documenting pandemic impacts in long-term care facilities, as noted in this literature review, knowledge gaps remain. Existing studies have often focused on negative psychosocial impacts, with limited information on adaptative strategies undertaken by long-term care providers during the pandemic. There are few studies from a Canadian context. Studies have largely drawn on a nursing perspective [10]; however, more recent work has brought increased interdisciplinary focus (e.g., staff in recreation, nursing, dietary services, and housekeeping [4, 8]), and recommendations are limited specifically related to pandemic planning, practice adjustments in the crisis, and post-pandemic recovery in this sector. Given these gaps, more research is needed to explore how the COVID-19 pandemic impacted care providers and their daily practice, with recommendations for proactively moving forward. To this end, this study examined the experiences of front-line long-term care providers, supervisors, and administrators across disciplines.

Methods

We used a convenience sampling approach [17], with the additional aim of sample diversity, to recruit long-term care providers who worked during the

pandemic. Interdisciplinary long-term care providers were recruited from multiple urban long-term care homes in a western Canadian region. Eligible participants were multidisciplinary care providers, supervisors, or administrators all working on the front-line in long-term care during the pandemic. They were identified based on a listing of staff within recruitment sites. Study information was cascaded via email and posters, and we invited all who wanted to participate in the study to learn about project aims and participation details. If interested in participation, care providers were sent information about the study. Those who chose to be involved in the study were contacted by a research team member to schedule their participation in an interview or focus group, based on availability and preference of data collection format. Focus groups comprised 10–15 participants per group. Focus group/interview questions elicited (i) the experiences of working in long-term care during the COVID-19 pandemic, (ii) the impacts of the pandemic on residents and care providers, and (iii) recommendations for care provision in a pandemic. These recommendations emerged from questions asking about lessons learned for pandemic planning relative to responses and practices. The semi-structured focus group/interview guide was created by the research team who collectively brought expertise in qualitative research (D.B.N., R.Z., J.H.) and gerontology (J.H., N.V., J.N.). Interview/focus group guide questions were informed by the literature and findings gained from previous COVID-19 studies [18–20], conducted by team members (D.B.N., R.Z.). Interviews and focus groups were facilitated by research team members (a research assistant trained and supervised by the research team, D.B.N., R.Z. and J.H.). In total, the research team conducted three focus groups and two individual interviews. We sought to balance power dynamics in the groups by inviting participants to take turns, thus encouraging all to have opportunity to share their perspectives.

All interviews were recorded, transcribed verbatim, and analyzed using a content analysis approach [21, 22]. This approach is useful for studies with an exploratory aim to ground data within the perspectives of participants. The data were analyzed using a three-step process: (1) reading transcripts multiple times to get a sense of the data (*reviewing*), (2) analyzing transcripts using an inductive approach (*organizing*), and (3) determining the underlying meaning of the data (*reporting*). The data were inductively organized into themes using a three-step process: (1) coding transcript data into meaning units (*open coding*), (2) organizing meaning units relative to emergent categories (*creating categories*), and (3) interpreting these meaning units and categories (*generating themes*). Analysis was undertaken by one team member (R.Z.), with other team members (D.B.N., J.H.) reviewing a portion of the coding, and supporting the categorization of codes, and the generation and confirmation of themes. Rigor was ensured through data saturation and an appraisal of the fit of emergent themes [23, 24], and peer debriefing [24] with team members working in gerontology or pandemic practice and/or research.

Results

Thirty-seven care providers participated in either a focus group or individual interview. Interviews and focus groups averaged approximately 1 h in duration. Participants comprised 13 front-line interdisciplinary care providers in practice areas such as nursing, social work, dietary/nutrition, physical therapy, education, occupational therapy, recreational therapy, maintenance, and 24 supervisors and administrators in long-term care across a range of front-line leadership roles. Twenty-seven participants were female, 10 were male, and all had practiced in long-term care prior to and during the pandemic.

Care providers stated that the COVID-19 pandemic imposed numerous changes and challenges in workplace practice that had considerable impacts on residents and their families, and on care providers. Three broad themes reflected care providers' experiences: (1) *learning about COVID-19 and emergent fear and shifts in the workplace*, (2) *observing multiple negative impacts*, and (3) *looking toward the future*. Each theme is described below.

Learning about COVID-19 and Emergent Fear and Shifts in the Workplace

At the onset of the COVID-19 pandemic, care providers described multiple experiences and emotions including feelings of uncertainty, initial denial about the occurrence or impact of COVID-19, and feeling overwhelmed due to challenges such as the vast amount and changing nature of COVID-19-related information. Many participants identified concerns about not being able to provide their best care to residents due to strict infection control protocols. Some supervisors and administrators additionally conveyed experiences of uncertainty in how to guide front-line staff in their care practices, including how to ensure safety and adapt to new service delivery approaches. Finding time to

efficiently convey new information and engage with residents and their families was described as extremely challenging, as an administrator recalled:

> *It [was] hard to keep up and communicate with all our residents and families on a more specific level when the orders are changing on a weekly basis. . .. Just keeping up with those [shifts in] information. . .. We need[ed] some time throughout [our day] to organize our thoughts and [determine] who was going to communicate to the families, and sometimes we overlooked that and you know, we always gave it to the [staff] on the floor to do that, but they need[ed] help.*

Negative Impacts

Impacts on Residents and Family Members

All participants stated that the COVID-19 pandemic sparked multiple drastic protocol changes in service delivery. These changes included (i) shutdowns or limitations of social, spiritual (e.g., religious services), leisure (e.g., art programs), and recreational services (e.g., exercise programs); (ii) restricted visiting protocols; and (iii) intense safety protocols (e.g., ongoing masking, interaction protocols when quarantining in an outbreak). As the pandemic progressed, such protocols continued yet shifted, with substantial negative impacts, for instance, the loss of social, recreational and spiritual programming, restricted visiting, and strict safety protocols that imposed deleterious psychosocial impacts on residents. Participants witnessed drastic physical (e.g., weight loss) and cognitive decline, lack of motivation, loneliness, and a sense of helplessness among residents. A participant stated that strict safety protocols created substantially challenged living conditions for some residents, notably those who were asymptomatic, as exemplified below:

> *If [residents]. . . were a close contact [with a COVID-19 patient], they would have to isolate for. . . up to two weeks of time and of course that got extended for quite a few times. So you know, [it started] with 12 to 14 days, but then it would get pushed maybe back again for another 14 days, if we got an outbreak, then isolate again.*

Strict visiting protocols also had negative impacts on residents who had deep relationships with family members or other supporters and/or who valued practices such as regularly eating culture-specific foods brought from outside the care facility. A participant illustrated such a situation:

> *Outside food is very important for some of our residents because of the cultural differences, and also they associate visits with their loved ones bringing in food so that was stopped when there were changes with no family members coming into the facility.*

Restricted visiting and quarantining protocols variably imposed negative impacts on residents who had additional cognitive issues, as illustrated by a participant:

> *For our security units, memory care units and dementia units, those residents generally speaking might be to some degree [a] little blissfully unaware that the pandemic is going on. But for a lot of them unfortunately, we see maybe a quicker decline or. . . their dementia progressing a little bit more as they struggle with the isolation.*

Participants observed negative psychosocial impacts (e.g., confusion, fear, lack of control) among residents who were not certain about how to handle changing COVID-19 protocols or were anxious about risks of infection spread. In contrast, several care providers observed that some residents seemed less impacted by protocol changes. For instance, some had negligible fear about their risk to the virus or adapted relatively seamlessly to changing protocols. A participant recalled that some residents had quickly mastered the use of remote technology to maintain contact with their loved ones.

Beyond residents, care providers observed substantial psychosocial impacts on residents' family members. For instance, some family members were deeply distraught due to their inability to support their loved ones' physical and mental health particularly during lockdowns and quarantines.

Impacts on Care Providers

Care providers recalled largely negative impacts on themselves and their colleagues as a result of pandemic shifts. Many described multiple stressors in their professional and personal lives. Stressors included (i) fear about contracting COVID-19, (ii) risk of infecting residents, (iii) uncertainty about safe and effective practice due to a lack of targeted information and/or changing information and protocols, (iv) exhaustion due to lengthy shifts on an ongoing basis, (v) lower morale due to heightened media coverage on the deficits of long-term care during the pandemic, (vi) a desire and pressure to optimize quality care in the face of aversive circumstances, (vii) continually needing to justify restrictive operational protocols to residents and their families, and (viii) the need to frequently update families about protocol change. The workplace at this time was characterized by terms such as frightening and uncertain, resulting in moral distress due to ongoing strains imposed by the pandemic.

Decreased job self-efficacy and satisfaction were described by care providers as they managed multiple tensions. For instance, participants described struggle in wanting to provide optimal care, yet adhering to restrictive protocols particularly early in the pandemic. These shifts were viewed to impede the quality of care that could be provided, as illustrated by a front-line care provider:

I know very early on with all quarantines and isolation stuff, I felt quite guilty. . .. You just felt completely overwhelmed and guilty that you can't possibly reach more residents . . . so there was a lot of guilt.

In another example, lowered job self-efficacy was associated with managing multiple demands and stressors, as described by the following participant:

I don't think any of us was able to provide the level of care that we normally do in regular days. It was fear, it was the increase in workload, it was the PPE donning and doffing, it was the residents eating meals in their rooms rather than coming to the dining room which has significant impact on the workload for healthcare workers, not to mention [residents'] own mental health. . .. So it was nowhere near where we normally provide care.

Many care providers adopted new roles such as navigating visitation restrictions and addressing the heightened anxieties of others. As a result of adopting such new roles and the strains being experienced, participants described feeling overwhelmed, as illustrated below:

[Residents] couldn't see their family members [so] you became their family, their friend, their like everything. [For] some people, in my experience, I had to be the last person that they saw before they [died] so it was incredibly [difficult]. . .and you take that home with you and then you can't sleep. . .. Just overwhelming.

For supervisory and administrative staff, managing quality care and supporting staff became a constant concern, along with other substantial stressors (e.g., outbreaks, fear, loss, grief). Stressors were described to have been managed in varying ways. Some participants described both negative coping responses (e.g., excessive drinking, not sharing with family about their stress) and positive coping responses (e.g., being hopeful, praying, sharing feelings with colleagues). Team cohesion and working as an integrated unit emerged as a buffer to stress. Beyond working together, contributing to needed tasks "in the moment" and fulfilling additional roles, organizational support was deemed crucial to helping staff manage daily stresses. Those in leadership roles described frequently checking in with staff to hear their experiences and concerns, and identify ways to support them.

Looking toward the Future

Lessons Learned

Although the COVID-19 pandemic was primarily depicted as a vastly difficult experience, participants also identified opportunities for learning and growth. Some reported new opportunities to improve their practice. For instance, several participants described advancing technology skills (e.g., learning to offer care via online platforms), deepening organizational capacity (e.g., efficiency in multitasking), and recognizing relational and empathic strengths in themselves (e.g., increased compassion, person-centeredness, greater understanding of others' needs). Several participants felt that they had adapted by being creative, listening to different perspectives when resolving a problem, and practicing flexibility in care. They described deepened experience and knowledge regarding the essential role of emotional and social care in promoting wellness among residents, and the value of staff collegiality and self-care in fostering team resiliency and adaptability.

Recommendations

Recommendations offered by participants were largely oriented toward improving pandemic readiness, ensuring strong resident-staff relationships and communication, and building staff and system capacity. Many participants highlighted the importance of holistic care that (i) supports physical, mental, emotional, social, and spiritual health, and (ii) is tailored to the individual resident and their needs. Lastly, several participants emphasized the importance of supporting the involvement of families in their loved ones' care even in the context of a pandemic.

To advance staff capacity, participants highlighted the need for specialized staff (e.g., more licensed practical nurses), training to address mental health issues among residents, and resources to support staff well-being. More funding for staffing and resources was advocated, as was evidence-based information to advance operational protocols in pandemic planning, practice during the pandemic, and pandemic recovery.

Discussion

This study explored the impacts of the COVID-19 pandemic on the work experiences of a small sample of front-line personnel, supervisors, and administrators in long-term care. Findings identify deeply challenging impacts of ongoing and shifting public health protocols on residents and care providers, thus expanding on the literature that addresses care experiences and their effects on interdisciplinary workers in long-term care [4, 8]. While studies have largely examined pandemic experiences from the perspective of nursing, these findings extend to experiences gathered from a multidisciplinary group.

Implications for Resident-Based Care

Addressing resident experiences, this study indicates that public health protocols had differential impacts on residents. Residents with existing challenges such as

dementia were generally noted as more likely to have worsening physical and mental health outcomes which is consistent with other literature [8, 25, 26]. While study findings resonate with some themes in the literature, new insights from this study additionally emphasize the important role of holistic care by the range of disciplines. Particular areas of allied health care (e.g., emotional support during resident isolation or worry, recreation amidst restrictive visitation and program reduction, spiritual care) became deeply important and needed. Integrating and valuing such disciplinary practices as essential in health emergencies such as a pandemic are critical to fostering well-being and stability to the extent possible in such constrained crises. As highlighted by participants in this study, ongoing support and activity, requiring interdisciplinary practice with residents and their families, are integral to helping residents and their families orient to service delivery changes and manage impacts on a daily basis.

Participants noted that during the pandemic, residents relied on care providers to support their physical, mental, socio-emotional, and spiritual care on a daily basis. The intangible features of pandemic-imbued caring such as heightened compassion, open-mindedness, flexibility, and a holistic approach emerged as competencies of long-term care providers in the constrained circumstance of the pandemic.

Attending to person-centered care further was demonstrated by attention to equity, diversity, and inclusion in concrete ways. For instance, ethnoculturally relevant care incorporates cultural dimensions in daily life activities, languages used, and food accessed. Study findings illustrated the importance of saliant practices (e.g., receiving cultural food to affirm ethnocultural identity and support nutritional needs, ethnocultural communication/engagement). Such a holistic care approach seems integral to optimal health and socio-emotional, relational, recreational, and spiritual well-being in the face of widespread restrictions and stress wrought by a pandemic or other large-scale disaster.

In a recent study, long-term care workers (e.g., nurses), who by default took on supportive roles that traditionally are offered by family members, notably became more cognizant of the value of holistic support to residents [11]. As demonstrated in our study, holistic care elements that might be viewed as less urgent given pandemic restrictions actually were practical and ethical imperatives. Considering not just the aim of survival, but also well-being and sustainability during and beyond the pandemic, needs to be a critical pandemic priority. Boamah and colleagues [27] found holistic support (addressing physical, psychological, and emotional needs) often provided by family caregivers in non-pandemic times became critical to the well-being of older residents. For McCormack and colleagues [28], and corroborated herein, holistic care requires concerted attentiveness to the whole person by considering the physiological, sociocultural, developmental, and spiritual dimensions of care need. According to McCormack and colleagues [28], care requires a holistic approach, working with the client's beliefs and values, sharing decision-making, ongoing engagement with the client and their caregivers, and a sympathetic presence [28].

Long-Term Care Providers

Care provider participants described inner tension in balancing safety via adherence to public health and organizational protocols, in the face of seeking to offer person-centered care. This tension resulted in provider experiences of personal and professional stress, which was heightened by structural and workforce challenges such as an insufficient number of trained staff and strained service capacity. Care providers further grappled with ongoing worry among, and pressures from, residents and their families to ensure quality of care amidst substantial constraint, change, and loss of control.

Similar tensions have been highlighted in the literature as care providers have been reported to have managed multiple tasks amidst limited staffing and resources [3, 10, 11, 29, 30]. Managing care expectations and risks simultaneously was emotionally and ethically challenging and physically draining for care providers, with impacts on mental health, professional identity, and professionalism [1, 3, 7, 29]. Jones and colleagues [3] suggested that such tensions could have been lessened by greater pandemic preparedness within the long-term care sector. Further, Genoe and Johnstone [30] noted potentially heightened challenges during the pandemic for care providers (e.g., those offering recreation therapy) if their roles in supporting older adults lack recognition or status.

Findings from our study add depth to the literature and amplify a call for proactive pandemic planning. For instance, while recognizing the value of allied health colleagues in care, the contradictory narrative and reality of less allied health team engagement (e.g., psychosocial and spiritual care resources) can be construed to imply differential priorities of care roles in a pandemic, thus potentially ascribing greater or lesser value to certain disciplines and disciplinary activities. Critical reflection on the contributions of various roles requires consideration in pandemic planning. These findings offer important implications for capacity building and ongoing learning to better support interdisciplinary and holistic

care in the aim of optimal resident, family, and staff wellness in a pandemic.

Overall, these findings suggest capacity building that supports proactive adaptation in constrained and evolving public health circumstances. Examples of such capacity building are increasingly emerging in the literature. For instance, one study reported benefits of dedicated external staff who provided ongoing education about infection prevention and control to front-line staff and managers, addressed staff concerns, and offered moral support to staff [16]. Helpful elements reportedly included a supportive physical presence and a nonpunitive approach in assisting care providers [16]. This external staff role was supplemented by additional teams (e.g., public health) who offered recommendations and supported care providers in navigating public health protocols [16].

In another example of proactive strategies, nurses in long-term care homes in Germany created a multiprofessional task force (e.g., quality improvement managers, hygiene specialists, safety officers) to translate public health requirements to operational protocols as well as to provide updated and timely guidance during the pandemic [11]. In a study exploring adaptation strategies, nurse managers collaborated with external organizations to address staffing issues [10]. Findings from these studies reveal the importance of creating sufficient infrastructure (e.g., a crisis management team, crisis policies) to address emergent need for protocol changes, provide clear and tailored guidance to long-term care providers, and efficiently and effectively attend to staffing and resource gaps. Lastly, relationality and reflection in care teams are noted to be vital in better supporting and sustaining relationships among staff peers, and with residents and their family members [30]. Better understanding how these relationships evolve has the potential to inform more comprehensive and targeted support strategies [30].

Organizational interventions and resources promoting mental wellness among care providers remain a notable gap. An existing scoping review by Byrd and colleagues [26] on interventions and policy measures undertaken in long-term care reveals a dearth of evidence on (i) psychological and rehabilitation interventions that address psychosocial impact and (ii) measures to support staff, thus leaving limited knowledge to guide long-term care.

As reflected in this study and other literature, long-term care providers were resilient by relying on personal assets (e.g., commitment, compassion, care), support from colleagues, managerial support (e.g., check-ins), and/or external mental health support to cope with workplace and adjustment-related stress [4, 8]. Researchers increasingly are calling for structural and policy supports to nourish resilience and promote well-being among long-term care providers [3, 4]. To support this goal, future research is needed to explore workplace approaches and infrastructural elements that foster resilience and nurture well-being among long-term care providers.

Study Limitations and Recommendations for Further Research

This study elicited the experiences of care providers working within long-term care homes in one Canadian region. Future studies with broader samples and greater geographic and sectoral reach are recommended, particularly with long-term care providers who work in public, private (for-profit), and not-for-profit long-term care settings. Notably, this research did not cover the range of types of care facilities (e.g., care levels). Addressing this diversity is needed in broadening understanding about pandemic impacts across various care contexts, with the aim of identifying the range of infrastructural and process requirements for optimal care and well-being. Our limited sample did not represent all disciplines (e.g., spiritual care) who support long-term care residents and their family members. For instance, Kuepfer [31] highlighted the role of pastors in providing emotional, social, and spiritual support to older adults in their rooms at long-term care homes.

While participants came from different disciplinary backgrounds (e.g., nursing, social work, nutrition, therapy) and had shared experiences in supporting residents and their families, we recognize that specific challenges may have occurred as they provided care as a provider within their discipline, i.e., unidisciplinary roles of care. For instance, in two recent studies, youth workers and educational assistants/consultants supporting vulnerable youth felt public health guidance emerging from the pandemic created vague guidelines on what were "essential" services, impacting what supports could be offered as well as the visibility and value of these workers in the collective caregiving discourse [19, 20]. Future inquiry is recommended to understand and address challenges that emerge across interdisciplinary teams *and* within specific disciplines. We also advocate for future research to explore wellness strategies that validate individual and collective efforts in a pandemic, and nurture well-being both during and after a pandemic.

In terms of resident and family experiences, future studies are needed to explore the range of experiences, including cross-cultural support needs – particularly important for residents from diverse ethnocultural, faith and linguistic backgrounds. Examining the lingering and long-term impacts of the pandemic is needed, as is exploring impacts on family members who could not visit their loved ones, including those who endured catastrophic grief and loss such

as end-of-life during the pandemic. Overall, future studies are warranted in addressing pandemic processes, strategies, and impacts in long-term care, with a focus on resource needs and, in particular, pandemic planning, care provision during the pandemic, and post-pandemic recovery.

Conclusion

This study has documented pandemic impacts on care providers in long-term care. Findings amplify the importance of proactive workplace structures and processes, including a wellness-oriented work culture and the sufficiency of resources. Such workplace and system proactivity and responsiveness are integral to more fully supporting holistic care and ensuring constructive and adaptive care within and beyond a pandemic.

Statement of Ethics

This study protocol was reviewed and approved by the University of Calgary, Conjoint Faculties Research Ethics Board (CFREB), Approval No. REB20-2223. Informed consent was obtained from all participants. This consent could be oral or written consent, as approved by the CFREB.

Conflict of Interest Statement

All authors declare that they do not have any conflict of interest.

Funding Sources

Funding from the Social Sciences and Humanities Research Council of Canada (#1008-2020-1041) is gratefully acknowledged. The funder had no role in the design, data collection, data analysis, and reporting of this study.

Author Contributions

D.B.N., R.Z., and J.H. contributed to study design, implementation, and drafting and editing of the manuscript. N.V. contributed to study design, implementation, and editing of the manuscript. J.N. contributed to implementation and editing of the manuscript.

Data Availability Statement

The data that support the findings of this study are not publicly available due to potentially containing information that could compromise the privacy of research participants. Further inquiries can be directed to the corresponding author.

References

1 Boamah SA, Weldrick R, Havaei F, Irshad A, Hutchinson A. Experiences of healthcare workers in long-term care during COVID-19: a scoping review. J Appl Gerontol. 2023;42(5):1118–36. https://doi.org/10.1177/07334648221146252

2 Conti A, Russotto S, Opizzi A, Ratti M, Nicolini D, Vanhaecht K, et al. Work-related stress among a cohort of Italian long-term care workers during the COVID-19 pandemic: an observational study. Int J Environ Res Public Health. 2022;19(10):5874–10. https://doi.org/10.3390/ijerph19105874

3 Jones K, Schnitzler K, Borgstrom E. The implications of COVID-19 on health and social care personnel in long-term care facilities for older people: an international scoping review. Health Soc Care Community. 2022;30(6):e3493–506. https://doi.org/10.1111/hsc.13969

4 Reynolds K, Ceccarelli L, Pankratz L, Snider T, Tindall C, Omolola D, et al. COVID-19 and the experiences and needs of staff and management working at the front-lines of long-term care in central Canada. Can J Aging. 2022;41(4):614–9. https://doi.org/10.1017/S0714980821000696

5 Fisher E, Cárdenas L, Kieffer E, Larson E. Reflections from the "Forgotten Front Line": a qualitative study of factors affecting well-being among long-term care workers in New York City during the COVID-19 pandemic. Geriatr Nurs. 2021;42(6):1408–14. https://doi.org/10.1016/j.gerinurse.2021.09.002

6 White EM, Wetle TF, Reddy A, Baier RR. Front-line nursing home staff experiences during the COVID-19 pandemic. J Am Med Dir Assoc. 2021;22(1):199–203. https://doi.org/10.1016/j.jamda.2020.11.022

7 Hoedl M, Thonhofer N, Schoberer D. COVID-19 pandemic: burdens on and consequences for nursing home staff. J Adv Nurs. 2022;78(8):2495–506. https://doi.org/10.1111/jan.15193

8 Hung L, Yang SC, Guo E, Sakamoto M, Mann J, Dunn S, et al. Staff experience of a Canadian long-term care home during a COVID-19 outbreak: a qualitative study. BMC Nurs. 2022;21:1–9.

9 Brady C, Fenton C, Loughran O, Hayes B, Hennessy M, Higgins A, et al. Nursing home staff mental health during the Covid-19 pandemic in the Republic of Ireland. Int J Geriatr Psychiatry. 2021;37(1):1–10. https://doi.org/10.1002/gps.5648

10 Gadbois EA, Brazier JF, Meehan A, Rafat A, Rahman M, Grabowski DC, et al. Perspectives of nursing home administrators across the United States during the COVID-19 pandemic. Health Ser Res. 2022;58(3):686–96. https://doi.org/10.1111/1475-6773.14104

11 Sander M, Dano R, Bieber A, Dammermann A, Fleischer S, Dinand C, et al. Challenges, strategies and consequences from the perspective of German nursing home managers during the first wave of the COVID-19 pandemic: a qualitative interview study. BMC Geriatr. 2023;23:164–16. https://doi.org/10.1186/s12877-023-03787-4

12 Hanna K, Giebel C, Cannon J, Shenton J, Mason S, Tetlow H, et al. Working in a care home during the COVID-19 pandemic: how has the pandemic changed working practices? A qualitative study. BMC Geriatr. 2022;22:129–9. https://doi.org/10.1186/s12877-022-02822-0

13 White EM, Wetle TF, Reddy A, Baier RR. Front-line nursing home staff experiences during the COVID-19 pandemic. J Am Med Dir Assoc. 2021;22(1):199–203. https://doi.org/10.1016/j.jamda.2020.11.022

14 Gray KL, Birtles H, Reichelt K, James IA. The experiences of care home staff during the COVID-19 pandemic: a systematic review. Aging Ment Health. 2022;26(10):2080–9. https://doi.org/10.1080/13607863.2021.2013433

15 Spilsbury K, Devi R, Griffiths A, Akrill C, Astle A, Goodman C, et al. SEeking AnsweRs for care homes during the COVID-19 pandemic (COVID SEARCH). Age Aging. 2021;50(2):335–40. https://doi.org/10.1093/ageing/afaa201
16 Yau B, Vijh R, Prairie J, McKee G, Schwandt M. Lived experiences of front-line workers and leaders during COVID-19 outbreaks in long-term care: a qualitative study. Am J Infect Control. 2021;49(8):978–84. https://doi.org/10.1016/j.ajic.2021.03.006
17 Sandelowski M. Sample size in qualitative research. Res Nurs Health. 1995;18(2):179–83. https://doi.org/10.1002/nur.4770180211
18 Nicholas DB, Zulla RT, Conlon O, Dimitropoulos G, Urschel S, Rapoport A, et al. Mental health impacts of the COVID-19 pandemic on children with underlying health and disability issues, and their families and health care providers. Paediatr Child Health. 2022;27(Suppl 1):S33–9. https://doi.org/10.1093/pch/pxab103
19 Nicholas DB, Zulla RT, Cielsielski J, Zwaigenbaum L, Conlon O. COVID-19 pandemic experiences of families in which a child/youth has autism and their service providers: perspectives and lessons learned. J Autism Dev Disord. 2024:1–12. https://doi.org/10.1007/s10803-024-06402-6
20 Zulla R, Nicholas DB, Spicer AA, Ciesielski J. The experiences of youth with vulnerabilities and their service providers: impacts and emerging lessons from the COVID-19 pandemic. Align J. 2024:66–74.
21 Elo S, Kyngäs H. The qualitative content analysis process. J Adv Nurs. 2008;62(1):107–15. https://doi.org/10.1111/j.1365-2648.2007.04569.x
22 Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Edu Today. 2004;24(2):105–12. https://doi.org/10.1016/j.nedt.2003.10.001
23 Lincoln YS, Guba EG. Paradigmatic controversies, contradictions, and emerging confluences. In: Denzin NK, Lincoln YS, editors. The Sage handbook of qualitative research. Thousand Oaks: Sage Publications Ltd; 2005.
24 Lincoln Y, Guba E. Naturalistic inquiry. Newbury Park: Sage; 1985.
25 Scerri A, Borg Xuereb C, Scerri C. Nurses' experiences of caring for long-term care residents with dementia during the COVID-19 pandemic. Gerontol Geriatr Med. 2022;8:1–9. https://doi.org/10.1177/23337214221077793
26 Byrd W, Salcher-Konrad M, Smith S, Comas-Herrera A. What long-term care interventions and policy measures have been studied during the COVID-19 pandemic? Findings from a rapid mapping review of the scientific evidence published during 2020. J Long Term Care. 2021;0:423–37. https://doi.org/10.31389/jltc.97
27 Boamah SA, Weldrick R, Yous ML, Gao H, Garnett A, Dal Bello-Haas V, et al. Picturing a way forward: strategies to manage the effects of COVID-19 related isolation on long-term care residents and their informal caregivers. Gerontologist. 2024;64(1):1–10. https://doi.org/10.1093/geront/gnad035
28 McCormack B, Roberts T, Meyer J, Morgan D, Boscart V. Appreciating the 'person' in long-term care. Int J Old People Nurs. 2012;7(4):284–94. https://doi.org/10.1111/j.1748-3743.2012.00342.x
29 DeVries D, Kemeny B. Recreational therapists' perceptions of the COVID-19 impact on older adult clients and professional practice: a two-part study. TRJ. 2023;57(1):13–45. https://doi.org/10.18666/trj-2023-v57-i1-11307
30 Genoe MR, Johnstone JL. The impact of COVID-19 on therapeutic recreation practice in long-term care homes across Canada. World Leis J. 2021;63(3):265–80. https://doi.org/10.1080/16078055.2021.1957011
31 Kuepfer J. Supporting spirits in changing circumstances: pandemic lessons for long-term care and retirement homes. Religions. 2022;13(7):584–14. https://doi.org/10.3390/rel13070584