The role of Social Support at Work for Staff in Care Homes for Older People in Coping with, and Recovering from, Occupational Trauma during the Covid-19 Pandemic

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Doctorate in Clinical Psychology (DClinPsy) Thesis (Volume 1) 2023

University College London (UCL)

UCL Doctorate in Clinical Psychology

Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

Part One is a conceptual introduction. This selectively reviews literature on social support at work for care home staff coping with, and recovering from, occupational trauma during and after the Covid-19 pandemic. An overview is given of the context of care homes for older people in the UK prior to and during the Covid-19 pandemic. Key theoretical explanations for how social support can promote coping and recovery after occupational trauma are then outlined. Current literature on care home staff's experiences of social support at work during the Covid-19 pandemic is reviewed. Gaps in current research include explorations of team experiences of support in the aftermath of the pandemic.

Part Two is an empirical study that aims to explore care home staff's experiences of social support at work during the pandemic and its aftermath, through the narratives told about the team's experiences. Interviews with 24 staff across two homes were analysed using narrative analysis. Staff described the ongoing emotional impact of the pandemic. One home's main narrative was that they supported each other through the pandemic and emerged a stronger team. In the other home, staff narratives were less unified and staff spoke mainly about team divisions, prioritising residents, and following procedures.

Part Three is a critical appraisal of the methodology used in Part Two, as well as the process of conducting research in the setting of a care home. Areas covered include the position of the Clinical Psychology researcher in the care home context and gaining participant feedback.

Impact Statement

This thesis examines the role of social support in recovery and coping after traumatic experiences during the Covid-19 pandemic, in care home staff. This has relevance for policy makers, clinicians, and academics.

Part one (a conceptual introduction) outlines several theoretical models for how social support can protect against the impact of traumatic experiences, demonstrating the utility of these for understanding care home staff's experiences during the Covid-19 pandemic. This is the first application, to my knowledge, of these theoretical models to the experiences of this particular staff group. This could inform future research, which could further explore the usefulness of concepts such as Collective Efficacy (from Social Psychology) in care home teams.

Part one also brings together different theoretical approaches to underline the importance of studying how groups of people might help each other recover from shared traumatic experiences. Clinical Psychology research is often critiqued as viewing mental distress and recovery as processes occurring within the individual, and this review collates and summarises useful theories of collective recovery. This may inform future research in teams as well as other groups.

Part two (an empirical study) adapts a narrative approach to analysis to the specific organisational context of care homes for older people. In doing so a novel approach to identifying collective narratives within teams is developed, which may be applied to other organisations in future research.

The empirical study also demonstrates that care home staff continue to experience psychological impacts from the Covid-19 pandemic three years after the beginning of the pandemic. This finding could be used to support an argument for the allocation of further resources to deliver specialist psychological support services for this staff group. The

findings of the empirical study, that different care homes have varied cultures of staff support, could be used to develop much needed organisational interventions to support care homes to improve staff's wellbeing. This is particularly important given the current recruitment crisis in the care home sector, internationally.

The empirical paper will be submitted to an academic journal for dissemination, enabling it to inform future research in this setting. It could also inform future narrative research in other organisational contexts. I will also take up further opportunities for dissemination, for example in the supervisor's research group, and in forums of care home research.

Individual participants commented that interviews allowed them to reflect on and process their experiences of the pandemic, as well as to celebrate their achievements. I have already presented a summary of the study results to one of the participating care home teams. Staff and management in this home commented that the presentation had a positive impact, as it encouraged them to talk about their experiences as a team and how they support each other. I plan to present a summary of key findings to the second participating care home in the near future.

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Acknowledgements

I would like to thank my three supervisors; Dr Marina Palomo, Dr Jo Billings and Dr Georgina Charlesworth for their support and kindness; I have learned so much from all of you. I would also like to thank my personal tutor Dr Katrina Scior who has supported me through several obstacles over the past three years.

I would also like to thank all of the staff in the two care homes for older people where I conducted this research, who welcomed me into their places of work and took the time to teach me about their experiences.

Thank you to Susan and Nick for showing me this career path, and to my mother for all the love and support that helped me to finish the project. Lastly, I would like to thank my grandmothers Joan Samwell and Rosemary Lavers.

Part One: Conceptual Introduction

The role of social support at work for care home staff coping with and recovering from occupational trauma during the Covid-19 pandemic

Abstract

During the Covid-19 pandemic, staff in care homes for older people internationally experienced significant changes to their work and suffered high levels of mental illness and moral injury. The aim of this conceptual introduction is to selectively review literature on the role of social support at work in enhancing coping in care home staff during the COVID-19 pandemic and in post-pandemic recovery.

Four key areas are covered. Firstly, an overview is provided of the context of care homes for older people in the UK, summarising operational changes, impacts on staff wellbeing, and experiences of occupational trauma during the Covid-19 pandemic. Secondly, key theoretical explanations for how social support can promote coping and recovery from traumatic events, are outlined: The Conservation of Resource Model, Social Cognitive Processing Theory, and the model of Social Support in Posttraumatic Stress Recovery. The concept of Collective Efficacy, from Social Psychology, is also outlined. The utility of these theories for understanding social support in the workplace in the wake of occupational trauma is discussed. Thirdly, extant literature on care home staff's experiences of social support at work during the Covid-19 is reviewed, highlighting the importance of management support, teamwork and team cohesion, shared experiences and discussing emotions, as well as conflict and division in teams. Fourthly, gaps in the current literature are highlighted, in particular, exploration of team experience over time, through later phases of the pandemic into a post-pandemic period.

Introduction

Between March 2020 and April 2021, 42,341 older people living in care homes in England and Wales died from Covid-19 (Office for National Statistics, 2021). The pandemic's devastating effect within older adult social care has been linked by many to policy decisions that prioritised the protection and resourcing of healthcare services (McGilton et al., 2020; Parker, 2021). This reflects historic disparities between health and social care sectors, with the latter having less public awareness and support (Daly, 2020), weaker regulation related to privatisation (Blakeley & Quilter-Pinner, 2019), and more precarious, lower paid work which is given lower status (Hussein, 2018).

Disparities can also be seen in the research landscape. Despite more people working in social care than the NHS in the UK (The Kings Fund, 2013), a systematic review highlighted less research on the wellbeing of social care staff during the pandemic (Moynihan et al., 2021). A later scoping review highlighted a specific paucity of research on the wellbeing of staff working in care homes compared to other care settings (Chemali et al., 2022). Researching "health and social care workers" as one group is one way to confer equality. In the face of gaps in research regarding care home staff, findings from other staff groups may provide relevant information. However, the vast differences between the health and social care sectors highlight the importance of specific research on the experiences, mental health, and wellbeing of care home staff. This introduction will therefore first outline the specific context of care homes for older people in the UK.

Sourcing References for this Conceptual Introduction

Literature was sourced by first identifying key systematic reviews of care home staff's experiences during the pandemic and identifying key literature from the reference lists. Literature on staff's experiences, as well as on theories regarding the role of social support in recovery from trauma, was also identified in discussion with project supervisors with relevant

expertise. The following key terms were also searched in Web of Science: “Social support, staff support, coping, care homes for older people / nursing home(s), Covid-19 pandemic / Coronavirus” and key literature selected from the results.

Context of Care Homes for Older People in the UK

General Context

Around 570,000 staff currently care for around 370,000 older people living in care homes in the UK (Skills for Care, 2021, Office for National Statistics, 2023). Residential homes offer support with tasks of daily living, nursing homes provide more specialist clinical support, and some homes offer a mix of the two. Care homes vary hugely in size with some caring for up to 200 older people with the average being just under 30. Provision has been increasingly privatized in the past decades which many people consider has led to an increase in more temporary and less stable employment (McGregor, 2007). Care home beds are generally commissioned and funded by local authorities and by fee paying residents.

Workforce and Working Conditions

Staff are employed as registered nurses, carers, and in managerial, domiciliary and administrative roles (Skills for Care, 2022). “Carers” (sometimes referred to as care assistants or healthcare assistants) make up the majority of the workforce and provide the majority of direct care to residents. In this introduction, “care home workers” will refer to all those for whom the care home is their main place of work (as opposed to professionals such as GPs and Clinical Psychologists, who work in care homes but rarely make up fixed members of the team).

The majority of care home workers are women (85%) and many have secondary caring responsibilities outside of work (Baines & Cunningham, 2015). In London, 68% of the adult social care workforce are from global majority ethnicities (Skills for Care, 2022), although 90% of management staff are white. The sector depends on migrant workers

(McGregor, 2007) many of whom work as carers and have nursing qualifications that are not recognised in the UK (Hussein, 2018).

Care home work is low paid and often precarious (Hussein, 2018; Testad et al., 2010). The current average wage of carers in UK care homes is just £9.50 per hour; this is below the national living wage (Skills for Care, 2022). Many homes only offer statutory sick pay (less than £100 a week), and a large-scale survey of staff revealed that 25% reported getting into debt due to taking time off work when ill (Unison, 2021). The devaluing of the workforce has been linked by some researchers to dynamics of sexism and racism in society, given that women, specifically migrant women and those from global majority ethnicities, are over-represented in the UK workforce (Hussein, 2018).

Job Demands, Staff Stress and Burnout.

Care home work, and particularly work that entails direct care provision, is widely considered high stress, fast-paced work in which staff face high emotional and physical demands (Hussein, 2018). Staff stress has also been associated with tensions between task-focused and relationship-focused models of care. Efficiency models of care focus on the tasks undertaken whereas relational models highlight the importance of therapeutic relationships (Leary, 2019). A scoping review found that positive, caring relationships with residents can be central to staff's satisfaction at work (Manthorpe & Moriarty, 2014) whilst conflict between a more task-oriented approach and a personal wish to care for residents as individuals, can lead to care home staff feeling unsatisfied and disempowered (Kadri et al., 2018).

A large-scale survey of care home staff in England prior to the Covid-19 pandemic found that one third suffered high levels of burnout (Costello et al., 2019). Low staffing levels and caring for residents showing challenging behaviour are some of the factors related to levels of burnout (Geiger-Brown et al., 2004). Previous research has considered the

demands faced by care home workers and how these affect their experiences of work, by using the “Job-Demand-Resource" model (Bakker & Demerouti, 2007). The model considers how job resources (elements of the job that increase motivation and fulfilment) buffer the impact of job demands, with burnout occurring when demands are greater than the job resources. Social support is considered a “resource” that can protect against burnout and lead to job satisfaction despite work being high demand. Social support at work has been defined as “emotional, informational, or practical assistance” that can be delivered either by colleagues or supervisors (Thoits, 2010). It has been demonstrated to protect against burnout and stress for care home workers (Åhlin et al., 2015; Woodhead et al., 2016) as well as reduce overall job strain (Hussein, 2018; Mcvicar, 2016).

The Impact of the Covid-19 Pandemic on Staff in Care Homes for Older People: Increasing Demands and Stressors

“Covid-19 has been the trigger that has exposed the inadequacies of the system” (Blanco-Donoso et al., 2021). A qualitative synthesis of international research on care home staff’s experiences during the Covid-19 pandemic highlighted the following stressors: poor working conditions, lack of skills and knowledge, mental health concerns, feeling undervalued and abandoned as a sector and fear of contagion (Gray et al., 2022).

The pandemic exacerbated pre-pandemic stressors, as well as introduced new ones. Many care homes internationally faced extreme staff shortages during the pandemic due to staff being ill, shielding, and leaving the profession in the face of pre-existing high vacancy rates and low staff to resident ratios (Daly, 2020). Pre-existing high workloads were exacerbated, as limitations on visits from external professionals and family members led to an increase in work to meet resident’s physical and emotional needs (Giebel et al., 2022). Infection Prevention Control procedures also required large amounts of additional work, as did the increased monitoring and reporting required from care homes (Giebel, 2022). In the

UK, care homes had to manage an influx of Covid-19 patients discharged from hospital, many of whom were infectious, a government directive that has since been found to be illegal in its failure to safeguard the lives of residents (Booth, 2022).

Staff were exposed to the death and suffering of residents with whom they had close relationships (Doyle et al., 2023; White et al., 2021), and often had to enforce life-limiting restrictions on residents, often those with dementia, who could not understand them (Beattie et al., 2023; Doyle et al., 2023; Hung et al., 2022).

Figure 1

Timeline of key events of the Covid-19 Pandemic in Care Homes for Older People, in the UK March 2020 – March 2021

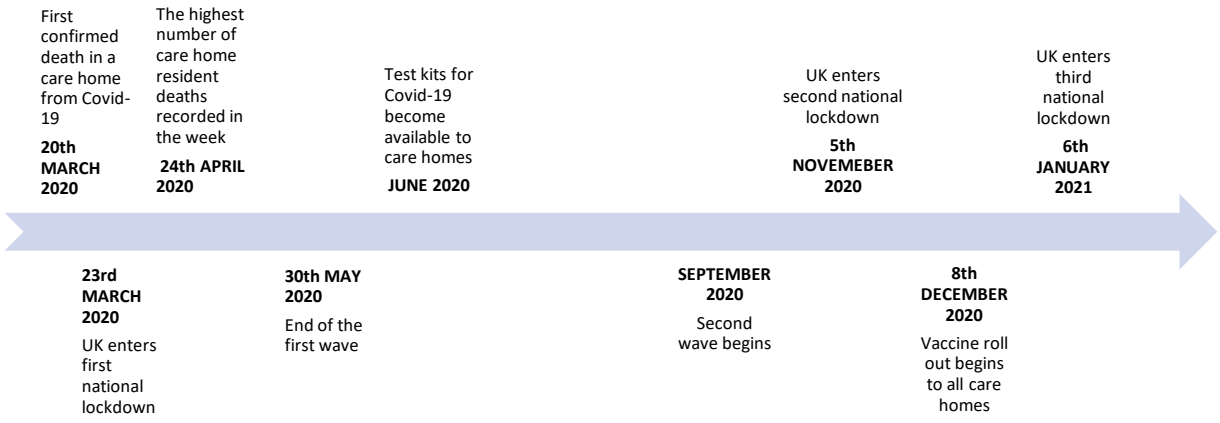
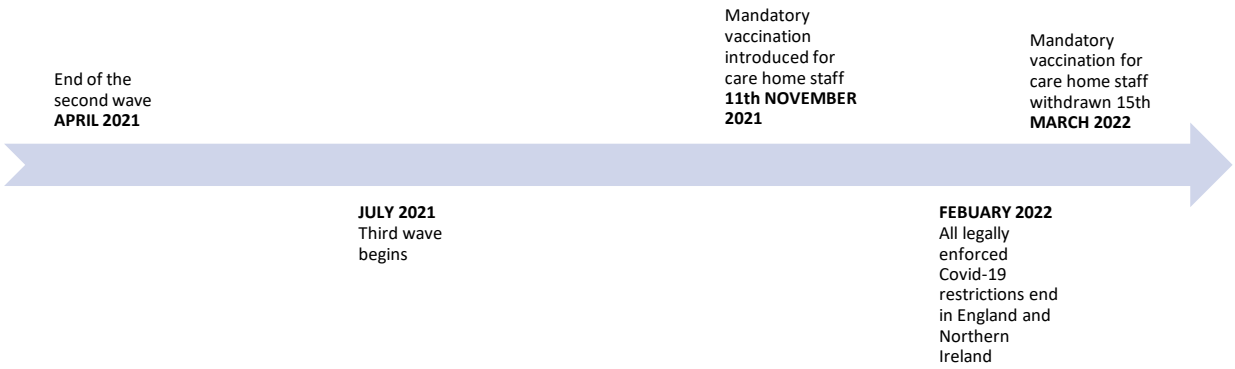


Figure 2

Timeline of key events of the Covid-19 Pandemic in Care Homes for Older People, in the UK March 2021 – March 2022



Psychological Impact of the Covid-19 Pandemic on Care Home Staff: Occupational Trauma

The psychological impact of traumatic events experienced whilst at work is referred to as 'occupational trauma' (Granham, 2012). Research on occupational trauma during the Covid-19 pandemic in care home staff has used outcomes of mental illness such as depression and anxiety, specific trauma reactions such as post-traumatic stress disorder (PTSD) and secondary traumatic stress.

Levels of mental health symptoms in care home staff during the pandemic were high, with one large sample study identifying that care home staff had the highest rates of PTSD compared to staff in any other community setting (Greene et al., 2021). A systematic review with a large total sample size of over 5000 included three studies which indicated that over 40% of participants met the clinical threshold of symptoms (Gray et al., 2021). However, whilst one study did find a decrease in mental wellbeing when staff retrospectively

reported their pre-pandemic mental health, no studies were longitudinal, meaning causation cannot be inferred. Secondary traumatic stress (also referred to as "compassion fatigue") (Branson, 2019) refers to how individuals become overwhelmed by direct or indirect witnessing of others' suffering and can result in symptoms similar to PTSD.

In summary, available evidence indicates the substantial adverse psychological impact of the Covid-19 pandemic for care home staff. Research has also examined how social care staff have coped with these difficulties.

Defining Coping and Recovery

Several studies examining coping in health and social care staff during the Covid-19 pandemic have used Lazarus and Folkman's transactional theory of stress (Beattie et al., 2023; Soubra et al., 2023) in which coping is defined as the process by which individuals employ cognitive and behavioural strategies to effectively manage demands (Lazarus and Folkman, 1984). The transactional theory of stress and coping describes how an individual's experience of stress depends on their appraisal of the demands of a situation, versus their ability to cope with it (Lazarus and Folkman, 1984).

"Recovery" from psychological trauma has been conceptualised as a dynamic process of forming new meanings that incorporate the complex and contradictory aspects of reality after a traumatic event (Lebowitz et al. 1993). Coping and recovery are related but distinct concepts. The use of effective coping strategies can be considered to make up the longer-term process of recovery with avoidance strategies (such as denial) less effective for longer term recovery than approach strategies (such as acceptance or positive reappraisal) (Luszcynska et al., 2009).

Social Support and Trauma Recovery: Key Theoretical Explanations

It is well evidenced by metanalyses that social support after exposure to traumatic events is a protective factor against developing PTSD (Ozer et al., 2003) and is associated

with the presence of post traumatic growth (Ning et al., 2023). Two meta-analyses have also replicated this finding across cross-sectional and longitudinal studies, specifically in the population of first responders (Guilaran et al., 2018; Prati & Pietrantoni, 2010). There are a number of explanatory models for how social support enhances coping and recovery. The Conservation of Resource model suggests that social support can be effective without discussion of the traumatic event. Social Cognitive Processing Theory, describes how the social environment can encourage or discourage individuals to cognitively process traumatic events via discussing them, therefore impacting recovery. The recently proposed model of Social Support in Posttraumatic Stress Recovery (Calhoun et al., 2022) specifically considers how individuals who have been through shared traumatic experiences might impact each other's recovery both positively and negatively. The concept of Collective Efficacy describes how a perception that the group can collectively cope in the wake of shared traumatic experiences, can enhance individual recovery.

The Conservation of Resource Theory

This theory developed by Hobfoll (1988) describes how, in traumatic events, an individual loses valued resources such as personal characteristics (physical wellbeing / self-esteem), material resources, or social resources (such as social support). A negative spiral in which loss begets further loss can follow the traumatic event. Social support after a traumatic event can compensate for lost resources, stopping this spiral and decreasing stress (Hobfoll, 1988). Individual differences in the kind of resources individuals possess pre-trauma can affect the importance of social support for their recovery. For example, the association between social support and post traumatic growth in the general population is increased for those who are caregivers (Ning et al., 2020), hypothesised to be because of this group's high pre-existing emotional and financial burdens.

This relates closely to the Job-Demand-Resource model, but distinctly refers to the loss of resources that a traumatic event might entail, as opposed to the day to day demands of work. The theory has been used as a possible explanation for the positive effects of social support on the mental health of first responders after traumatic incidents at work (Prati & Pietratoni, 2010).

This theory suggests that social support can be protective against the impact of traumatic experiences, without needing to specifically speak about the experience itself. A narrative synthesis highlighted that emergency workers appreciated relaxed time with colleagues after potentially traumatic incidents at work, appreciating humour and casual conversations with colleagues, even if the incident was not discussed (Auth et al., 2022).

Social Cognitive Processing Theory

Social Cognitive Processing Theory describes how an individual's environment can either encourage or discourage the cognitive processing of traumatic experiences. In contrast to the Conservation of Resource Theory, this processing occurs by directly discussing traumatic events. Social environments that encourage disclosure, offer adaptive interpretations of events, as well as model adaptive coping mechanisms can enhance recovery (Lepore, 2004). In contrast, critical and shaming reactions from others might discourage disclosure and processing and maintain negative beliefs about the self that increase vulnerability for PTSD (Lepore, 2004). The model has been used in previous research to consider how organisational culture can deter workers from discussing the impacts of traumatic experiences at work, with colleagues (Auth et al, 2022; Evans, Pistrang, Billings 2013).Click or tap here to enter text.

Social Cognitive Processing theory also suggests that new and adaptive appraisals of traumatic events may be perceived as more credible if they come from those who have had

similar experiences. Those who have survived similar experiences might also be particularly well placed to model adaptive coping strategies that they have learned.

Workers can value discussing traumatic experiences with trusted colleagues. Several systematic reviews in different clinical contexts have demonstrated that workers choose to discuss events with colleagues (as supposed to family or friends) specifically because they can relate more directly to their experiences, offer reassurance and normalise reactions. Contexts include: after patient assaults on psychiatric wards (Zhang et al., 2021); ambulance workers after critical incidents (Auth, 2022); nurses after committing nursing errors resulting in patient harm (Cabilan & Kynoch, 2017) and nurses after failed patient resuscitation attempts (Blomquist & Lasiter, 2022). Colleagues offering reassurance that they would have acted the same way after certain critical incidents is highlighted as supportive, whilst concerns that colleagues might not agree with the way incidents were handled, was cited by some as a reason not to discuss events (Auth, 20220). This may be particularly relevant to frontline workers' recovery, given the risks of moral injury and related PTSD in this staff group.

Whilst Social Cognitive Processing Theory suggests different ways in which frontline workers might support each other in the wake of traumatic events, the theory has been further developed by Calhoun et al (2022) in their model of Posttraumatic Stress Recovery, to incorporate more about how particular relational dynamics might impact individuals' recovery.

Model of Posttraumatic Stress Recovery

Calhoun's model focuses on the role of social support in recovery from traumatic stress, by considering how interpersonal coping (e.g. via relationships) may impact intrapersonal coping (e.g. changes to schemas, emotional regulation) (Calhoun et al., 2022). The model outlines how biological vulnerabilities (such as HPA axis reactivity, influenced by

past experiences of trauma) combine with environmental influences to affect how individuals are impacted by traumatic events, which intra and interpersonal coping strategies they use and their subsequent recovery. The model details the potential challenges of mutual support between those who have experienced a traumatic event. It pays particular attention to how the impacts of traumatic experiences; such as emotional dysregulation, cognitive deficits and high levels of anxiety, can mean that individuals may both require more support from others and be less able to support others.

Those who have undergone shared traumatic experiences might engage in mutually unhelpful coping strategies, such as mutually avoiding mentioning the traumatic event. They also might engage in co-rumination over traumatic events: defined as dwelling on negative affect and problems in an interpersonal context in a way that fails to alleviate stress and generate new coping strategies (Calhoun et al 2022). In a study of emergency workers, Stephens & Miller (1997) found that communication about negative aspects of work with supervisors and colleagues was correlated with Post Traumatic Stress Symptoms (Stephens et al., 1997). However, this study is cross-sectional and cannot infer causation.

Covid-19 is an example of an event where workers have lived and worked through shared traumatic events that have affected their whole team, and to some extent their whole profession. This suggests the benefits of examining not just interactions between individuals, but how support might function on a collective or group level, in the wake of shared traumatic experiences.

The Concept of Collective Efficacy

Collective efficacy is a concept developed within Social Psychology, defined as a shared belief amongst members of a group in their ability to cope with a particular situation (Bandura, 1997). It is made up of two factors: “Social control” (the perception that the group

or community will be able to initiate unified action) and "Social cohesion" (perception of social support within the group) (Bandura, 1997).

Collective Efficacy has been demonstrated to protect individuals against the impact of traumatic experiences in the context of natural disasters. Higher collective efficacy (rated both at the individual and community level) has been found to lessen the likelihood that individuals will develop PTSD after exposure to collective traumatic events (Heid et al., 2017; Ursano et al., 2014). Collective efficacy is also associated with lower levels of psychological distress and secondary traumatic stress (Caricati et al., 2022) and has been found to mediate the relationship between stress appraisal and burnout (Prati et al., 2011) in emergency responders and crisis workers.

In summary, there are a number of different theoretical explanations for the role of social support in promoting coping and recovery, in the context of traumatic experiences. Some of these involve direct discussion of traumatic experiences, and some of them do not. Social interactions can have negative, as well as positive, effects on individuals' recovery from trauma, and interactions specifically between people with shared traumatic experiences can be both detrimental as well as helpful to recovery. The theory of collective efficacy also suggests that groups of people's collective beliefs about their abilities, can also impact individual's experiences of recovery.

Social Support and Recovery from trauma: Individual Differences

Individuals also differ in the extent to which they seek and need social support in the wake of traumatic events and the effect that it has on them. Personality profiles, gender and culture play a role. A meta-analysis indicated that individuals with higher extraversion traits are more likely to use social support as a coping mechanism (Connor-smith & Flachsbart, 2007). Studies have also demonstrated that the relationship between extraversion and lower PTSD symptoms, is mediated by high levels of social support (Jia et al., 2015; Ceodbanu et

al., 2015). Although these two studies are well powered, there are to my knowledge no meta-analyses that corroborate these findings.

Some studies demonstrate that men are less likely to seek support for their mental health when in male dominated professions (Milner et al., 2019), and qualitative research demonstrates that some first responders feel that male-dominated workplaces make them less likely to seek support after traumatic work events (Auth et al., 2020). Meta-analyses have also found that gender does not moderate the relationship between social support and trauma recovery in both the general population (Ning et al. 2020) and in first responders (Prati & Pietrantoni, 2010) suggesting that, although men may be less likely to seek support, they may derive the same benefits from it.

The influence of culture has also been examined. A recent literature review discovered inconsistent findings regarding whether the association between social support and PTSD varied across cultures. More consistent evidence for cultural differences was found in the kinds of social support that people prefer to receive (Hansford & Jobson, 2021). Multiple studies comparing East Asian and European American participants, found that the former tended to be helped by unsolicited emotional support in which it is not obligatory to explicitly discuss the stressor, whilst the latter often found solicited support that explicitly discussed stressors, most helpful (Hansford & Jobson, 2021).

This review considers European cultures examples of "independent", and East Asian ones examples of "interdependent" cultures. However, the huge group variance within these two groups has been highlighted (Campos & Kim, 2017), as has the lack of research on this topic with many cultural groups such as Eastern European and cultural groups on the African contintent (Heim et al., 2022). This may make these results less relevant to staff in UK care home teams. It does however, highlight that culture is important when considering staff's potentially varied preferences for support.

There are, to my knowledge, no studies that specifically investigate how individual differences impacted care home staff's experiences of social support at work during the Covid-19 pandemic. However, there is a large body of evidence that demonstrates that lacking other resources increased health and social care worker's vulnerability to PTSD, as is suggested by the Conservation of Resource Model already outlined. A systematic review of health care worker's experiences highlighted that being young, female, not being a graduate, having low medical training and not living with a partner, all increased workers' risk of developing PTSD (D'Ettorre, 2021). Another systematic review found that lower household income increased the risk (Greene et al., 2020). The care-home work force contains a high number of female, non-graduate workers with low levels of medical training and low income, suggesting that workplace support could be a particularly important factor for staff in this group.

Staff from minoritized ethnicities in a large UK sample of over 11,000 healthcare staff, were found to have higher rates of PTSD compared to white ethnic groups (Melbourne, 2022), felt less secure raising concerns in the workplace and were more likely to experience discrimination at work, than their white colleagues (Melbourne, 2022). Variance in rates of PTSD was fully explained by differences in socio-demographic and work-related variables indicative of structural racial inequalities (such as BME staff being more likely to work night shifts and longer shifts) (Melbourne, 2022). These findings suggest that social support at work may be both particularly important for BME staff, and something that discrimination may prevent them from accessing. This paper is however currently only accessible as a preprint and has yet to be peer reviewed, meaning findings should not be used to inform clinical practice. A scoping review on the experiences of ethnically minoritized care home staff did however include this paper and highlighted a serious lack of studies on the

experiences of this group (Thompson, 2023). The dearth of other research suggests the potential value of considering such results, albeit provisionally.

In summary, lack of other resources and vulnerability to structural inequalities may increase some staff's need for social support, whilst male staff and those who are introverted may be less likely to seek support when they need it. Research on cultural differences also highlights that individuals have different preferences for the kind of social support they find most helpful, and that some people may find unsolicited support more helpful.

Care Home Staff's Experiences of Social Support at work, during the Covid-19 Pandemic

I will now selectively review relevant quantitative and qualitative literature on care home staff's experiences of social support at work during the Covid-19 pandemic, considering the relevance of the above theoretical models.

Quantitative Research

A limited number of quantitative studies have specifically considered the role of social support at work in care home staff's coping in the context of the Covid-19 pandemic. Two studies by the same authors use the Job Demand-Resource model to demonstrate how social support could buffer the effects of traumatic experiences. Low social support, combined with high pressure at work, was associated with increased levels of post-traumatic stress symptoms (Blanco-Donoso et al., 2021) whilst another study demonstrated that high levels of social support at work when demands at work were high, were associated with greater job satisfaction (Blanco-Donoso et al., 2022).

Two systematic reviews of quantitative studies of healthcare workers' experiences have demonstrated the importance of social support. One review across healthcare staff in hospital settings in the first year of the pandemic found social support was correlated with lower post-traumatic stress symptoms (D'ettorre et al., 2021). No staff in this review,

however, worked in a care home setting. Another international systematic review focused on healthcare workers demonstrated an association between social support and lower rates of poor mental health (Labrague, 2021). Although the review itself makes no mention of staff working in a care home setting, two out of the 31 studies include care home staff as participants (Blanco-Donoso et al., 2021; Luceño-Moreno et al., 2020) whilst seven of the papers included do not make it clear whether any participants work in care home settings or not. This limits the applicability of these findings to the care home setting. In summary, quantitative evidence for the importance of social support in coping with traumatic events in this staff group, remains limited.

Qualitative Research

Support from colleagues was highlighted as an important theme in a systematic review and meta-synthesis of qualitative evidence for care home staff's experiences during the first year of the pandemic, which included 15 studies (Gray et al., 2022). Three of Gray's seven themes from the meta-synthesis are related to receiving support from colleagues: communication, support and the positive impact of Covid-19 as leading to increased teamwork. However, the majority of papers in this review use Thematic Analysis, which can be less useful at picking up ambivalence, conflict or complexity in participants' accounts (Joffe & Yardley, 2004).

A systematic review and meta-synthesis of qualitative research on healthcare workers' experiences of resilience during Covid-19 and previous pandemics (from 2002 – 2022) including 112 papers provided more detail about the kinds of support that were valued between colleagues. This review found that support from colleagues was the main source of support participants referred to (Curtin et al., 2022). Themes identified that referred to support from peers were: 1) solidarity and working together 2) connection with peers 3) clear and attentive communication 4) leading with courage (feeling supported by compassionate

and present managers) and 5) practical supports boosting morale. “Connection with peers” referred to the experience of team cohesion, feelings of solidarity, camaraderie and having a shared goal. One quote was used to illustrate this theme: “You are part of a group and everyone is altogether, like a single fist – then that really gives you strength” (Dopelt et al., 2021).

Another meta-synthesis, specifically of nurses’ experiences during the pandemic, also highlighted “team cohesion” as a major theme, here defined as having a sense of the team’s “collective power” (Fernández-Basanta et al., 2022). Both this and Curtin’s meta-synthesis only contain studies based in hospital settings, meaning the relevance of these findings to care homes may be limited. However, much of the qualitative research specifically within care homes highlights similar themes to Curtin’s meta-synthesis: support from managers, teamwork and team cohesion, and sharing experiences and discussing feelings.

Support from Managers

Many studies indicate the importance of the presence or absence of management support for staff. Managers being present on the floor during the shift and being accessible and approachable to answer questions made staff feel valued and supported (Beattie et al., 2023; Yau et al., 2021; Zhao et al., 2021, Havaei et al., 2022), while the absence of management left some staff feeling abandoned (Bunn et al., 2021; Connelly et al., 2022). Some staff described the development of reciprocal trust via management demonstrating compassion and empathy (Beattie et al, 2022), while a supportive approach to infection prevention control was defined as non-punitive (Bunn et al., 2021). In contrast to this, some staff expressed that a top down, punitive management style, resulted in staff feeling unsupported and contributed to burnout, mistrust of management, low morale and poor adherence to protocols (Yau et al 2021). One strength of this study is the range of

participants, including public health professionals, senior leadership, managers and frontline staff, allowing for multiple perspectives on the same team-wide phenomenon.

One study presents one manager's view on staff discussing their feelings in the team (Connolly, 2022). This study used narrative analysis on individual interviews, one of which was with a care home manager. The manager describes the importance of "resilience" as a feature that allows staff to "move on" from traumatic experiences of the pandemic, rather than "dwelling" on them, and described frustration with staff who wanted to keep discussing emotional reactions from the pandemic (Connolly, 2022). Social cognitive processing theory would suggest that rules that might inhibit the expression of emotion within the team, perhaps discouraging the discussion of events, can prevent the processing of traumatic experiences. This single case study gives one example of a managers' beliefs about whether staff should discuss events, although it cannot draw any conclusions about the actual effect of this on staff's experiences.

Teamwork and Team Cohesion

"Teamwork" and "team cohesion" were cited by many care home staff as something that helped them work in challenging circumstances during the pandemic (Bunn et al., 2021; Doyle et al., 2023; Rutten et al., 2022; White et al., 2021). Several of these studies are online surveys and whilst one strength of this methodology is large sample sizes it can also encourage less in-depth participant reflection compared to interviews. Bunn et al. also included in-depth interviews, revealing that a shared sense of purpose and effort amongst the team led to many staff feeling supported (2021).

In Hung's 2020 study in a Canadian care home, a sense of shared resilience in the team was highlighted as contributing to individual staff feeling pride in their professional identity (Hung et al., 2022). This study used in-depth interviews and focus groups within the

same care home, the latter allowing staff to reflect on experiences together, although perhaps meaning staff were less likely to discuss negative experiences of teamwork.

Findings from this Canadian study also may not be widely applicable as, unusually, this team experienced increased staffing levels during the pandemic and staff commented that consistency of staff in the team had strengthened their sense of shared resilience. A sense of cohesion, co-operation and unified strength amongst staff was present across multiple home contexts in the UK (Beattie et al., 2023; Connelly et al., 2022). These two studies conducted in-depth interviews with participants, although authors in Beattie's study do note a low response rate to interview requests, indicating a possible response bias for those wanting to share positive experiences. Staff speak about the importance of "banding together" to "stay afloat" (Connelly et al., 2021) and also note how essential team support is in order to cope with individual stress "...I don't think any of us would cope if we didn't have each other to keep going" (Beattie et al, 2021).

Staff's experiences that a sense of collective purpose, support and ability in the team helped them to cope individually in the face of highly stressful and traumatic experiences, may usefully relate to the concept of collective efficacy (Bandura, 1997).

Sharing Experiences, Discussing Feelings

Staff spoke about how discussing feelings and sharing experiences with one another increased coping (Beattie, 2020). Another study based in Canada interviewed 52 carers and found that staff "relied on each other to discuss their feelings" and that many staff felt that "shared fears and shared experiences" brought them closer (Titley et al., 2023). This study's large sample size might also be considered a weakness in qualitative research, as breadth might come at the expense of a more in-depth understanding of participant experiences (Sandelowski, 1996). Studies also make specific reference to the fact that shared experiences

meant that colleagues were some of the only people who they felt understood what they were going through (Connelly et al., 2021, Beattie et al., 2020).

Other studies have highlighted that, whilst shared experiences helped colleagues to feel understood by each other, supporting colleagues was at times an ambivalent experience (Billings et al. 2021). Some staff feared burdening their colleagues by requesting emotional support or discussing difficult events, and others felt burdened by supporting colleagues in a context when they themselves were emotionally depleted (Billings et al., 2021) Only four out of 25 participants from this qualitative study were based in a care home context, limiting conclusions that can be drawn about care home staff's experiences.

This finding was also replicated in a grounded theory study which interviewed health and social care staff 12 –18 months after peak of the first wave in the UK, mapping factors that influenced coping for health and social care staff over time (Soubra et al., 2023). The Covid-19 pandemic constituted fluctuating stressors for staff over several years, indicating the importance of studying staff's reflections on how their experiences changed over time. Staff in this study could experience supporting peers as a burden (Soubra et al., 2023). However, only one out of 20 participants in this study worked in a care home, again limiting what can be inferred from these findings.

These findings do suggest, in line with Calhoun's model of post-traumatic stress recovery, that mutual support between those with shared traumatic experiences may be challenging, as those who are suffering themselves may have depleted abilities to support others.

Divisions and Tensions in Staff Teams.

The experiences of the pandemic also led to divisions in care home staff teams. Titely et al.'s study described professional hierarchies in teams, with carers receiving less important information than their qualified colleagues, leading to them feeling less valued

(Titley et al, 2021). A strength of this study is that it includes a large sample of solely carers (as supposed to qualified nurses) who provide the majority of direct resident care.

Many homes had to use agency staff more frequently (Doyle et al., 2023; Nyashanu et al., 2022) and some permanent members of staff commented that this created difficulty in the team, with some voicing perceptions of agency staff as less engaged and less willing team members (Doyle, 2023). Rutten's Dutch study also highlighted that participants believed communication and support within teams had strengthened, but between teams had worsened (Rutten, 2021). Some staff also described conflict and stress in the team when colleagues were perceived as not taking infection control policy seriously (Connelly et al., 2021).

Connelly's study also highlights how divisions and tensions within teams could be created by increased stress. This study used grounded theory to analyse 40 in-depth interviews with care home staff, to determine processes that diminished or supported staff's resilience. A spiral was identified in which support from colleagues reduced stress, encouraging further positive interactions between colleagues. High stress could also create conflict and tension between colleagues, reducing support between colleagues, and leading in turn to further stress and even less support (Connelly et al., 2021).

This evidence can be understood in terms of the Conservation of Resource model, as resources are lost or gained in a spiral after the experience of traumatic events. In this example, however, the evidence refers to periods of chronic stress as supposed to specific traumatic events. It also demonstrates that individuals exhibiting symptoms of trauma and stress might be less equipped to offer each other mutual support.

Summary of findings

Existent qualitative research highlights several different ways in which social support at work functioned for care home staff during the Covid-19 pandemic. Key themes are the importance of management support, teamwork and team cohesion, discussing

emotions and the pros and cons of supporting colleagues through shared traumatic experiences, and tensions and divisions in the team.

There is a paucity of evidence on staff's experiences of specifically discussing traumatic events with colleagues. This might be because staff in care homes for older people place greater value on more practical forms of support and a sense of collective strength. It is also possible that discussion of specific traumatic events, and a time for reflection and sense-making, might come later. One participant in Beattie's study contrasted a current state of stress and survival the team was experiencing, with the difficulties that might emerge with future reflection: "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." (Beattie et al., 2022).

Extant research also indicates an interesting variability in staff's experiences, with some discussing how the pandemic increased supportive relationships in the team, and some talking about how it led to greater conflict and division between colleagues. The evidence suggests a polarised experiences amongst care home staff. The spiral effect identified in Connelly's study could be linked to this. Extant evidence also suggests that team wide factors, such as management style, resources and consistency of the team (e.g. lower agency staff) might impact differences in experiences of support. There is also some suggestion that cumulative stress over time may diminish a team's capacity to support each other (Soubra, 2023).

Gaps in Current Research

Much of the current literature examines staff's experiences in the first year of the pandemic, with a minority of studies examining experiences from the second year (Soubra et al., 2023) and none researching staff's experiences after this point. Evidence suggests,

however, that traumatic events can have long term impacts. A systematic review of studies from previous pandemics identified that healthcare workers can experience distress up to three years after an outbreak (Sirois & Owens, 2021) whilst almost 20% of hospital workers in China met the threshold for PTSD two years after the start of the Covid-19 pandemic (Liu et al., 2023). Delayed onset PTSD is a subtype of the diagnosis (DSM-V) with theory suggesting that symptoms may be present, but individuals may experience an initial numbing of emotional responses (Andrews et al., 2007).

Whilst extant evidence indicates that social support at work helped staff cope during the initial stages of the Covid-19 pandemic, Calhoun's theory of Post-Traumatic Stress Recovery highlights the ongoing impact that social interactions can have in the process of longer-term recovery (Tedeschi & Calhoun, 2004).

Extant research also commonly combines staff participants from across different care homes, with few studies focusing on participants within individual care homes, and no studies, to my knowledge, offering comparisons of different care homes. Given that the literature demonstrates varied experiences of support and suggests links with organisational level variables, such as managerial style and teamwork, this suggests that it is important to research the experiences of specific care home teams.

Social-cognitive processing theory and the concept of Collective Efficacy both illustrate that individuals can affect each other's appraisals of traumatic events, and that shared appraisals of shared traumatic events can positively or negatively impact individual experiences of recovery. However, no research so far has examined how care home teams collectively appraise the traumatic events of the Covid-19 pandemic.

Conclusion

Whilst existent research indicates the importance of social support at work in helping care home staff cope with events of the pandemic, little is known about the role

social support might have played in longer-term recovery within care home teams. One way in which social support might encourage recovery is through forming shared meanings and ongoing reappraisals, of traumatic events. Extant research also shows that social support might have functioned differently in different care home teams during the pandemic. This suggests the importance of investigating the stories that specific care home teams tell about their experiences of the pandemic and its aftermath.

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Part Two: Empirical Paper

Social Support at Work in Care Homes for Older People during the Covid-19 Pandemic in the UK: a Narrative Analysis

Abstract

Background: During the first year of the Covid-19 pandemic staff in care homes for older people experienced high levels of stress, traumatic events and adverse psychological impact. Social support at work has been highlighted as helping care home staff to cope during this time. Little is known however about how different care home teams might have used social support during the start of the pandemic and in the following years.

Study aims: The aim of this study was to explore how staff teams experienced social support at work, through the narratives told about their team's experience of the Covid-19 pandemic and its aftermath.

Methods: Semi-structured interviews were conducted with 24 staff across two London care homes. Data was analysed to identify "collective narratives" that participants from each team used to make sense of their team's experiences of the pandemic, as well as less dominant counter-narratives.

Results: Staff in both homes described the ongoing emotional impact of past events of the pandemic. The two homes had different narratives. In one home there was a clear unified narrative across most participants that they supported each other through the pandemic and emerged a stronger team. In the other home, staff narratives were less unified, and staff spoke mainly about making sacrifices for residents, divisions in the staff team, and following procedures.

Conclusions: Cultures of how staff support each other within care homes teams may vary greatly, this should be considered when implementing any psychosocial interventions for staff in the care home context. Different teams have different collective narratives regarding the traumatic events of the Covid-19 pandemic, which may have implications for staff recovery.

Introduction

Covid-19 has had a devastating impact globally, and 80% of people who died in the first year of the pandemic were over 60 (Kai Wong et al., 2022). In the UK 42,341 care home residents died from Covid in the UK (Office for National Statistics, 2021) between March 2020 and April 2021. Staff in care homes experienced traumatic events at work and high levels of mental illness and secondary traumatic stress (Greene et al., 2021; Laher et al., 2022).

Emerging evidence demonstrates that social support at work had important impacts on care home staff's wellbeing during the first year of the pandemic (Ning et al., 2023; Ozer et al., 2003). It is well established in several meta-analytic reviews that social support is a protective factor against the psychological impacts of traumatic experiences (Ning et al., 2023; Ozer et al., 2003), and this has been replicated in meta-analyses specifically with emergency workers following occupational trauma (Guilaran et al., 2018; Prati & Pietrantoni, 2010). However, the kinds of social support at work that effectively protect from the impacts of occupational trauma are less well established. Research suggests that the kinds of interactions workers find supportive after occupational trauma are varied and dependent on individual factors as well as what is accepted and encouraged within the organisation's culture (e.g. views about expressing emotion at work) (Evans et al., 2013).

Emerging evidence from health and social care staff also shows that the kind of support staff wanted from each other during the Covid-19 pandemic was varied, and that peer support came with both benefits and challenges (Billings et al., 2021; Soubra et al., 2023). Qualitative research specifically examining the experiences of care home staff demonstrates that some staff consider teamwork and team cohesion, discussing emotions with colleagues, as well as compassionate, present and available management as important factors in allowing them to cope during the pandemic (Beattie et al., 2023; Bunn et al., 2021; Connelly et al.,

2022). Studies also demonstrate that some staff experienced tension and division in the team, as stress led to negative interactions with colleagues, in turn causing further stress (Connelly, 2022).

Existing research has been conducted during the first year of the pandemic, and little is known about care home staff's experiences in the years that followed. Evidence from previous pandemics suggests that staff can experience adverse psychological impacts for years afterwards (Alberque et al., 2022; Sirois & Owens, 2021). It has been demonstrated that team level factors (such as teamwork and management support) play an important role in staff experiences, but there are few qualitative studies which include multiple staff from the same care home team. Several theoretical areas, such as the Social Cognitive Processing Model (Lepore, 2004), and the Post Traumatic Stress Recovery Model (Calhoun et al., 2022) indicate that how groups of people collectively appraise shared traumatic experiences, can impact individual members' longer-term recovery.

Calhoun's Post Traumatic Stress Recovery model highlights how individuals' intrapersonal coping strategies (e.g. changes to schemas and emotional regulation) are impacted by interpersonal coping (e.g. via relationships). The model highlights how individuals who have undergone shared traumatic experiences can impact each other's recovery positively (for example by sharing adaptive reappraisals of events) and negatively (for example engaging in mutual avoidance and co-rumination) (Calhoun et al., 2022).

This suggests the importance of examining how staff from different care home teams make meaning out of their experiences of the pandemic, two and a half to three years after the start of the pandemic. This empirical study aims to identify what narratives are present in two different care home teams about the team's experiences during the Covid-19 pandemic, with a specific focus on narratives about social support at work.

This study will use a narrative approach. Narrative approaches focus on how people make sense of their experiences through telling stories about them (Murray, 2003). “Collective narratives” are defined as stories that groups of people tell to make sense of shared experiences (Caddick et al., 2015). Collective narratives are co-constructed by many members and exist on the group level (Caddick et al., 2015). Organisations can be considered “collective story-telling systems”, which influence how individuals within them make meaning of their experiences (Boje, 1991). Organisations can also be considered “polyphonic” (Hazen, 2007) and may contain a multitude of different voices and stories within them. In this study I aimed to stay aware of this, and to identify both collective narratives, as well as the variety of narratives that may exist within the same team.

Methods

Study design, Participants and Procedure

This study uses a qualitative methodology. Semi structured group and individual interviews were conducted and analysed using a narrative approach. A critical realist approach was adopted in which narratives are viewed as language constructs that nevertheless reflect real psychological and social processes, and have real effects on the world (Olsen, 2009).

Two care homes for older people were recruited by convenience, by circulating a study advert (Appendix B) to a wide pool of non-NHS run care homes for older people through the supervisor’s professional network. The first two homes that responded to the advert were selected for the study. These homes will be referred to by the pseudonyms Bendall Lodge and Rowan Close. Participants within both care homes were selected using a mixture of convenience and purposive sampling. The inclusion criteria were staff of any role who had worked in the home for any length of time. Newer staff were included because, although they may not have been present during the pandemic, they may still have an

awareness of team level stories about that time. Care was taken to recruit staff from a range of employment lengths. Exclusion criteria were staff under the age of 18, and those who did not have sufficient level of English to participate in interviews.

The concept of "data saturation" has been criticised as having little conceptual clarity. In this study I chose an a priori minimum sample size of 10 staff in each home. This was based on previous research, which has demonstrated that larger sample sizes are often required to identify collective narratives, than individual narratives (Caddick et al., 2015). A total of 12 staff were interviewed in each home due to time constraints and a wish to keep analysis manageable, as large samples can prevent in-depth analysis in qualitative research (Sandelowski, 1995).

Managers shared recruitment information with staff over WhatsApp and email (see Appendix B) and the study was also introduced to staff in a team meeting in each home.

11 visits were carried out to Bendall Lodge in total, from April – July 2022, and 11 visits to Rowan Close from September – November 2022. This included one night shift in each home. I was present in communal areas during these visits and staff interested in taking part in the research could approach me. Potential participants were offered a study information sheet (Appendix C) and a participant consent form (Appendix D). All those who took part in interviews were entered into a prize draw to win one of 3 £30 retail vouchers (a separate prize draw for each home).

Participants were given the choice of either group or individual semi-structured interviews and could decide how long interviews lasted. An interview guide was created that addressed the main research question (Appendix E). A broad opening question was used to encourage participants to begin to tell their own stories, as is usual in narrative research (Wells, 2011). Open questions were then developed around support and change in consultation with project supervisors. A group of care home advisors (professionals who have worked across multiple

different homes during Covid-19) approved this early version of the guide. Feedback was also sought from the first two participants in the first home, leading to the first question in the guide being rephrased to specifically ask about team experiences (See Appendix E). This may have affected these first participants' answers, perhaps meaning that they spoke more about individual and less about team narratives. It is unlikely that this had a large impact on the overall results however, as these participants did still discuss some team level experiences. Interviews were audio recorded if participants consented and handwritten notes were taken during the interview if the participant did not consent to audio recording.

Throughout the research I maintained reflective notes on the process of the research in order to help maintain critical distance from the material, question emerging findings and reflect on my own positionality (Reissman, 1993).

Adaptations to the research for the Care Home Setting.

The National Institute of Health Research highlights the importance of researchers adapting their methods to fit flexibly with the setting of care homes for older people (Enrich, 2014). Care homes for older people are busy environments and staff are time poor with often unpredictable workloads. This study made the following adaptations: semi-structured interviews could be of flexible lengths to suit participants' varied availability, participants could choose if they wanted to be part of a group or individual interview depending on what they felt most comfortable with and what was appropriate given the home's staffing levels, and written notes were also used as an alternative to recording interviews if participants preferred this. Interviews took place in the environment of the care home during staff's working day, for them to be convenient and accessible for staff. This was also following NIHR advice that researchers take time to understand the specific environment of each care home, and build relationships with staff, over the course of the research.

Analysis

Analysis was conducted based on Caddick et al.'s (2015) approach to identifying collective narratives. A narrative was defined as an explanatory story, told within the team about the team's experience of the pandemic.

All audio recorded interviews were transcribed and notes from interviews that had not been recorded were typed up, along with reflective notes made after each interview. The following process of analysis was done firstly with one home and then the other. Firstly, I immersed myself in the data by reading and re-reading each transcript whilst listening to the recording (if available) and re-reading reflective notes. Following this I then went back through the transcripts and inductively coded them to identify narratives about that team's experience of the pandemic (see Appendix F for a coded section of transcript, and links made with reflective notes).

I met with project supervisors to discuss emerging findings in the data. The data indicated that, in each home, there were certain narratives about the team's experience of the pandemic that were more dominant than others, as well as narratives that opposed these more dominant stories. Given this, I chose to present the data from each home in 3 sections. 1) A "headline narrative" which was a succinct summary of the main collective narrative across participants in that home, followed by a summary of the main collective narratives in the home. 2) Examples of these main narratives as told in individual interviews. 3) "Counter-narratives": key stories staff told that opposed these main narratives.

This choice followed principles that the role of the qualitative researcher is to construct an evidenced and useful interpretation of the data, as supposed to a perfect or exhaustive representation (Willig, 2008).

Credibility checks and rigor

I checked my own understanding of key themes and concepts with participants as interviews took place. A section of the interview transcript was inductively coded by another researcher within the research team and disparities in results discussed to check any blind spots I might have in relation to the data. Understanding of narratives was discussed as a research team to increase the validity of findings. The team consisted of myself and three project supervisors GC, MP and JB. GC is an associate professor and consultant Clinical Psychologist specialising in research psychological support for people with dementia and their carers, with extensive experience working in care homes. JB is an associate professor and consultant Clinical Psychologist specialising in researching staff working in high-risk roles. MP is a Clinical Psychologist with a special interest in staff support in care homes and other health and social care settings.

All participants were contacted to give feedback on a summary of the main narratives in their home and those who agreed were asked if they felt it represented their home's experience well. Three participants gave feedback, and all said that they felt their home was well represented. If participants had disagreed with my interpretation of the home's main narratives, then I would have documented these views after my original analysis. If participants felt that I had misunderstood what they intended to say, then I would have consulted my research team and amended my summary accordingly.

Researcher Perspective

Reflection on the researcher's assumptions, interests and identity is important in qualitative research, as these factors affect all parts of the research process: the area chosen, how questions are devised, interactions with research participants and how results are analysed (Willig, 2008). I am a white British, 30-year-old cis woman and a Clinical Psychology trainee. During the beginning of the Covid-19 pandemic I worked as a healthcare

assistant on a psychiatric ward. Prior to this, I had also worked in a nursing team when the team had suffered a traumatic event. My interest in how teams cope in the wake of shared occupational trauma, comes from these experiences. From my training in Clinical Psychology I carry an assumption that speaking about traumatic events in the context of therapeutic relationships can be beneficial for individuals. My interest in group therapy also means I hold a specific interest in how groups of people might make meaning out of experiences together. I discussed with my supervisors how these assumptions might present bias in my selection of questions and analysis of data. We kept this in mind when discussing findings and made sure attention was paid to kinds of support that did not involve talking. Prior to the research I had no experience working in care homes for older people. This lack of experience may have meant that in interviews and later on in data analysis, I might have missed out on important features of participants' accounts that more of an "insider" eye would have noticed. Discussion of findings with the project supervisor MP, who has extensive experience working with staff in care homes for older people, was intended to mitigate this possibility.

Ethical Approval and Ethical Considerations

Ethical approval was granted for this study by the UCL Research Ethics Committee (Ethics ID: 22277.001). Record of approval is included (Appendix A). Several ethical implications were considered. Participants could potential revisit upsetting events during interviews. Participants were clear they could stop the interview at any time and could choose what they spoke about. Staff were also referred to a specialist support service if they disclosed struggling with their mental health. The potential emotional impacts of teams hearing about their colleagues' potentially negative or difficult experiences of support and teamwork, was also considered. This was mitigating by the decision to feedback a general summary of results to the team with sensitivity, having discussed possible areas of difficulty with project supervisors beforehand. Feedback would highlight positive experiences as well

as perhaps discussing more negative ones and anonymise participants' contributions. (See Appendix A for more details).

Results

Care home Characteristics

Bendall Lodge

Bendall Lodge is a London care home for older people which provides both personal and nursing care, with a resident capacity in the 60s. The home manager had been in post for around 8 years. The home is run by a medium sized parent company operating around 10 other care homes for older people around the UK. During the pandemic the home had had to employ agency staff for the first time in 10 years. The manager reported that a small number of staff had left the team during the peak of the pandemic but had since returned.

Rowan Close

Rowan Close is a London care home for older people offering personal and nursing care. The home has a capacity for around 80 residents and a similar number of staff and is run by a large parent company. The home has a long history of high manager turnover, had had no manager for several years before the current manager started in late Spring 2020 and employed agency staff throughout the pandemic. A member of the administration team reported that many staff had left during the pandemic.

Participant Characteristics

12 Participants were recruited at Bendall Lodge, and 12 participants were recruited at Rowan Close. Participants at Bendall Lodge were mainly carers (6), with several nurses (3), two members of the management team (also qualified nurses) and one member of domiciliary staff. The majority of participants had worked in the home since before January 2020 (8), whilst four staff had joined the home after that time. Six participants had worked there for more than five years. The manager of the home had worked there for eight years.

Participants at Rowan Close were mostly nurses, team leaders or coordinators (6), with 2 domiciliary staff, and a smaller number of carers (2), one member of the management team and one administrator. Seven participants had joined the home after January 2020, one participant had worked there for more than five years, and the manager had worked there for two and a half years (arriving in Spring 2020). See Table 1 for Participant and home characteristics. See Table 2 for Participant ethnicity, age and gender demographics across the two homes.

In both homes interviews ranged between 20 and 90 minutes depending on participants' availability, with the majority of interviews in both homes being over 30 minutes long. Four out of 24 participants opted out of having interviews recorded, notes were taken during these interviews. Three interviews in Bendall Lodge were conducted jointly with two participants, and one interview with three participants concurrently. In Rowan Close, one interview was conducted jointly with two participants.

Reflecting on the Impact of Group vs. Individual Interviews

Participants were offered the choice of group or individual interviews to make the research both accessible to staff who felt more comfortable participating in a group, and those who felt more comfortable participating alone. Individual interviews were also useful in the event of busy shifts where two staff could not be spared at the same time. In accordance with Caddick et al. (2015) this research conceptualised collective narratives as stories that groups of people tell about their experiences. Individual interviews were therefore conceptualised as also giving access to wider collective narratives. It was expected however, that group interviews would perhaps elicit more reflections on team relationships and shared experiences, by merit of colleagues being together. This turned out to be the case, with participants more likely to discuss shared experiences in group interviews and reflect on how the team experienced events together. Group interviews also tended to elicit more emotional

responses from staff, perhaps because being around familiar colleagues allowed staff to feel more comfortable, and also because staff would trigger off memories in each other.

More staff chose to have group interviews in Bendall Lodge, and this may have impacted how staff were more likely to speak about the pandemic in "emotional and relational" as opposed to purely "procedural" terms. However, this difference between homes was also present when comparing individual interviews, suggesting that it represented a valid difference aside from interview format.

Table 1

Table of Care Home and Participant Characteristics

	Bendall Lodge	Rowan Close
Type of care provided	Nursing and residential	Nursing and residential
Resident capacity	Approximately 60	Approximately 80
Parent company	Medium sized	Large
Years manager in post	8 years	2.5 years
	Participant Characteristics (/12)	
Employed > 2.5 years.	8	5
Employed > 5 years.	7	1
Nurses / team leaders	3	6
Carers	6	2
Management team	2	1
Domiciliary staff	1	2
Administration staff	0	1

Note. Participant numbers are out of 12.

Table 2

Participant Demographics

	Bendall Lodge	Rowan Close
Ethnicity		
Latin American	1	
British Caribbean / Black British	2	1
White Eastern European	2	1
White European (other)		1
British Dual Heritage	1	
Black African	3	4
Filipino	2	1
White British	1	1
British South Asian		1
South Asian		1
Turkish		1
Age		
18-25	2	1
26-35	2	4
36-45	2	3
46-55	1	2
56-65	4	
65+	1	
Gender		
Male	1	2
Female	11	10
Non-binary		

Table 3
Summary of Narratives in both Care Homes

Bendall Lodge	
Headline Narrative	We supported each other through this traumatic experience, and now we're on the other side and we're stronger for it.
Main Narratives	
Care	"We support each other, in that way we are like a family (…) You don't expect that from colleagues, you expect that from family."
Connection and Unity: Collective Remembering	"And then – you know when things were easier at work – we reassured ourselves, we said: we did well, we came together, we did our best in the most difficult time. And that makes us feel better."
Survival	"So it was traumatic in that time, but we pulled through. We're on the other side of it now."
Counter Narratives	
Lack of Communication	"So they (nurses) know who has Covid and we (carers) do not."
Ongoing Uncertainty	"But still, it makes you wonder, have questions."
Rowan Close	
Headline Narrative	We made sacrifices for our residents, a lot of staff left the team, following procedure was what got us through.
Main Narratives	
Differences between staff	"A lot of staff were cancelling, sick notice – they were afraid. But some staff were so brave (…) So that was those good staff who were really there."
Duty and Sacrifice	"We were not focused on ourselves - we were focused on the residents."
Procedure and getting on with it	"You don't have time to think about it – you have to get on, just move on."
Counter Narratives:	
Family	"This team is less like a job and more like a family."
We should have talked more	"Probably if we had had more conversations about what was going on we would have been better off emotionally."
Improved teamwork	"I think we're more attentive now, about [each other's] mental state – than how we were before."

Summary of Main Narratives at Bendall Lodge

"So they feel - some of the team, not all of the team - that they've supported each other through this horrible situation and now they're at the other end and they've become stronger in themselves because of it." Bendall Lodge manager.

The headline narrative at Bendall Lodge was one of care, connection, unity and survival.

Participants spoke about having passed from an initial state of fear and uncertainty (which several participants spoke about as "traumatic"), to greater stability with more information, and clearer set routines (7 Participants gave this narrative). Almost all participants described the team as being like a family (6) and there was a common narrative that the home had "come through" the pandemic and "done well" in the management the pandemic, due to staff supporting each other and working as a unified team (5). Many participants spoke about how the pandemic had made them a closer and "stronger" team (5).

There was a narrative across several staff that Bendall Lodge had not been as badly hit by the pandemic as other care homes (3), although staff varied in their memories of how many residents had died.

There was a strong narrative that staff at Bendall lodge had supported each other throughout the pandemic with various practical acts of care, such as covering shifts and sharing tasks if a colleague was ill or had difficult family circumstances (7). The level of support was presented as a special feature of the Bendall Lodge culture that improved staff wellbeing, and as essential to the home continuing to run well (e.g. by ensuring sufficient staff numbers). Staff said that during the pandemic, they had spoken to each other about their worries, shared advice with each other, and expressed emotion with each other, for example by crying together. There was also a strong narrative that management had supported staff

emotionally (4), for example making time in monthly supervision to ask staff how they were feeling about specific residents dying who they had worked with.

Many participants said that speaking about the team's past experiences during the pandemic (5) was emotionally difficult and three staff specifically told me they did not want to participate in interviews to speak about Covid-19 because it had been such a difficult time. Participants spoke about how the team coped with this difficulty by remembering the experience in ways that felt manageable: for example using humour and focusing on elements of survival and bonding.

Examples of main narratives.

Care: Caring for each other and the residents like a family, Johno and Isabella's Interview.

In this and all narratives that follow, all staff have been given Pseudonyms. Isabella, a nurse, and Johno, a carer – gave a joint interview in which they told a story about how the team had come through the pandemic due to their caring and supportive nature. Protecting against the psychological impact of Covid-19 within the team was spoken about by Isabella as part of one's professional duty as a healthcare worker:

"... during the pandemic it was a physical but also mental illness too, that was very important. We support each other, in that way we are like a family. If you are isolated you become depressed, anxiety. So in that way you feel supported [outside] the roles, you will be fine."

At the same time the level of support that the team gave each other was spoken about as going above and beyond what was expected within a professional context, as Isabella said of the support she had received from colleagues when off sick with Covid: "You don't expect that from colleagues, you expect that from family."

Johno also commented on how he felt that the need to share more personal information with each other during the pandemic had led to better communication and teamwork.

Preventing the residents from feeling socially isolated during the pandemic was also presented as an important part of professional practice that supported their mental health. Supporting residents in the face of many of them not being able to see their families, was also talked about by Johno as at times having felt like more than a professional relationship: "...you're seen not just as someone who looks after a resident at that point. You're seen as almost their friend, or it's a therapeutic relationship, but you're seen as their friend – there's more to it than what it is."

The experience of being herself ill with covid, was presented by Isabella as a lesson in empathy that she connected back to her professional practice:

"In that time, I put myself in the shoes of the residents – most of the residents here are bedbound. Getting somebody to bring food, drink, to change, to be washed – it is frustrating for the person, so in that week I experienced more empathy."

Connection and Unity: Collective emotional experience, collective remembering. Simon and Sayeeda's interviews

Simon and Sayeeda, both members of the management team at Bendall Lodge and qualified nurses, gave separate interviews in which they both foregrounded the staff team's emotional experience of the pandemic. They both described initial fear, distress and confusion in the staff team caused by frequently changing government information, with more calm and stability coming once clear infection prevention routines were in place. Sayeeda frequently referred to the staff team as having had unified experiences:

"It was really tough for staff we all felt it – in one way or the other, because it affected all of us, all of us had the symptoms at some point, all of us probably didn't come to work at some point…"

Both Simon and Sayeeda also referred to turning points in the home's experience of the pandemic as emotional moments that staff experienced together. Simon told a story of a particular day in which he had felt the collective atmosphere of the home change. He described one day that had been especially emotionally difficult, as two residents had died on the same day. He spoke about how, although the day itself was very difficult, things got easier in the home after that – with fewer residents dying.

"...it was a horrible feeling, it was a horrible feeling to have those two people go and – it was – it was quite emotional (…) But it seemed as though after that, the whole atmosphere changed. And it was a palpable change, you could feel it – we all felt it… it was like there was more oxygen in the room, you could breathe easier."

Sayeeda also described one moment when staff had collectively felt that things were improving in the home:

"I remember one day we were having breakfast here, pastries and stuff and we said – tough times are going, tough times are fading away. I remember that day we didn't have any agency on. And that makes us feel like – ok (pause) – we felt emotional to be honest with you. Anytime someone is wheeled out – the dead body, we felt fear of death, I remember – oh."

Here Sayeeda describes how the moment when things became easier at work, was also an emotional moment when staff began to reflect on their experiences of fear and of loss. She describes how this process of reassuring each other, and creating a narrative of past events of the pandemic, began once the peak of the crisis was over: "And then – you know

when things were easier at work – we reassured ourselves, we said: we did well, we came together, we did our best in the most difficult time. And that makes us feel better."

Sayeeda spoke about how staff continued to remember events of the pandemic, giving an example of a particular moment when they had ducked out of the way of a resident's sneeze to avoid infection, that she had just remembered with staff only a few weeks ago:

"It was only a couple of weeks ago that we reflected on that - I said do you remember? [Gives a knowing look and smile that she gave to staff at that moment] They said oh god we remember - "

During her interview Sayeeda showed how, when remembering this moment together, her and other staff ducked down imitating their past movements and laughed together.

Surviving the pandemic: humour, bonding and continued sadness: Ellie, Hope and Rose's Interview

Ellie and Rose, two carers, and Hope – a nurse – gave a group interview in which they told a story that went back and forth between reliving the fear, confusion and trauma of the early days of the pandemic, and the team's current use of humour when remembering the pandemic. They expressed the lingering emotional impact of the events of the pandemic, as well as situating it in the past as something they had overcome.

"…even, even I mean now it's second nature putting on a mask – but when it first came you didn't know which way to put it on, you couldn't breathe – and it was really you know, mind racing thinking am I going to survive this? (…) But like anything in life it's you – with time you get used to it – you adapt, and you get used to it – and we all pulled together."

Emotional memories of the pandemic resurfaced throughout the interview, and Ellie began to cry when she remembered a particular resident who had died. She chose to continue the interview, and Rose explained how difficult it had been for staff when residents died, because of the strong bond that can form between staff and residents. Both Ellie and Rose expressed how it had been difficult coming back to work after a break and finding that residents had died since one's last shift.

Ellie, Hope and Rose all expressed the difference between remembering the pandemic now and what the experience had been like then. They also all expressed ambivalence around what it was like to remember certain experiences.

Ellie: "I think it's like - it's something we laugh over, then it wasn't like that – but now we laugh about it – like, this really happened. Like it's out there now – but at first I was so, so – it was so hard. (...) Very hard. But it's something – you don't want to remember it, you don't want to think about it, that such thing happened.

Rose: It's a traumatic event."

Ellie believed the team did not currently talk about their past experiences during Covid-19 enough, whilst Hope reflected on how she had initially been sceptical about an interview revisiting the experiences of the pandemic, before realising that it was a relief to talk about it.

Hope: "Because it's something now thinking about it when you first came I was just thinking, how can she come about Covid. But now I'm just beginning to realise it's something that you are keeping in your chest "

Ellie: "- yeah, yeah -"

Hope: "- But you don't realise is there."

Counter-narratives

Lack of communication, Suspicion of Information Shared

Rose, a carer, told a story that contrasted with narratives of unity and teamwork. She spoke about how carers had at times not been told in formal handovers which residents had Covid-19 and which ones did not, whereas the nurses knew this information. This had led, Rose said, to carers having to share information amongst themselves. Rose described feelings of anger when she had learned that the resident who she had just completed personal care for was Covid positive and she had not been told. She described how she had been told that if she wore her PPE correctly then she had nothing to worry about, and – although she laughed whilst describing this, she discussed how it made her feel angry at the time.

Uncertainty and Ongoing Questions

Anne, a carer, expressed a suspicion that correct information had not been shared between staff, and between staff and management, at the beginning of the pandemic. She spoke about how she thought that residents who were brought back into the home from hospital, who the hospital staff said were negative, were in fact positive. She described one particular occasion when she had watched hospital staff whisper to one another as they brought a patient in, which had raised her suspicions. Anne also expressed a general sense of ongoing uncertainty and unanswered questions regarding the events of the pandemic and whether the staff team knew the truth of what had happened.

Summary of Main Narratives at Rowan Close

The headline narrative in Rowan Close was one of division in the staff team, duty and sacrifice, procedure and "getting on with it."

There was less of a sense of a unified narrative about the home's experience of the pandemic, amongst Rowan Close participants. Several participants who had been present spoke about the peak of the pandemic as being a depressing time at Rowan Close. (4

Participants gave this narrative). Two of these staff felt that social distancing and everyone's concern for their own safety had meant staff had interacted less and had been less "bonded". There was a common narrative that many staff had called in sick or had stopped working during the pandemic, and that in the face of this the team had struggled with staff shortages (5). Several participants also spoke about how the majority of staff who had worked at the beginning of the pandemic had since left; however, people were conflicted as to whether this had been because of the pandemic or not.

Several participants spoke about how Rowan Close had undergone change and improvement, after having had longstanding difficulties in the staff team (5). These difficulties were described as being separate to and pre-dating the pandemic, and were often explained as there having been some staff who had brought "negativity" into the team (4). Some staff also spoke about this "negativity" persisting despite many staff having left (2).

Many of the participants at Rowan Close had started in the home after the peak of the pandemic. These participants tended to say that they knew the beginning of the pandemic had been difficult for the staff present, often listing the fact that residents had had to isolate in their rooms, and that many had died. These staff spoke about current procedures to keep Covid out of the home as part of normal everyday practice: "Covid - it's like normal life now" (4).

In comparison, two clinical staff who were present at the beginning of the first peak spoke about Covid as a feared and ongoing threat that the home needed to stay ready and prepared for (2). There was a strong narrative told by some staff of making sacrifices for the residents, and that staff were responsible for bringing Covid-19 into the home (4). The majority of participants recounted lists of procedures (such as daily testing) that they still used as a staff team to prevent outbreaks, with one participant referring to procedure as "that's what got us through" (8). Staff spoke about how they had expressed emotion together

(such as crying together) and also how they had supported each other by sharing information and concerns.

Many participants spoke about how the home continued to experience repeated "outbreaks" and one member of the team referred to these as "endless." Members of the management and administration team spoke about the immense administrative workload that had come with the pandemic, and how they had experienced external monitoring as supportive. There was a narrative across many participants that, during the peaks of the pandemic, staff had not spoken with one another about their experiences ("Get in, do the job, get out") (4). There was also a narrative that the team did not currently talk about their past experiences during the peaks of Covid-19, with several participants saying this was because there were new challenges to focus on. (3).

Example Narratives

Divisions in the staff team: Mariana's interview

Mariana, a nurse and team leader who had worked in the home for several years, gave an interview during her night shift that centred around the fact that some staff had stayed and kept working whilst others had left. She also told stories about how team leaders had had to allay staff fears and persuade them to work under difficult circumstances. Mariana described how a lot of staff had been scared to come into work and so had cancelled their shift because of sickness. She contrasted this with staff who had stayed working in the home:

"So some staff were really determined to – so – it is what it is, we're still going to face it, we're still going to do it (…) – they were here even when the agency cancels, or permanent staff cancel, there were some really good staff who were always there."

Mariana told a story of how a member of staff had tried to avoid delivering personal care to one resident who was a suspected Covid-19 case, by saying there was insufficient

PPE. Mariana said she had known that the real reason for the staff members' hesitancy was her underlying health condition. Mariana described how she had encouraged the staff member to enter the residents' room, wearing correct PPE. Mariana's reflection on her story seemed to demonstrate both an understanding for individual fears, and the idea that these fears should not be acted on in the face of professional duty:

"But in my concept it wasn't that she didn't want to do it – it was just that she was thinking, what could happen to her. But in clinical setting you don't have to think about that – because you know what you sign up for, in the job, what you've got to do."

Marians also spoke about how team leaders had used alternative narratives to counteract staffs' fear, when scientists had described Covid-19 as untreatable early on in the pandemic:

"So just apply your compassion and empathy skills and go ahead and do what you're supposed to do. And just stay strong, you'll be fine. We give them words, such words, and they ended up to do what they want to do – or the care we've got to do."

This demonstrates a conflict in Mariana's narrative, the conflicting ideas of work being a choice ("what we want to do"), and the idea that personal choice should be disregarded in the face of the work needing to be done.

Sacrifice and continued duty: "Prioritising the residents." Leticia and Rahmi's Interview.

Leticia and Rahmi both occupied leadership positions in two departments at the home. They had both worked throughout the pandemic, taking on a great part of the responsibility of running the home during staff shortages. Together they told a story of having made sacrifices for residents and described a sense of continued duty and alertness to the threat of Covid-19. They also referenced the bonds created between staff who had worked through the pandemic.

Rahmi described the immense fear and uncertainty that staff had experienced at the beginning of the pandemic, as well as the absence of management support:

"It was frightening, because residents were getting unwell, staff all getting it, staff dropping. (…) So – um. It was actually quite traumatic. We had nobody here everyone's going off sick, now we had no management – no, no one. Ambulances not coming up here."

Rahmi also spoke about the ongoing fear that she felt looking back at the pandemic:

"Wow… we did that [sounding proud]. Because looking back you don't think on it do you, you think – did we do that? But there's that fear - I don't know about yourself I always have that fear; it's winter again, is something else gonna come up."

Leticia also often expressed not wanting to return to past times and would often follow this with detailed lists of PPE stock and procedures in case of another outbreak. A continued state of alertness to Covid-19 was also presented as carrying over into one's current personal life. Leticia described how:

"Me personally I don't go anywhere... Anything with a crowd I won't go. Because you know this Covid thing isn't going anywhere and I may get Covid if I'm in that crowd. So how would your residents feel? (…) I always question it. Will I bring covid into the home? Is that me? Will I cause the next outbreak?"

Both participants frequently repeated the phrase that it was staff who brought Covid-19 into the building, as opposed to residents. Leticia described using this as a way of reminding new staff of the importance of testing, and their responsibility towards residents.

Both Leticia and Rahmi spoke about personal harm during the pandemic: such as having washed their hands so much that they bled, contracting UTIs because of being too scared to go to the toilet and remove PPE during one's shift, and forgetting to eat during 12 hour shifts. Rahmi told a story of a particularly difficult point in the pandemic when the team had found out that one of their colleagues had died after contracting Covid-19. She described

how everyone working had gone outside the home and cried together, before getting back to work:

"And I remember that day. We all went out through the laundry room, we took everything off [our PPE] and we just burst out crying. Every single one of us. And then we just focused – right, the residents. And we just got right back in."

Leticia and Rahmi reflected on how they felt that the team had prioritized care for the residents over care for themselves: "We were not focused on ourselves – we were focused on the residents." This was presented as something that had been necessary given the extreme workload: "I wasn't thinking about those [staff] who left, I was thinking – how are we going to look after the residents."

Both Rahmi and Leticia described a bond between those who had experienced the beginning of the pandemic, who were now a minority in the team due to high turnover. Leticia described: "When people [other staff who weren't present] talk about covid – we chuckle and we look at each other because we know that back then it was two of us on the unit, when she needed me I was there." During the interview both Leticia and Rahmi frequently finished off each others' sentences, laughed together when describing particular experiences, such as miming having to wear makeshift PPE – again demonstrating the bond that this experience had created between them.

Procedure and "Getting on with it": "You don't have time to think about it, you have to just get on, move on", Carl's Interview

One member of the management team, Carl, gave an account of the pandemic which was structured around the presence or absence of external monitoring and support. He also commented that he did not know much about staff's emotional experiences:

"We had to do a capacity tracker every day and that went into how many staff you had, how many were sick, how many had symptoms, how you isolate, how you cohort, how

are you restricting access to families, how are you screening. And you missed – if you didn't do the capacity tracker for one day, you'd get a phone call."

Monitoring was presented as having gone hand in hand with support, with a CQC inspection regarding whether PPE was being used correctly or not, having been experienced as useful and supportive. Carl spoke about key events, such as outbreaks, in terms of the involvement of external actors: "And you know the guidance, the policing, the monitoring, it all just seems to just to slowly slip away – there was months here in the summer of last year that we didn't have any covid at all."

A feature of Carl's account was the ever-unfolding list of new tasks and events in the home vying for time and attention. Carl spoke about this as both being part and parcel of the profession: "Working in healthcare you get used to sort of mini crisis after mini crisis, you just get on with it*"* and also as a particular feature of this home, which was described as having an unusually high number of "issues" in the staff team. These issues were generally spoken about in terms of a sense of "negativity" that had existed before the pandemic.

Carl also spoke about how he was unsure how Covid had affected the staff team~~,~~ and said that he had never heard a member of staff speak about how Covid might have affected them emotionally. The fact that people just "got on with it" was situated as a reason for people not speaking about it, and also a reason for why members of the management team might not know how staff were discussing their experiences:

"You know over the past two years I don't think they do [talk about their experiences of the pandemic] and if they do, then I'm not party to those conversations. And it's really, in terms of all the stuff that's going on here with all the issues I've got (…) it's really not on anyone's agenda to be honest."

A member of the administrative team who gave a separate interview with similar themes, also said that the management team did not currently talk about their experiences over the pandemic, due to the volume of work:

"We only talk about Covid if someone asks for this report, this and that – I think – because we're too busy! You know – there's no time to be thinking about – oh, this happened oh you know. No."

Counter-Narratives

A Grieving period in the home

Debra, a nurse who had started working in the home after the second wave of the pandemic, spoke about how the home was "coming out of a grieving period" when she arrived. She said that many residents dying had had an emotional impact on the team, citing the emotional bond that can form between staff and residents as important: "This team is less like a job and more like a family." She spoke about how longer-term staff would currently speak about residents they had lost, often prompted by empty rooms or particular clinical discussions.

"Probably if we had had more conversations about what was going on we would have been better off emotionally."

Leticia, a head of department, voiced how she felt that not discussing their experiences together had had a negative impact on staff:

"I think that if we did speak about it back then, I wouldn't have so much resentment for covid. And – I'm angry because of what happened. I'm angry because it came, did its damage, staff left, we worked so hard – but if we had known we could have done more, I'm not happy about that. But we never spoke."

Esme, a carer also described how it was a "relief" to talk about Covid-19 in the interview, and described how people's emotions were evident despite not being expressed:

"People say that they don't want to talk about it – but you could see that people were distressed, they washed their hands so much. We didn't express what we felt with each other – we just came to work, did what we had to do – went home."

"I think we're more attentive about your mental state – than how we were before."

Peter, a member of the kitchen staff told a story about how he felt that the team were now more attentive about each other's mental health, than they were at the start of the pandemic – when people had mainly been concerned about physical wellbeing. Peter spoke about this new sense of concern for mental wellbeing, coming from colleagues as well as from management.

Another staff member, Erika, also reflected that they felt that the experiences of the pandemic had meant the team were better at teamwork. Erika noted that she felt this sense of "team bonding and joining around a purpose" was present when the home was in outbreak, but otherwise absent.

Comparing narratives between the two homes

Similarities

Participants across both homes described how a deep bond could exist between staff based on the shared experiences of the pandemic. They described how this bond was often communicated non-verbally – e.g., with knowing looks between staff. Across both homes participants described how they used humour when remembering their experiences of the pandemic together and demonstrated this in interviews. Across both homes staff also spoke about experiences of extreme fear and uncertainty that characterised the early stage of the pandemic.

Whilst referring to the team as a family was a main narrative in Bendall Lodge, one staff member in Rowan Close also described the team in this way, referencing the close relationships that staff had with residents. Several Bendall Lodge participants referred to how

the pandemic had created stronger ties in the team, and this was similar to the narrative presented by a minority of participants in Rowan Close who suggested that the team had grown more concerned with each other's wellbeing and better at team working.

Differences

Participants from Bendall Lodge were more likely to tell stories about the pandemic that centred on emotions and relationships, whilst participants at Rowan Close talked more about procedure. The management team at Bendall Lodge also spoke about the staff team's collective emotional experience, whilst the Rowan Close management spoke mainly about procedure and external monitoring – with a member of the management team saying that he did not know if staff had been emotionally affected by pandemic. This contrasted with the emotional impact that several members of the staff team, said that the pandemic had had.

In Bendall Lodge, narratives were also more consistent across all participants. Participants spoke about constructing shared meanings out of their experiences of the pandemic: "When things got easier at work, we reassured ourselves – we did well, we came together, we did our best in the most difficult time. And that makes us feel better." In contrast, there was not such a unified narrative as to how the home had come through the pandemic, at Rowan Close. Participants there did not describe a process of shared meaning making, with one participant commenting that the interview was the first time she was reflecting on the pandemic:

"It makes you wonder at the fact that we actually did that – we actually - ok we're not through the pandemic because it's still around, but you think we were under a big massive, grey cloud and now we've all come out of it. And we came out of it together. And you don't think about that do you – you think, we did this, we did that – but you don't look back and think – we were all in this together, and we achieved something."

Here the participant highlights the difference between a sequence of events ("we did this, we did that") and what could be described as a process of meaning making ("we were all in this together, we achieved something"). Participants at Rowan Close who had been present at the beginning of the pandemic also spoke about the current, ongoing demands of outbreaks and the importance of remaining alert and vigilant. This was in comparison to participants at Bendall Lodge, who were more likely to situate the pandemic as something in the past that they had overcome.

Discussion

The aim of this study was to find out what narratives staff tell about their teams' experiences during the Covid-19 pandemic in two care homes for older people. Particular attention was paid to narratives about support. Twelve staff were interviewed in each home between April and November 2022. Narrative analysis was used to identify main narratives and counter-narratives in each home. This is the first study, to my knowledge, to compare accounts of the pandemic across staff teams. It is also one of the few studies of care home staff's experiences more than two years after the beginning of the pandemic.

Despite interviews taking place two and a half to three years after the start of the pandemic in the UK, many participants described its ongoing emotional impact. Narratives differed across the two homes. In one home staff spoke mainly about supporting each other through the pandemic and emerging a stronger team. This home had a clear unifying narrative across participants. In the other home staff spoke mainly about making sacrifices for residents, divisions in the staff team, and following procedures. This home had less of a clear narrative across participants. A minority of participants in each home also expressed narratives counter to these main narratives.

This study supports research from previous pandemics which has found that health and social care workers can experience long term psychological impacts and changes to their behaviour in the aftermath of a pandemic (Alberque et al., 2022, Sirois & Owens, 2021). Participants in our study described ongoing distress at remembering the pandemic and continuing to restrict activities outside of work out of fear of contagion.

This study adds to large body of evidence that staff experienced longer hours of more intense work and heightened personal risk, which contributed to stress and emotional distress (Gray et al., 2022, Boamah et al., 2022). Participants spoke about a lack of PPE, were unsure whether new admissions from hospital were positive with Covid-19 and were confused about changing government guidelines. These experiences have been highlighted as consequences of how the protection and resourcing of care homes was deprioritised by the UK government in comparison to health services, during the pandemic (Daly, 2020). Participants in this study reported high levels of fear, both for their own health and for that of their dependents, in the face of higher risk work. Narratives in one home encouraged staff to keep working in the face of increased personal risk and prioritise professional duty over personal need (for example, encouraging staff to care for residents with Covid-19 despite staff being worried about their own underlying health vulnerabilities).

Worsening working conditions during the pandemic are particularly concerning given the devalued nature of this workforce. Low wages, job precarity, precarious immigration status, low socio-economic status and the largely non-unionised nature of the workforce make it harder for care home workers to leave jobs or push for better conditions when conditions worsen (McGilston, 2020, Daly, 2021). At the time that the pandemic hit the UK, over a quarter of the residential care home workforce were living in, or were on the brink of, poverty (The Health Foundation, 2022). This again limits staff's power in the job market and ability to freely choose work they are comfortable with.

Narratives that encourage working at increased personal risk are also potentially concerning given that care home workers' often low socio-economic status puts them at increased risk of poor health outcomes if infected with Covid-19, whilst secondary (and often ternary) caring responsibilities meant that falling ill impacted workers' dependents (Gray et al., 2022).

Prior to the pandemic it has been noted that narratives that focus on the moral duty of care workers and the virtuous and selfless nature of the work, can both function to justify the poor material conditions of the work, and form an important part of care workers' self-value and identity in the face of such poor conditions (Kadri, 2018). In this study, narratives of self-sacrifice were both used to encourage staff to keep working at great personal cost and in the context of worsening material conditions, particularly staff shortages. However, they also seemed to form an important part of some staff's sense of identity and pride.

Previous research had demonstrated that narratives about the importance of professional duty could both help nurses to feel resilient during Covid-19, and lead to nurses feeling as if they were personally failing in duty if they could not "keep going no matter what" (Connelly, 2022). One care home in this study had many staff leave during Covid-19, alongside narratives present in the team that those who stayed were the "good staff." This could suggest the importance of offering ongoing support to staff who do choose to leave care home work during challenging times, as it is both possible that they left because of particularly difficult experiences (Cimarolli et al., 2022) and that narratives around duty may create feelings of guilt or shame, which can be a risk factor for PTSD (Laher et al., 2020).

It has been highlighted that care home workers can be afforded little agency over their work and that low control can increase job strain in this context (Hussein, 2019). This study found that some carers felt frustrated and less valued as team members when they were not informed which residents had Covid-19, also found in an earlier study (Titley et al., 2021).

Little is known about why residents' Covid-19 status was not shared with carers in some teams. One possible reason may have been to try to contain staff anxiety, however this study suggests it may have also heightened staff stress. It is also concerning given the raised health risks of this group (Greene et al., 2020) as not knowing who was positive may have hindered this group from protecting themselves from infection.

There was a strong narrative present in one home that staff were responsible for bringing Covid-19 into the care home, intended to encourage staff to take precautions. However, evidence indicates that stressing personal responsibility may also increase staff vulnerability to developing longer term mental health complications, such as PTSD (Laher et al., 2020).

One strength of this study is that participants came from varied ethnicities that were broadly reflective of the London care home workforce (Skills for Care, 2022): most participants were first generation migrants, a minority from British-BME groups and the only White British participants were both home managers. Several participants spoke about experiences specifically linked to being migrants: the difficulty of being far away from friends and family and fear over having to advocate for oneself in the health service in one's second language if one became ill with Covid-19. This highlights the importance of future research into staff wellbeing accommodating staff with low levels of English, as these staff are likely to have specific experiences of work that are less well known. The potential lack of wider support networks that recent migrants can experience highlights the importance of the workplace as a source of support, particularly in the increased strain, risk and uncertainty of the pandemic. Previous research has highlighted the importance of wider social networks for protecting against experiences of precariousness for migrant live-in care workers (Bochove & Kleinsmiede, 2019).

No participants spoke specifically about how their cultural background may have impacted their experiences of support during the pandemic. This may have been because it was not a specific focus of the research, and the focus on collective narratives may have meant interviews were less likely to bring up these individual differences. This study did however demonstrate high variance in staff's preferences for support during and after the pandemic, with some wanting more discussion and some none. Previous research has demonstrated that individual preferences for different kinds of social support are shaped by culture (Hansford & Jobson, 2021), suggesting this this is likely to be a factor in staff variances in this research, although implications regarding specific cultural differences cannot be drawn from this study's findings.

It is notable that this study highlights high reported levels of collaboration and support amongst a very culturally diverse staff team in one home. Previous research has highlighted that cultural differences between staff can be a source of conflict (Smith et al., 2006) and have potentially negative impacts on peer support (Chen et al., 2020) in care home teams. It has also been noted that a deskilling and marginalisation of migrant workers can lead to a lack of cohesion in care home teams (Tingvold & Munkejord, 2021). Interestingly, this current study highlights high levels of collaboration and support amongst a culturally diverse staff team in one home. Further research is needed that explores how cultural differences or similarities between staff may impact networks of support in staff teams.

No participants in this study spoke about how discrimination based on ethnicity may have impacted their experiences of support during the pandemic. This may have been because interviews did not specifically ask about this. Evidence has established that BME healthcare workers were more likely to experience PTSD and certain poor working conditions (such as a lack of PPE and high exposure to Covid-19) during the pandemic in the UK (Thompson, 2023). The majority of participants in this study were from minoritized ethnicities, and their

experiences of trauma, as well as working overtime and lacking PPE should be considered in this context of these known systemic inequalities.

The results of this study replicate previous findings that teamwork was an important way of coping with traumatic experiences during the pandemic for many care home staff (Beattie et al., 2021; Gray et al. 2022; Bunn et al., 2021; Doyle et al., 2023). Staff mainly described supporting each other through practical help with work, practical help when ill, sharing worries and expressing emotions together. Whilst staff in one home referred to support from their colleagues as the most important thing that helped them through the pandemic, staff in the other home said they did not have the resources to offer support to colleagues.

These differences may in part reflect pre-existing differences in team relationships: with a strong pre-existing culture of mutual support in Bendall Lodge and longstanding difficulties and high turnover in Rowan Close. This would align with previous research findings that "positive" or "negative" spirals existed in care home teams during the pandemic, whereby a supportive atmosphere could lower stress and increases staff's ability to further support each other (Connelly, 2022).

Differences between management in the two homes may also have played an important role. Previous research has highlighted how care home managers can influence staff to form positive, interdependent relationships with each other leading to lower turnover which in turn can further strengthen team relationships over time (Backman et al., 2023, Toles & Anderson, 2011, Zhang et al., 2014). Previous research from the pandemic has described how compassionate management can help develop reciprocal trust within teams (Beattie et al., Yau et al., 2021; Zhao et al., 2021). Rowan Close's long history of inconsistent management may have contributed to fewer positive, interdependent relationships reported in the staff team. Staff also reported a period at the beginning of the pandemic where the home

lacked management, and this along with staff shortages may have contributed to a situation in which staff did not have capacity to focus on supporting each other.

This study also suggests different management styles across the two homes. Management in Bendall Lodge modelled reciprocity in the staff team, for example encouraging staff to notice when their colleagues might need extra support due to personal circumstances and attempting to flexibly accommodate staff's personal circumstances (e.g. allowing staff to leave early if a family member was ill). The Bendall Lodge management spoke about the team's experience in relational and emotional terms, whilst Rowan Close's management mainly spoke about the pandemic in procedural and administrative terms. "Relational-leadership", in which listening and empathy from leaders increases the intrinsic motivation of employees, is often contrasted with "task oriented leadership", which focuses on oversight and monitoring of employees' tasks (Anderson et al., 2005). Some have considered relational-leadership more appropriate for the care home context (Anderson et al., 2005), and it has been linked to greater staff satisfaction (Cummings et al., 2010). It is notable however that, although the leadership style appeared more task oriented, staff at Rowan Close did also describe feeling supported by management and valued their presence when they were available.

It is also worth noting that several challenges in the care home context can make relational leadership less possible. High turnover limits managers' ability to form relationships with staff (Zonneveld, 2020). Care home managers also often lack support from HR departments, meaning that their particular skillset (and any gaps in that) can have a large effect on the team (Haunch et al., 2023). Managers also often voice having a lack of training in specific leadership skills (Orellana et al., 2017).

This study found some notable differences in how the two staff teams spoke about the events of the pandemic. In Bendall Lodge, management and other staff spoke about

sharing positive re-appraisals of events with each other once the worst of the crisis was over (e.g. “we are a stronger team now”) and reported that this made them feel better, whereas those in Rowan Close did not talk about sharing positive reappraisals. Post-traumatic growth theory suggests that individuals co-construct new meanings in the wake of traumatic events that can support personal growth (Tedeschi & Calhoun, 2004). Some researchers have applied this to organisations, describing how group level positive reappraisals of traumatic events can facilitate closer group bonds and allow for positive change within the group (Alexander et al., 2021).

The variance in individual staff’s preferences for wanting more discussion of events of the pandemic or not, could reflect individual differences in preferences for verbally processing traumatic events. Some staff also expressed that it was important to “move on” due to the ongoing challenges faced by the home that required attention and meant there was no time for reflecting on the past. This also reflects the context of ongoing challenges for UK care homes since the pandemic, including flu pandemics, a cost-of-living crisis, a crisis in staff recruitment which has been worse than pre-pandemic levels, and the continued impact from financial losses during the pandemic (Skills for Care, 2023, Economic and Social Research Council, 2023).

Strengths and limitations of this study

One strength of this study was that it included a range of staff, including administrative and domiciliary staff, carers, nurses and managers, as well as staff working regular night shifts. It also included staff from a wide range of ethnicities representative of the care home workforce in the UK. Drawing participants from the same two care homes allowed for comparisons between teams. Interview questions were open-ended, allowing for a focus on participants’ experiences.

This study also has limitations. Participants interviewed may not be typical of narratives present in the rest of each team, meaning that firm conclusions cannot be drawn about differences between the two teams. The two homes were visited at different time points after the pandemic, and this could account for differences in how staff presented their narratives. This seems unlikely however, given that participants from the two teams also gave different accounts of their experiences over time. It is also possible that staff experiencing particularly adverse psychological impacts from the pandemic were less likely to take part, meaning this research may have missed out on important voices of those who had had different experiences. Although theory around recovery from traumatic experiences suggests that some narratives found in the homes are more likely than others to support recovery from trauma, this study cannot draw firm conclusions about the actual effects of these narratives on staff stress and wellbeing in this context without further data.

Clinical implications

Some care home staff are experiencing psychological impacts and stress, two and a half years after the start of the pandemic. Previous research has suggested the importance of screening health and social care staff for mental health conditions after the pandemic (Billings et al., 2021). These findings suggest the benefit of ongoing screening and provision of psychological support, years after the beginning of the pandemic.

Many staff spoke about the importance of peer support and team discussion, supporting previous research which suggests that a mix of peer, individual and organisational interventions may be most acceptable and effective for health and social care staff after the pandemic (Billings et al., 2021). A recent systematic review found that evidence was of poor quality and inconclusive regarding the effectiveness of psychosocial interventions immediately after occupational trauma in frontline workers (Billings et al., 2023) and the lack of interventions specifically for care home staff has been highlighted (Schoultz et al., 2022).

The former review did however note that voluntary options to come together and normalise experiences after occupational trauma are valued by staff and there is no evidence that they do harm. Some staff in this study wanted further reflective spaces, whilst others said they did not want to further discuss the pandemic, supporting the idea that reflective spaces should be voluntary.

Some staff in this study said that their team began to reflect on the emotional impact of the pandemic once the "worst was over", that this "post-peak" period could bring difficult emotions of loss, sadness and anger, and that team level positive reappraisals of events were particularly important at this time. Research indicates that people can begin to feel the emotional impact of traumatic events, after initial periods of high stress and practical demand have ended (Andrews, 2007), and has also suggested the importance of supporting health and social care staff during the "early recovery" period after a crisis such as Covid (Billings et al., 2021).

Some staff reported continuing to restrict their activity outside work to prevent infection in their place of work, years after the peak of the pandemic. Restricting life outside work could have a long-term impact on staff's wellbeing. Managers and team leaders may do well to remain aware of this possibility and could offer reassurance to staff that they can protect residents from infection without making large sacrifices in their personal lives.

Some staff in this study said that language was a barrier to them accessing healthcare services in the UK, reflecting wider research that language is one of the main barriers to accessing health services for migrants to the UK (Pandey et al., 2021) and to Europe (Krystallidou et al., 2023). This highlights the importance of any psychological support services for care home staff offering interpreter services.

This study also demonstrated that staff in one home continued to remember and talk about experiences with colleagues for the first-time, years afterwards, in a way that they

found helpful. This again suggests the benefit of allowing staff to discuss memories at their own pace and with their choice of colleagues, and offering voluntary opportunities for wider team reflection. The latter may be particularly important in teams that have had high turnover since the pandemic, as there may be fewer opportunities to remember experiences with colleagues. Staff who left care homes during the peak of the pandemic may also lack these opportunities. Although this is a highly under-researched topic, it is possible that some care home staff resigned because they were particularly psychologically impacted (Cimarolli et al., 2022) suggesting the importance of any psychological support also being offered to staff who left during the pandemic.

Recent quantitative studies have documented the high levels of sub-clinical chronic stress and burnout in nurses in healthcare settings up to two years after the start of the pandemic (Alfonsi et al., 2023; Izdebski et al., 2023; Martin et al., 2023). This study also highlights that some staff continue to feel distressed by experiences of the pandemic at a sub-clinical level, whilst choosing not to speak about their experiences. Managers and team leaders who support staff might do well to bear in mind this possible "hidden burden," how it may impact staff's wellbeing, as well as perhaps increase some staff's vulnerability to stress in future scenarios that could trigger memories of the pandemic; for example, future outbreaks, resident deaths and personal bereavements.

This study provides compelling evidence that pre-existing supportive relationships within care home teams can make staff more able to support each other during times of increased stress. This supports previous qualitative research findings that a sense of family within care home teams can aid individuals' coping in times of stress (Beattie et al. 2020). This suggests that teams that historically struggle with high turnover and have less supportive team relationships, would benefit from being offered additional support during periods of high stress. Previous research has suggested that present and well supported leadership, is

one additional form of support that could be offered (Bunn et al., 2021). Previous research has also suggested that, in the longer term, effective leadership training for care home management and training in communication and conflict resolution skills for care home staff can help improve team relationships and reduce turnover (Haunch, 2023).

This study also reinforces previous findings that individual care homes have multi-layered and varied cultures of staff relationships, support and team work, which affect the experiences of staff (Etherton-Beer et al., 2013; Tyler & Parker, 2011). It supports previous recommendations that any interventions to support staff well-being in care homes should consider the unique features of that home's culture (Venturato et al., 2020).

This study's results also appear to offer an example of effective care home management practice in the aftermath of the pandemic which is also supported by previous research. Managers might do well to acknowledge particularly challenging periods and their passing and congratulate the team on their achievements (Backman, 2023). Naming possible emotions that staff might be feeling during these challenges may also help demonstrate compassion from management, build connection with staff and help staff reflect on their experiences. Modelling a sense of unity and reciprocity in the team during difficult periods may also be helped by finding ways to talk about the team as a whole and shared team achievements (Tyler & Parker, 2011). In pandemic contexts, managers may also do well to encourage staff and resident wellbeing and protection to be seen as equally important (for example one narrative used at Bendall Lodge was "Protect yourselves, and through that you protect the residents") as opposed to narratives that promote staff self-sacrifice. Management demonstrating concern for staff's personal circumstances, flexibly accommodating shift requests where possible, and showing an awareness of the impact that the death of specific residents may have on staff who know them well, may help to model compassion and care in the team (Bunn et al., 2021, Zhao et al., 2021, Havaei et al., 2022).

Directions for future research

It is important that the prevalence of mental illness in care home staff continues to be assessed in the years following the pandemic, particularly with longitudinal research to examine how staff coping impacts mental health in the longer term. Mixed methods studies could examine the association between certain narratives present in the team and staff's psychological outcomes. Development of quantitative measures of cultures of mutual support within care home staff teams would facilitate further explorations of possible associations between supportive staff cultures and wellbeing outcomes. Alongside this, further in-depth ethnographic studies that use observations alongside interviews, could further elucidate the mechanisms that create supportive staff cultures in this setting. This could then be used to inform evidence-based interventions at the team level.

Conclusion

Cultures of how staff support each other within care homes teams may vary greatly, this should be considered when implementing any psychosocial interventions for staff in the care home context. Different teams have different collective narratives regarding the traumatic events of the Covid-19 pandemic, which may have implications for staff recovery.

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Part Three: Critical Appraisal

A Critical Appraisal of the Choice of Methodology of Part Two (Empirical Paper) and Delivery of the Research in the Setting of Care Homes for Older People

Introduction

This critical appraisal will focus on two key areas. Firstly, I will reflect on the strengths, weaknesses, and implications of my choice of methodology for my empirical paper. The National Institute of Health Research has commented on the importance of more research being conducted in care homes for older people, and the unique challenges of this. The second part of this critical appraisal will reflect on conducting research in this setting.

Reflections on the Methods of the Empirical Paper

The Pros and Cons of Choosing Interviews over Observations

My supervisors and I received ethical approval to conduct observations of consenting staff during their working day in addition to conducting group and individual interviews. We thought this could give us more information on how staff interacted and, perhaps, remembered the pandemic together in a more naturalistic setting. However, it was decided before beginning data collection not to use this option. This was because I realised my primary research question (which stories staff told about their experiences of the pandemic, with a particular focus on experiences of support) could be effectively answered using interviews alone. Eliminating observations gave more time for interviews. Another reason was advice given by another researcher with extensive experience conducting studies in this setting, that observations were unlikely to capture any more "naturalistic" staff interactions than group interviews, as staff would still be aware of my presence when being observed.

Whilst it was possible to answer my research question effectively using interviews alone, the research process also made me aware of the value of observations as part of narrative analysis. "Dialogical Narrative Analysis" (Frank, 2012) often uses observations

alongside interviews to consider how narratives affect how people behave, feel and think, as well as how people use narratives to have specific effects on others. Using observations may have allowed this study to come to more conclusions about the functions of different narratives within the teams. I came to some hypotheses based on participant reports in their interviews about the possible function of some narratives (for example how one team used the narrative "we did well" to reassure themselves) however further hypotheses might have been discovered by conducting observations. It could have been useful to observe specific team meetings, as well as reflective meetings that one of the teams had with an external facilitator about their experiences during the pandemic.

The strengths of using Semi-Structured interviews, to discuss recent, potentially traumatic events

Beginning the interviews with a "grand tour" question ("Can you tell me about this team's experiences over the past 2.5 years of the pandemic?") proved to be important in a way that I had not anticipated. The open question allowed staff to start wherever they liked and to focus on what they thought was most relevant.

This proved important given that staff were discussing relatively recent, often traumatic experiences which they had often not previously discussed. Many participants gave accounts that jumped around in a non-linear way and spoke about the emotional impact of having new memories resurface during the interview. This underlined for me the importance of allowing staff to choose which memories they discussed, to begin wherever felt most relevant for them, and not to exert pressure in the interviews to discuss certain parts of the pandemic. More structured interviews would have given less space for this participant-led process.

Strengths and Weaknesses of identifying main and counter narratives

I chose to present my data by describing main collective narratives, an approach based on Caddick et al.'s (2015). I made the key adaptation that I also presented "counter-narratives" present in the data. Caddick et al.'s paper captures collective stories amongst a veteran mental health peer support group who meet voluntarily (Caddick et al., 2015). An organisation with employees is a group of people who come together less voluntarily, making it more important to capture differences of opinion that are likely present. In this way this adaptation proved effective for this study.

One of the benefits of this analysis was that it was a parsimonious way of presenting the data, that also captured the "polyphonic" nature of the organisation, allowing me to represent something of how individuals reproduced "collective" narratives in their interviews. This study used predominantly individual interviews to identify collective narratives demonstrating a way that group level narratives could be researched in this setting without using larger focus groups of staff (often not possible as this would disrupt resident care).

The role of researcher interpretation in the analysis

This choice of analysis did sacrifice the detail of individual accounts, in order to identify broader group level patterns. Other kinds of narrative analysis complete more in-depth analysis of individual accounts, preserving key features of each participant's particular story.

The timings of the research had an influence on how I interpreted the data as I conducted interviews in one home before conducting them in the other. This meant that as I was absorbing and reflecting on emerging findings in the second home I was doing so in comparison to the first. For example, on entering the second home I was immediately struck by the lack of a cohesive narrative about the home's experience of the pandemic and this was due to having just experienced the clear narrative present in the first home. Being in the second home also allowed me to re-consider elements of the narratives in the first home

which I had perhaps not noticed but which became clear in comparison. This ongoing process of comparison which the timing created, could be considered a strength of the research. However, it should also be noted that different elements of narratives in each home might have stood out if they had been compared to different homes.

Reflections on the Participant Feedback Process

Although I did ask for feedback from all participants, only one participant in each home gave feedback. Requesting feedback from participants was difficult as I did not consistently collect participants' contact details during their interviews, an oversight when planning the research. This meant that after the interviews I contacted participants again by attending the home, seeing if they were available and asking then if they would like to give feedback. I also sent a blanket email to all staff in the home via the home manager reminding staff of my email address. Collecting the contact details of those participants who were interested in giving feedback would have enabled me to more proactively reach out to collect feedback on the analysis.

The lack of participants willing to give feedback could also have been an indication of participants being time poor. Whilst the two participants who did give feedback said that they thought my interpretation was an accurate presentation of how the home spoke about Covid-19 the lack of further feedback is a weakness of this research.

Reflections on Conducting research in Care Homes for Older People

Practical Lessons Learned regarding time, space and accessibility

I learned several practical lessons about conducting research in a care home setting. These included how to best deliver research within the routine and physical space of each care home as well as making the research accessible to non-native English speakers.

Staff on the night shift often had more time than staff on the day shift and so this proved a good opportunity for more extended reflective interviews. I was able to attend the

home on the same day each week due to the rest of my course commitments. However, in one of the homes (Bendall Lodge) the majority of staff worked the same days each week meaning that attending on a range of days would have allowed me to approach a greater range of participants.

The physical space that was available in each care home affected the likelihood of staff conducting group interviews. In one home staff took their breaks often together in the same large lounge and this meant that staff frequently elected to do group interviews. In the other home staff often left the home for their breaks as supposed to take them together and this meant that organic opportunities for group interviews arose less frequently.

Language and Accessibility

Quite a few staff's level of English was not sufficient for the interview, however sometimes I was not able to determine this prior to offering them the consent sheet and then realising they could not understand it. This was not a good use of participants' time. A better way would have been to gauge that potential participants' English was at a sufficient level via casual conversation before offering the consent sheet.

During the course of brief conversations with staff whose English was not sufficient for full interviews it was clear that not speaking fluent English during the pandemic was in itself a factor that greatly affected staff experience and also likely related to other significant factors. One staff spoke about the fear of getting ill and not being understood when calling an ambulance. Another staff member discussed how scary it was getting ill when all of one's family were overseas (an experience likely to correlate with more recent migration and lower levels of English). This demonstrates that by not being able to include staff with lower levels of English in this research specific important experiences of the pandemic were missed. Future research could consider additional funding for interpreters, consider paying staff for

longer interviews in order to check understanding, and could also use an "easy read" shorter version of the consent and participant information sheet.

Reflections on Recruitment

Before I began interviewing staff I spent time in each home learning about the unique setting and routines, talking to staff informally about the research and having meetings with the manager. This supported the implementation of the research. Being present in the home allowed me to connect with staff in informal conversations over their work context, current issues and events in the home and this seemed to help staff feel comfortable around me and more comfortable in subsequent interviews.

The manager advised that most staff would not approach me if I was sitting in the home and so advised me to approach staff on their breaks or when the home was not busy and ask if they could spare a few minutes to hear about the study. This was indeed the case and I found that most participants were recruited by me striking up a conversation with them and them perhaps returning when they had more availability. On reflection, this perhaps indicated that I could have spread the word about the study better in the home before conducting interviews – e.g. through posters, more presentations to staff groups.

This method of recruitment was time intensive as I would sit in the home often for many hours, waiting to speak to participants or catching participants on a break. This flexibility was essential as events in the home are unpredictable and participants' availability changed regularly. However, one possible way around this would have been to apply for more funding, to be able to reimburse participants sufficiently for their time after or before shifts. As I had limited funding for this project, I opted for a prize draw as supposed to directly reimbursing each participant for their time. However, more consistent reimbursement might have helped to secure participation quicker, and also would have made it acceptable to conduct interviews at the beginning and end of staff's shifts, when they were free from duties

and could devote more consistent time to the interview. Reimbursing participants in this way and using time outside of direct care responsibilities is considered acceptable in guidelines on research in care homes (National Institute of Health Research, 2014).

Lack of Resident Voices: Half the Story?

This research focused on the experiences of care home staff and did not include the views of residents. In some senses this focus was important. The wellbeing of care home staff is often spoken about in research as instrumental to achieving high quality resident care, rather than valid as a goal in itself, and researchers have pointed out that this devalues staff's personhood (Kadri et al., 2018). However, it is still the case that stories about the home's experiences of the pandemic do not just exist amongst staff, but amongst both staff and residents. In this sense this research may have only captured "half the story." Other research has effectively combined staff and resident views, at times highlighting interesting differences between the two (de Medeiros et al., 2012).

Power and Positionality: Clinical Psychology in the Care Home Setting

It is considered an important part of qualitative research to consider which power structures shape researcher / participant interactions (Foley, 2002). This research caused me to reflect on the intersecting power structures of migration status (e.g. As a non / UK national), professional status (e.g. NHS vs. social care employee) and economic power, and how these affected my interactions with care home staff.

The devaluing of work in the social care sector in comparison to healthcare is often linked by researchers to the fact that migrant women (many of whom are qualified healthcare professionals who's qualifications are not accepted in the UK) are over-represented in the low paying jobs in the workforce (Hussein, 2018). In this way professional, migration and economic status are intertwined – meaning that whilst many carers are first generation immigrant, NHS employed GPs and Psychologists are predominantly UK born nationals. I

am a UK born national, and am often assumed to be because of my accent. I also wore my NHS badge when present in the care homes. It was my perception that staff in the home, on first meeting, would often behave towards me as if I was a visiting senior professional whom it was part of their job to assist. I tried to mitigate this to some extent, by making it clear to staff that taking part in the research was voluntary.

Care work has been characterised by some researchers as a job in which high demands, and responsibility over resident's wellbeing are often married with limited autonomy (Conolly et al., 2022). I was aware of how moments of this "limited autonomy" that staff can experienced, might have interacted with the research. For example, in one home on one occasion the manager addressed a room full of staff and told them to go and speak to me in order to help me with my research. This meant that many staff came to hear about the research, although when I made it clear that participation was voluntary, most of them left. This made me aware of how important it is to try and gain meaningful consent from staff, in an environment that is often hierarchical.

It has also been noted that, alongside limited autonomy, care home staff can experience high levels of external scrutiny and monitoring. On one occasion when I was present in one of the homes, a professional from the home's parent company joined the end of a staff meeting and conducted a spot check of staff's expertise on a particular topic by asking staff questions at random, a process which seemed to make staff nervous. This atmosphere of scrutiny, might also have been exacerbated by the Covid-19 pandemic. Previous research has captured that many staff experienced the "bad press" that care homes received over the course of the pandemic, as bringing an increase in criticism and scrutiny without increasing practical support (Boamah et al., 2022). Care homes were also compared to each other, for example in published statistics of how many residents had died (Office for National Statistics, 2021).

I wondered how this atmosphere, might have affected how staff experienced the research process. During some interviews I wondered if staff approached the interview as a "test" of their expertise (for example regarding infection prevention control), or as a test of how well the home had done on certain factors during the pandemic. On reflection, the finished results of this study do point in some ways to one home having performed "better" at something than the other (in this case having a more positive seeming culture of staff support).

Feedback of Research Findings to the Care homes: A Sensitive Process

Each care home was offered a presentation of the results from their home. At the time of writing results have been presented to Rowan Close, and have yet to be presented to Bendall Lodge. A 10minute PowerPoint presentation was given in Rowan Closes' team meeting, attended by about 20% of the team, and a one-page summary of results was also circulated to all staff. I was also present in the home for an hour the following week, and staff were told they could approach me if they wanted to discuss anything from the presentation.

The main consideration was to present results accurately whilst taking into account the sensitivity of the subject matter. Many care home staff in the UK reported finding press coverage of care homes during the pandemic critical and stigmatising (Gray et al., 2022), and the possibility of moral injury in this staff group has been well documented (Laher, 2022). The presentation therefore aimed to reflect and validate staff experiences, celebrate their achievements and prompt team reflection, without a sense of blame or criticism.

One way of doing this was to use open questions instead of definite statements: for example, rather than provide a critique of how narratives of self-sacrifice could have been detrimental to staff wellbeing, the presentation asked the question: "What effects do staff think these narratives may have had on the team?" To protect staff anonymity, summaries of main narratives were presented along with anonymised quotes, rather than summaries of

individual interviews. Care was also taken to highlight to staff that these experiences were not necessarily representative of the whole staff group.

Care was taken to use easy read English to include staff with low levels of English comprehension, and given the brief time allowed to the presentation, the main narratives and counter narratives were distilled. Focus was given to participant quotes, rather than researcher analysis, again to give staff time to reflect on their and their colleague's experiences more directly. Staff gave brief general feedback that the presentation had been "moving" and had "sparked conversation" in the staff team about that time. No staff attended the optional session to discuss findings. This may have been due to a lack of interest, and also difficulty staff have taking time off work during shifts. I plan to present the results to Bendall Lodge in a similar fashion.

Conclusion

Research should be carefully planned to adapt to the care home setting, taking care to include staff with lower levels of English, possibly residents and ensuring ample opportunities for staff feedback. Reflection on power dynamics between researcher and participants and how these can be held in awareness and if possible mitigated, is vital for this setting.

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Appendix A

Ethical Approval

UCL RESEARCH ETHICS COMMITTEE OFFICE FOR THE VICE PROVOST RESEARCH

30th May 2021

Dr Jo Billings
Research Department of Clinical, Educational and Health Psychology UCL

Cc: Rosie Skan

Dear Dr Billings

Notification of Ethics Approval with Provisos
Project ID/Title: 22277/001: Organisational trauma, resilience and recovery: exploring the current experience of London care home teams following the COVID-19 Pandemic in the UK.

I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the UCL REC until **1st June 2023.**

Approval is subject to the following conditions:

Notification of Amendments to the Research

You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form' https://www.ucl.ac.uk/research- ethics/responsibilities-after-approval

Adverse Event Reporting – Serious and Non-Serious

It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report

At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

In addition, please:

- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research;
- note that you are required to adhere to all research data/records management and storage

  procedures agreed as part of your application. This will be expected even after completion of the study.

  With best wishes for the research. Yours sincerely

  Professor Michael Heinrich
  Joint Chair, UCL Research Ethics Committee

Appendix B

Research Advert Circulated to Care Home Managers

Dear X,

My name is Rosie Skan and I am a researcher at University College London. I'm contacting you to tell you about some research me and my supervisors Marina and Jo, are conducting in London Care Homes.

Our research looks at the current experiences of care home staff. We know the pandemic has put extraordinary demands on care home teams and that staff's experience of this may vary widely. We want to find out more about how different teams and individuals have coped with potentially difficult experiences, in order to understand more about how to support teams in the future.

If you are interested – we would like to start with a conversation about how the research could fit flexibly around the particular needs of your home. At the end of the research process – we would also like to feedback our findings to your staff team, to see what they think of them. We hope this process could give staff a chance to see their stories reflected back at them, as well as to reflect on their experiences as a team.

If you would be interested to find out more, then please do get in touch.

Best,

Rosie Skan

WhatsApp Message template to contact Care Home Staff.

Hello staff at (Insert name of care home).

My name is Rosie, I'm a researcher in Psychology. My colleagues Dr Marina Palomo and Dr Jo Billings and I, are currently researching experiences of London care home staff –

and we'd like to see if some of you at (insert name of care home) would be interested in taking part.

We know the pandemic continues to put extraordinary demands on care home staff and that staff's experience of this varies widely. We want to find out more about different staff teams' experiences since the start of the pandemic, with a focus on current experiences of work, in order to better understand how teams work together during exceptional circumstances, and how to better support teams in the future.

We would like to interview anyone, either individuals or as a group, who would be interested in telling their story. If you would like to find out more about this research and how to take part, please get in touch with Rosie on (EMAIL).

Thank you for your time and we look forward to hearing from you!

Rosie, Jo and Marina.

Appendix C

Participant Information Sheet

Participant Information Sheet For Staff at X (Insert Name of Care Home)

UCL Research Ethics Committee Approval ID Number: _____

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Organisational trauma, resilience and recovery: Exploring the experiences of care home staff following the COVID-19 pandemic in the UK.

Division of Psychology and Language Science UCL

Researcher(s): Rosie Skan (EMAIL)

Principal Researcher: Jo Billings

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

1. **What is the project about?**

We know that the COVID-19 pandemic has put extraordinary demands on staff teams in care homes for older people. Staff's experiences of this may vary widely.

We know that team relationships are important when organisations go through challenging or potentially traumatic experiences – and we are interested in how different people have coped during this time. That is why we want to find out more about your current experience of working as part of this care home team.

Why have I been chosen?

We would like to speak to any staff who work at (Insert name of care home), no matter how long you have worked there.

2. **Do I have to take part?**

No, you do not have to take part. If you decide to take part you can keep this information sheet and will be asked to sign a consent form. If you do want to stop being part of the research, we will ask you what you would like us to do with your personal data that we have (name, age, gender etc.) You have a month after your interview to decide if you would like us not to include your anonymised interview transcript in our final report.

3. What will happen to me if I take part?

If you would like to take part, then we will contact you to organise a time to interview you. This can either take place in the care home where you work face to face, or via video call – depending on covid regulations and your preferences. The length of your interview will also be flexible depending on how much time you would like to spend – e.g. it's fine if you only have 10 minutes, or a whole hour.

You can also choose to have the interview together with one or more of your colleagues if you would like – again we can arrange for this to happen in the care home where you work, or by video call.

You can also choose to be observed during your work at the care home. This would mean that the researcher would accompany you for part of your working day that you felt comfortable with them observing. The researcher would be observing you in order to understand more about your experience of your working day.

You can choose to take part in all, or none, of these three parts of the study: group interviews, individual interviews and observations.

At the beginning of the interview or observation we will ask you to sign a consent form to take part in the research. We will also ask you for your age, gender, ethnicity how long you've been working at this particular home and what your role at the home is. We hope the interview will feel more like a relaxed conversation, where we will ask you some broad questions to hear about your experience of working at the home. We may ask you in general whether there have been any particularly difficult experiences during the covid pandemic, and what it was like for you after these experiences. It is your choice what you speak to us about.

Once we have collected everyone's interviews and observations, we will look at the data and pick out certain important themes that come up regularly across different peoples' answers. We will then present some of these themes back to your staff group – in order to hear your thoughts on what we have found.

4. Will I be recorded and how will the recorded media be used?

Where possible, we will record the interviews (audio only) so that we can remember exactly what was said. Any recordings will be stored securely, no one outside the project will be allowed to access the recordings, and they will be deleted as soon as they have been converted to written text. This written text will take out anything that specifically identifies you, and then it will also be stored securely. With observations, the researcher will take brief notes whilst observing you. These will not contain any personal details – and will be typed up and kept securely.

5. What are the possible disadvantages and risks of taking part?

We will ask some questions about areas of general difficulty at work. Some of the experiences that participants choose to talk about may of course be distressing. We will go at your pace, and you can stop an interview whenever you like.

Support after interviews can be offered by the NCL Wellbeing Hub. You can also ask the researcher if you would support accessing this.

https://keepingwellncl.nhs.uk/

6. What are the possible benefits of taking part?

Some people who participate in similar studies say that interviews can provide a useful and reflective space to think more about their past experiences, both individually and as a staff team. At the end of the project, a summary of the research findings that anonymises all individual participant contributions, will also be made available to the care home team. It is possible that this may prompt useful discussion and reflection in the staff team, and perhaps serve as a record of staffs' experiences during the time of data collection.

It is our belief as a research team that the voices of care home staff are not heard enough in the creation of policy and funding decisions, and this research (which we hope to publish) will make a small but important contribution to spreading awareness of the needs and experiences of care home staff.

7. What if something goes wrong?

If as a participant you have any complaints about your experience in the study – you may make a formal complaint to:

Jo Billings (Principle Researcher).
UCL Division of Psychology and Language Sciences.
26 Bedford Way, London WC1H 0AP.

If you feel that your complaint to the above address has not been handled satisfactorily, please contact the Chair of the UCL Research Ethics Committee - ethics@ucl.ac.uk

8. Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified in any publications. You will not be able to be identified in the research summary that is fed back to the team at the end of the research – this will discuss broad themes. No other members of staff or management in your care home will have access to any of the data recorded during your interviews, this will only be accessible to members of the research team. If you would like to be interviewed at the same time as your colleagues, then the researcher cannot guarantee that other staff taking part in the interview will not share information outside the interview.

All interview transcriptions will be stored securely in password protected computer files and all identifying information removed, and your signed consent form (with your name on it) will be kept separately.

We will be using an automated transcription service to transcribe data that is external to UCL. However this data remains the property of the research team and will keep the same level of protection and confidentiality.

9. Limits to confidentiality

If information emerges that makes the interviewer concerned for the participant's or someone else's safety, then information may have to be disclosed to a third party – in compliance with standard safeguarding procedures already in place in all social care settings.

10. What will happen to the results of the research project?

The data collected during research will be summarised into themes (a research method called "thematic analysis") which will be included in the researcher's Doctoral thesis, as well as written up and submitted to be published in a scientific journal, that the public can access. Some anonymised quotes from participants will be used to point out particular themes.

One the final thesis and report have been completed, the anonymised interview data and observation notes will be kept securely by the research team for 10 years. It will only be made available for other research projects supervised by the Principle Researcher (Jo Billings).

11. Local Data Protection Privacy Notice

Notice:

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice:

For participants in research studies, click here

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The categories of personal data used will be as follows:
Name (full name only present on consent form / consent recording).
Email addresses / contact numbers (used to contact participants).
Gender.
Age.
Ethnicity.
Current Role in this care home.

Length of time employed by this care home.

The lawful basis that would be used to process your *personal data* will be performance of a task in the public interest.

This only special category data that will be collected by this study will be participants' ethnicity.

The legal basis used to process *special category personal data* will be for scientific and historical research or statistical purposes.

Any personal data (e.g. the phone number or email address of participants) will be held until all interviews and feeding back of research data has been completed. Anonymised interview transcripts will be securely kept by the research team for 10 years, and used only in projects supervised by the principle investigator. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

16. Contact for further information

For any further information please contact Rosie Skan

Thank you for reading this information sheet and for your interest in this study. You will be given a copy of this information sheet and a consent form, if you choose to be part of the study.

Data Protection Privacy Notice

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice:

For participants in research studies, please see https://www.ucl.ac.uk/legal-services/privacy/ucl-general-research-participant-privacy-notice.

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The lawful basis that will be used to process your personal data is: 'Public task' for personal data.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Appendix D

Participant Consent form

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study: Organisational trauma, resilience and recovery: Exploring the experience of work for London care home teams following the COVID-19 pandemic in the UK.

Department: UCL Department of Psychology and Language.
Rosie Skan
Principle researcher: Jo Billings
UCL data protection officer: Alexandra Potts data-protection@ucl.ac.uk

This study has been approved by the UCL Research Ethics Committee:
Project ID number: (Insert once approved).

Thank you for your interest in our research. The person organising the research must explain the project to you before you agree to take part. Please ask us any questions you have before you decide. You will be given a copy of this Consent Form to keep.

I confirm that I understand that by ticking each box below I am consenting to this element of the study. I understand that, if I leave a box unticked, it means that I DO NOT consent to that part of the study, and this means I will not take part in the study.

		Tick Box
1.	*I confirm that I have read and understood the Information Sheet for the above study. I have had enough time to think about this. I understand the study. Any questions I had have been answered properly.	
	I would like to take part in (Please tick one or more of the following): - A group discussion. - An individual interview.	

	- An observation.	
2.	*I understand that, if I change my mind after the interview or observation, and do not want to take part in the research – then my data will not be used. I can decide this up to one month after I give my interview. After this time, the researcher may still include my interview in the final research.	
3.	*I choose to take part in this study. I understand that information about me *(my gender, my age, my ethnicity, my current role in the care home, the length of time I have been working at the care home)* will be used but my name will not be used in the final research. I understand that according to data protection legislation, 'public task' will be the lawful basis for processing, and 'research purposes' will be the lawful basis for processing special category data.	
4.	I understand that all my personal information will remain confidential – meaning, only members of the research team will see it. If I choose to take part in a group interview, then I understand that the researcher will ask all interviewees present not to share information outside of the interview. However, I understand that the research cannot guarantee this. This will only change if the research team are worried about someone's safety. I understand that my data collected in this study will be stored anonymously and securely. When the research paper is written, you will not be able to identify me in the paper. The name of the care home will not be included in the paper. I understand that in the final research, the researcher may use some quotes from my interview – but will keep me anonymous.	
5.	*I understand that my information could also be looked at by people at University College London, for audit and monitoring purposes (i.e.. for them to check that the research is being done properly, and keep track of all the research done at the university).	
6.	*I understand that I can stop an interview at any time, and do not have to give a reason why. I understand that in the	

	month after my interview or observation, I can choose to withdraw my data, at which point all my personal data will be deleted. If I choose to leave the study after this time, then all my personal data will be deleted but my anonymised transcript will be kept and included in the final study.	
7.	I understand the any risks of being in the study. I know the support that is there, if I become upset during the study.	
8.	I understand what benefits might come from being in the study.	
9.	I understand that my information will not be given to any commercial organisations, and that only the study researchers are responsible for my information.	
10.	I understand that I if take part in the study, I will be entered into a prize draw to win a £20 gift voucher. There will be 5, £20 gift vouchers available.	
11.	I understand that the data I give, during an interview or observation, will be used to write a report, which will be published. I would like to have a copy of this report. Yes / No.	
12.	I allow my interview to be audio recorded. I understand that the recording will be deleted as soon as it has been transcribed (typed out as a written text). If you do not want your interview to be audio recorded, you can still be in the study.	
13.	I understand that to be in the study I have to be: Be a member of staff in a care home [Insert name of particular care home] Over the age of 18.	
14.	I understand that if I want to make a complaint, I can contact:	

	(Jo Billings). OR ethics@ucl.ac.uk	
15.	I voluntarily agree to take part in this study.	
16.	I understand that the personal data I have provided will be used to describe the group of people taking part in the research, and to contact me to organise taking part. I understand that all this personal data will be deleted after the finished report is written (June 2023). I understand that the anonymised data I give (anonymised written interviews or observation notes) to be kept for a maximum of 10 years and used in future research that is directly supervised by the Principal Researchers (Jo Billings or Marina Palomo).	

If you would like your contact details to be kept so that you can be contacted in the future by UCL researchers. They would contact you to ask you if you would like to be in similar studies.

Please choose by ticking:

	Yes, I would be happy to be contacted in this way	
	No, I would not like to be contacted	

_____ _____ _____

Name of participant Date Signature

Data Protection Privacy Notice

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice:

For participants in research studies, please see https://www.ucl.ac.uk/legal-services/privacy/ucl-general-research-participant-privacy-notice.

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The lawful basis that will be used to process your personal data is: 'Public task' for personal data.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Appendix E

Interview Schedule

Introduction:

- Introduce self and outline the project.
- Provide with participant information sheet and consent form.
- Complete consent form, including checking consent to audio record interview or not.
- Ask time participant has available for interview.
- Gather demographic data: Gender, Age, Ethnicity, role in the home, length of time working in the home.

Making the participant comfortable:

- Engage in a natural flow of conversation if the participant brings it – e.g. If the participant starts talking about an aspect of the home / their day today, then demonstrate interest and ask any further questions. This is to demonstrate to participants' that all of their experiences are valid for the research.

Broad first question:

- *Can you tell me what the team has been through in this care home, over the past 2.5 years? You can start wherever you like, and don't worry if there are things you can't remember – I'm just interested in your experience, there is no correct answer.* (This question was changed after feedback from initial participants. The original question was: Can you tell me about your experiences working in this home over the past 2.5 years?)

Probes to help participants continue / deepen their narratives:

- *And what was that like for you?*

- *What effect do you think that had on the team?*
- *What was that like for the team?*
- *Do any specific examples / particular moments come to mind?*
- *Could you say more about that?*

Change:

If you think of the team at the beginning of the pandemic / (or when you arrived) and the team now, does anything come to mind? Could you speak about that?

Support:

When things were difficult during that time, was there anyone you went to for support?

When things were hard at work during that time, what did you do?

During that time, you and your colleagues, what did you talk about at work?

How did you speak about Covid together, during that time? Do you remember any particular conversations?

As a staff team, do you talk about that time, now? And how do you talk about it?

Introducing narratives described in previous interviews:

For example: "some people describe this team as a family, what about you – would you use that word, how would you describe it?"

Ending of the interview:

Is there anything else you think it would be important for me to know about this team / your experiences?

Appendix F

Section of coded transcript with links to reflective notes

Transcript	Codes (Possible collective narratives highlighted in colours)	Reflective notes
P9: There was a time like – like I was saying – it's a time that sometimes you don't want to remember because now, there are certain residents who they might refuse medication, but normally if they see their family they would be compliant, and it's - family is a very important aspect of a human being. Regardless where you are. So it was traumatic in that time. In dealing with patients and trying to explain	Not wanting to remember the pandemic Equality with residents Surviving the trauma together	*I notice that it takes the participants a while to speak about Covid in the interview, perhaps this links to them not wanting to remember?* *I have the feeling she is moving on before she gets into more difficult*

to them, when they don't understand it. But um – we pulled through it. We're on the other end now. *Do you ever talk about it together? Obviously we're talking about it now – but as a staff team, how do you speak about it now?* P7: I don't think we talk about it enough. Yeah – I don't think so. It's not like before. P8: We kept talking about – oh so and so might have it - but no we don't discuss it anymore. P9: It was a difficult time, in the sense that even if you sneeze you would get a stare. (everyone starts laughing).	We don't talk about the pandemic enough	*memories – situating them in the past by saying "we pulled through"*

Even at work? P9: Everywhere! On the train, like you have got leprosy or something (laughs) oh god. - oh dear. I hope it won't come back again, because it wasn't a good thing at all. *Do you think it's changed the way you work together at all?* P7: I think it bring us closer. Like. I don't think it changed anything else. P8: No, nothing changed. P9: People have gone back to their old ways, more relaxed, and – the team is um – more – what can I say.	Using humour together (Reflective notes: The pandemic brought us closer, we looked after each other like a family Real sense here that the team was very close, before the pandemic	*Lots of lightness, friendly physical contact between participants in this interview* *Moving from joking – to how difficult it was, back and forth all the time.* *It's so common in this home for staff to talk about being like family*

P8: I have told her that we are like family here. P9: Yes. P7: I think more yes. We look out for each other.	Keeping each other safe	*Agreement, atonement between participants*