The experience of care home staff during COVID-19:

A narrative analysis

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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.

Signature: 

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Overview

This thesis captures and synthesizes the experiences of care home staff during the COVID-19 pandemic.

Part one is a thematic synthesis of qualitative literature on care home staff coping and resilience during the COVID-19 pandemic. Three major themes encompassing care home staff coping and resilience were identified: psychological, social, and practical. The results of this review are discussed in terms of existing literature on coping and resilience. Implications of the review include how to best support care home staff in the future.

Part two is a qualitative study that uses narrative analysis to capture and explore the stories told by care home staff about the entire COVID-19 pandemic. Interviews were conducted with six care home staff and individual narrative summaries were created for each participant. A cross-case analysis identified two shared narratives across participants. Firstly, participants found COVID regulations to be either helpful or harmful within the care home. Secondly, throughout their narratives, participants compared social care against the NHS. The results of this study are discussed with reference to moral injury, as well as prior findings on coping and resilience. Implications of the results are considered in terms of improving care home staff wellbeing, policy making and the crisis around recruiting and retaining care home staff.

Part three is a critical appraisal that reflects on the selection of the project, the process of conducting the research and the findings. The interviews and analysis process are considered in terms of narrative ideas. The findings are examined in context of the wider literature on post-traumatic stress disorder.

Impact Statement

The COVID-19 pandemic had a detrimental impact on care homes. As a result, the wellbeing of care home staff has been significantly affected. This is reflected in the current staffing crisis that care homes face in the United Kingdom (UK). Despite this ongoing issue, there is less literature on the experience of care home staff during COVID-19 pandemic compared to the volume of research conducted with healthcare staff. Therefore, the research in this thesis adds to a gap in the literature on care home staff experiences. This thesis has implications for understanding the experience of care home staff during the COVID-19 pandemic, which can be used to help care home staff recover from their experiences. Both the review and empirical paper are intended for publication to disseminate the findings.

The thematic synthesis provides an overview of how care home staff coped and built resilience during the pandemic. The synthesis integrates and amplifies the findings on coping and resilience that individual studies identified, therefore the findings of this review can be used to support care home staff to cope and remain resilient in the future. The results highlighted the importance of occupational identity as a source of resilience. Positive relationships between care home staff and their managers and leaders were also essential for staff to cope with the pandemic. If managers understand how care home staff have coped and built resilience, this knowledge can be used to guide managers in supporting their staff. Additionally, clear guidance and training were found in this review to facilitate staff coping, which organizations and policy makers can implement to support staff in the future. As this is a synthesis of multiple global studies on care home staff, the findings could be generalized to international care home staff. However, caution should be taken when

generalizing the results of this review, as each country has a varied health and social care context.

The empirical paper captured and examined the narratives of six care home staff working in the UK during the pandemic and explored cross-case narratives between participants. The cross-case analysis identified that participants were divergent in terms of whether they found COVID-19 regulation to be helpful or harmful to care homes. Policy makers and regulatory organizations could use the results of this study to understand how care home staff responded to COVID-19 policy. The results also highlighted that care home staff felt undervalued and forgotten in comparison to their National Health Service (NHS) colleagues, highlighting the effect of the disparity on care home staff. Some narrative themes discussed by participants suggest that care home staff may have been affected by moral injury and this warrants investigation in future research to ascertain the prevalence and impact of moral injury amongst care home staff. The narratives documented in this study can be read by other care home staff to support them in feeling less alone in their experiences of the pandemic, particularly if they are experiencing moral injury. At a national and public level, this research highlights the important contribution care home staff made, and the impact that their sacrifice has on their continued wellbeing. Recognizing and valuing the contribution of care home staff at a national level could be beneficial in terms of staff recruitment and retention, which would ensure the quality of care that residents receive.

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Part 1: Literature Review

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Part 1: Literature Review

Care home staff experience of coping and resilience during COVID-19: A thematic synthesis

Abstract

Background

During the COVID-19 pandemic, care home staff worked through unprecedented conditions, experiencing poorer mental health and moral injury. Emerging qualitative research has explored how care home staff coped and built resilience during the pandemic, but this has not yet been synthesized.

Aim

To synthesize the qualitative research on care home staff experiences of coping and resilience during the COVID-19 pandemic.

Method

MEDLINE, PsycINFO, Web of Science, CINHAL, Embase, Emcare and PTSDPubs were searched. The reference lists of final papers were also searched to identify any other relevant studies. A thematic synthesis was conducted.

Results

Twelve studies were included in the final thematic synthesis (N=314). The themes summarised how care home staff coped and built resilience during the pandemic. The themes identified were: (1) psychological (occupational identity; personality; cognitive strategies) (2) social (personal relationships; work relationships) and (3) practical (practical strategies at work; practical strategies at home).

Conclusions

The results of this review found that care home staff coped and built resilience via psychological, social, and practical methods. Understanding these strategies could improve care home staff wellbeing in the future.

Introduction

The COVID-19 pandemic has had an unprecedented impact on care homes across the world. Care homes experienced high numbers of resident deaths (Comas-Herrera et al., 2022). During the first wave (until June 2020), 40-80% of all COVID deaths were linked to long-term care facilities (WHO, 2020). Staff were at risk by continuing to work: 115,500 health and care workers are estimated to have died from COVID-19 globally between January 2020 to May 2021 (WHO, 2021). Care homes were often short-staffed because of COVID-19 infections and staff had to make difficult moral decisions about isolating residents from their loved ones (Gordon et al., 2020; Xu et al., 2020).

Working during the pandemic has affected the psychological wellbeing of care home staff. Laher et al. (2022) found that care home staff had a high prevalence of moral injury. Moral injury is defined as witnessing or involvement with traumatic events that contravene an individual's values or ethics (Griffin et al., 2019). Experiencing occupational moral injury has been associated with post-traumatic stress disorder (PTSD) and depression (Williamson et al., 2018). A systematic review by Gray et al. (2021) found that care home staff experienced symptoms of PTSD, anxiety, and depression.

However, experiencing traumatic and stressful events such as the COVID-19 pandemic does not always result in the development of mental health difficulties. An explanation for this could be variations in staff resilience and coping. Both resilience and coping have been associated with positive mental health outcomes and lower psychological distress in healthcare staff who worked during the pandemic (Jeamjitvibool et al., 2022; Labrague, 2021). Additionally, some healthcare staff

have reported improved mental health as a result of working during the pandemic, such as experiencing post-traumatic growth (Finstad et al., 2021). Therefore, it is important to understand how resilience and coping can protect staff against the negative effects of the pandemic, and even result in positive outcomes such as post-traumatic growth.

Resilience, Coping and Post-traumatic Growth

Resilience is a broad term used in a range of research disciplines including psychology, ecology, and economics. As a result, resilience can encompass many different processes (Ungar, 2018). In psychology, resilience has multiple definitions (Sisto et al., 2019). A widely cited paper condenses the definition of resilience to "adversity and positive adaptation" (Fletcher & Sarkar, 2013). Definitions of "adversity" and "positive adaptation" also vary. Adversity could range from everyday stressors to major life events. A definition of what constitutes "positive adaptation" varies depending on the type of adversity experienced. For example, after a traumatic event, an absence of mental health difficulties may be classified as resilient, whereas exceptional functioning such as above-average academic achievement may be classified as resilient in the context of daily stressors. Fletcher and Sarkar (2013) highlighted that psychological research has historically examined resilience as either a trait or a process. When resilience is defined as a trait, it is a set of resources that an individual can draw on, including their own personality and characteristics as well as external support (Windle, 2011). When resilience is defined as a process, it is seen as dynamic and interactive between the individual and the environment, occurring over time (Rutter, 2012).

Resilience is also a controversial topic in the literature in terms of whether it is a helpful concept. When resilience is defined as a trait, it can be seen as something that you either possess or not, which can lead to blame being placed on the individual (Luthar & Cicchetti, 2000; Mohaupt, 2009). This is true particularly in challenging contexts such as economic hardship (Hickman, 2017) or refugees who experience continued violence (Pulvirenti & Mason, 2011). Additionally, there is debate about whether resilience is a positive concept, as it can allow individuals to remain in situations of elevated stress for a long period of time. For example, resilient individuals may refrain from leaving an abusive partner (Sinclair et al., 2020). Therefore, conceptualising resilience as a trait is controversial and potentially harmful.

Defining resilience as a trait is narrowly focused on the individual. An individualistic approach to resiliency ignores that wider system change influences resiliency. For example, a longitudinal study by Liew et al. (2018) found that children's peer relationships mediated the effect of resiliency on reading ability. This suggests resiliency can be influenced by social systems. Ungar's (2018) theory of systemic resilience conceptualizes that patterns of resilience can be identified across multiple systems, including biological, social, cultural, and ecological systems. Similar to Fletcher and Sarkar's (2013) definition, Ungar (2018) outlines that resilience occurs in the context of adversity. Additionally, in line with Rutter's (2012) definition, Ungar (2018) outlines that systemic resilience is a process, which includes persistence, resistance, recovery, adaptation, and transformation. Therefore, current research conceptualises resilience as a process rather than a trait.

Coping strategies are defined as behavioural and cognitive efforts to manage both internal and external demands (Lazarus & Folkman, 1984). Although closely

aligned, there is a conceptual difference between coping and resilience. Rutter (2007) suggested that coping strategies mediate the link between an individual facing a challenge and ultimately building resilience. Fletcher and Sarkar (2013) theorized that resilience influences the appraisal of adversity, whereas coping refers to the strategies that are employed following the appraisal of the event. This is similar to Lazarus and Folkman's (1984) transactional theory of stress and coping. In this theory, an individual's appraisal of a situation affects the level of stress they experience. If a situation is deemed as stressful, an individual could interpret this as either a threat (a potential for harm) or a challenge (a potential for growth). This interpretation is dependent on an individual's perceived ability to cope with the stressor. Their perception of their ability to cope influences whether they choose an emotion-focused coping strategy or a problem-focused coping strategy (Carver et al., 1989). Emotion-focused coping strategies are aimed at soothing distress, whereas problem-focused strategies focused on actively working to change the stressor (Carver et al., 1989; Lazarus, 2006).

As discussed, coping strategies and resilience can result in the reduction or absence of psychological distress. However, post-traumatic growth is defined as positive psychological change that occurs after experiencing trauma or adversity (Tedeschi & Calhoun, 2004). By nature, traumatic events are disturbing and distressing and can result in poor psychological outcomes, but individuals can also experience growth alongside their distress. Post-traumatic growth can take the form of renewed appreciation for life and purpose, enhanced interpersonal relationships and connection with others, a sense of personal strength and a feeling of value (Habib et al., 2018). Tedeschi and Calhoun (2004) outline that post-traumatic growth is distinct from other concepts of growth that occur in environments of continual

low-level stress, such as the process of resilience. Additionally, they caveat that post-traumatic growth is not a coping mechanism, but an outcome that occurs from experiencing trauma.

Although the three concepts of coping, resilience and post-traumatic growth are similar, there are distinct differences. Resilience is a dynamic process of adapting in the presence of a stressful or traumatic event, whereas post-traumatic growth is conceptualized as enhanced functioning that exceeds pre-trauma levels (Tedeschi & Calhoun, 2004). Finally, coping strategies are the methods used to manage a stressor and are predictive of post-traumatic growth (Armstrong et al., 2014; Kirby et al., 2011; Prati & Prati, 2009).

Resilience, Coping and Post-traumatic Growth during the COVID-19 Pandemic

Much research on coping, resilience and post-traumatic growth has been conducted with healthcare staff during the COVID-19 pandemic. A systematic review of 31 studies on healthcare staff resilience and coping during the pandemic showed that staff used both emotion-focused and problem-focused coping strategies, and that resilience and coping were associated with positive mental health and psychological outcomes (Labrague, 2021). However, this review only included studies that were conducted before October 2020, which is relatively early in the pandemic. Healthcare staff have endured the fluctuating threat of COVID-19 for more than three years to date, therefore the results may lack historical validity. Fourteen of the 31 studies (45%) were conducted in China, again limiting the applicability of the results to staff in other countries. A later meta-analysis of healthcare staff during the COVID-19 pandemic by Jeamjitvibool et al. (2022) found higher resilience was correlated with lower psychological distress. Again, 54% of the

studies included in the review were conducted in China. Finally, a review by O'Donovan and Burke (2022) found that amongst other factors, resilience and coping strategies were associated with post-traumatic growth in healthcare staff. However, O'Donovan and Burke (2022) included pre-pandemic studies of post-traumatic growth in the review and only 44% of the total studies were focused on the COVID-19 pandemic. As the pandemic was an unprecedented situation for healthcare staff, the factors involved with developing post-traumatic growth may have been different from pre-pandemic factors. Despite this, these reviews of the literature suggest that resilience and coping are associated with positive psychological outcomes in healthcare staff during the COVID-19 pandemic, including post-traumatic growth.

The reviews by Jeamjitvibool et al. (2022) and Labrague (2021) analysed quantitative data reviewing resilience and coping in healthcare staff. Their results identify that resilience and coping is important for healthcare staff but not *which* coping strategies are being used or *how* resilience is built or maintained. O'Donovan and Burke's (2022) review did synthesize a range of factors that predicted post-traumatic growth. However, they only included three qualitative studies, which were not focused on COVID-19. This again limits the understanding of *how* healthcare staff came to experience and develop post-traumatic growth during the pandemic. Qualitative research better allows for the identification of positive experiences and factors that may be missed in quantitative research. A review of qualitative research by Curtin et al. (2022) synthesized 121 studies conducted during major global pandemics, including COVID-19, and found six main themes of healthcare staff resilience. These were: (1) moral purpose and duty, (2) connections, (3) collaboration, (4) organizational culture, (5) character and (6) potential for growth

(Curtin et al., 2022). However, this review included studies on other viruses such as Ebola and SARS. These outbreaks were different in comparison to COVID-19, which was endured for longer, resulted in international lockdowns and had a wider global impact.

Current reviews on coping, resilience and post-traumatic growth during the COVID-19 pandemic (Curtin et al., 2022; Jeamjitvibool et al., 2022; Labrague, 2021; O'Donovan & Burke, 2022) have focused on healthcare staff. However, care home staff have faced unique challenges during the pandemic. Both care home staff and healthcare staff were concerned by a lack of Personal Protective Equipment (PPE), delays in COVID testing, and infecting others (Greene et al., 2021; White et al., 2021). However, White et al. (2021) found that in addition, care home staff were managing high levels of patient isolation and the deaths of residents that they may have had long-standing, close personal relationships with. Additionally, care home staff experienced negative media coverage in comparison to heroic portrayals of medical staff (White et al., 2021). Due to the unique challenges that care home staff have faced during the pandemic, current reviews on healthcare staff resilience and coping may not be relevant to care home staff. To date, and to the author's knowledge, no review of the literature has explored how care home staff have coped and built resilience during the COVID-19 pandemic.

Aim

The aim of this review is to understand how care home staff coped and built resilience during the COVID-19 pandemic by synthesising the qualitative research in this area.

Methods

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance was followed throughout this review (Page et al., 2021).

Search Strategy

Scoping searches were conducted to identify key concepts, subject headings, existing reviews and terminology. These were conducted with databases of interest as well as PROSPERO to identify any reviews in progress. A subject librarian at University College London (UCL) was consulted on database identification and development of the final search strategy. The final databases searched were MEDLINE, PsycINFO, Web of Science, CINAHL, Embase, Emcare and PTSDpubs. Search terms for care home staff, resilience and COVID-19 were adapted from two previous reviews (Kunzler et al., 2020; Nussbaumer-Streit et al., 2020). Key search terms related to the population ("care home staff"; "care staff"), the intervention being the impact of COVID-19 ("COVID-19"; "Coronavirus"; "SARS-CoV-2") on resilience, coping and post-traumatic growth ("resilience"; "post-traumatic growth"; "coping"). Terms related to qualitative research were also included ("qualitative"; "interviews"; "grounded theory"; "thematic analysis"). The full search strategy also included relevant subject headings for each database (Appendix 1). The final search of all databases was conducted on 25th of January 2023. The reference lists of retrieved papers were searched to identify any relevant studies.

Selection Criteria

Original, published, qualitative research on the experiences of care home staff during the COVID-19 pandemic, focusing specifically on resilience, coping and post-traumatic growth was included. Mixed-method research was also included if the

qualitative results were reported in full and could be extracted separately from quantitative results.

In terms of the population inclusion criteria, any care home staff were included (nurses, managers, support staff, administration staff etc.). Studies on healthcare staff were included if data from care home staff was separable from healthcare staff data. Studies where resilience or coping was a main concept or theme were included, even if part of a wider set of themes on care home staff experience. Research that focused on care staff that primarily worked in patients' own homes (home-care staff) was excluded to ensure population homogeneity.

Data Screening and Extraction

Once the full search was conducted, titles and abstracts of each identified paper were imported into the reference manager EndNote (Version 20.4.1.). Duplicate papers were removed via the Endnote de-duplication tool and then hand-searched to remove any papers that were not automatically identified. Titles and Abstracts of each paper were screened. Potentially relevant papers were then retrieved and read in full. Any queries about the relevance of a paper were discussed with the research team and an agreement was reached. The research team consisted of myself, and three clinical psychologists (MP, JB and GC). MP is a Clinical Psychologist with many years of experience working with care home staff and a special interest in staff support in health and social care settings. JB is a consultant clinical psychologist and associate professor, with extensive experience of systematic review and meta-synthesis methodology and more than 22 years of experience working in healthcare. JB specialises in clinical work and research with staff working in high-risk roles. GC is a consultant clinical psychologist and associate professor

specialising in the development, delivery and evaluation of interventions to address the psychological needs of older people and their support network in mental health, physical health or social care settings.

A full description of the data screening process is documented in the PRISMA flowchart (Figure 1). After the final papers were selected, the data was manually extracted and reported (Table 1) summarising Reference (Author and Year of Publication), Study Design, Analysis, Participants (Number), Country and Main Findings.

Quality Appraisal

The Critical Appraisal Skills Programme (CASP, 2018) checklist for qualitative research was used to assess the quality of each study included in the thematic synthesis (Table 2). The CASP checklist was chosen as it is recommended by Cochrane for assessing the quality of qualitative research (Noyes et al., 2022). The CASP checklist also covers the underpinning principles of qualitative research which can be summarised into three key domains: assessing how the study was conducted; reporting of results; and usefulness of findings (Tong et al., 2012). The authors of the CASP (2018) tool do not suggest a numerical scoring system as the tool is not intended to provide a quantitative rating. As agreement on quality in qualitative research is difficult due to the interpretative nature of the research, the aim of the current quality appraisal was to provide an overview of current research quality and to publish the full results of this appraisal to allow readers to make their own evaluation of results (Lachal et al., 2017; Walsh & Downe, 2005). Therefore, each study was given a rating of “Totally met”, “Partially met” or “Not met” for each of the ten CASP criteria. A second external researcher used the CASP checklist to

review two of the final papers which were selected using a random number generator. This was then compared against the original ratings.

All relevant studies were included as part of the thematic synthesis irrespective of their quality or sample size. Research into care home staff experience of the COVID-19 pandemic is a new topic and therefore the number of published studies on this topic is limited. Lower quality studies could still provide useful accounts from care home staff and therefore were included in the thematic synthesis. Therefore, the quality appraisal was used to assess the overall quality of research on this topic and understand trends of weakness and strength in the literature.

Thematic synthesis

The thematic synthesis was conducted in line with a methodology set out by Thomas and Harden (2008). For each paper, data relating to care home staff coping strategies and/or resilience from each paper was extracted and collated. This included both direct quotes from participants as well as text describing the results. The data was then imported into NVivo Pro 12 software and analysed thematically.

The aim of the analysis was to provide a comprehensive synthesis and summary of themes arising across the whole body of literature. Therefore, an inductive method was employed to capture all major themes as well as any inconsistencies. The first part of the analysis process was to actively read and re-read the relevant results to become familiar with the entire dataset. After this, initial codes were generated inductively to remain close to the original data. These initial codes were reviewed and collated in terms of both similarities and inconsistencies across codes to develop initial themes. Themes were then organised into sub-themes and overarching main themes. The themes were presented to the research team to ensure

their relevance and face validity. The results of the thematic synthesis include examples from original studies to evidence the themes generated.

Reflexivity

Reflexivity is a key part of any qualitative research including the thematic synthesis of qualitative studies. In this thematic synthesis, my contribution and influence on the analysis was continuously evaluated along with the wider research team. I am a Trainee Clinical Psychologist, with prior experience of generating original qualitative literature, including both thematic analysis and narrative analysis. I am a healthcare professional who worked during the COVID-19 pandemic, but I have not worked extensively with care home staff. This provides advantages and disadvantages when analysing this data. An advantage of being unfamiliar with care homes is that I was able to generate initial inductive codes and themes that remained close to the original data rather than any pre-existing assumptions due to experience of working with care home staff. This allowed care home staff experience to be at the centre of the analysis. However, a disadvantage of a lack of experience in care homes was the potential for the results to lack face validity. As I have experience of working clinically during the pandemic, this may have also influenced the initial coding and theme generation process. Other members of the research team with extensive experience of care homes reviewed the codes and themes throughout the analysis process.

Results

In total, 4496 papers were retrieved: MEDLINE (1100); PsycINFO (236); Web of Science (585); CINAHL (610); Embase (1247); Emcare (610) and PTSDpubs (4). After removing duplicate papers, a total of 2090 papers were

screened via their title and abstract. Sixty papers were included but eight papers could not be retrieved, therefore 52 papers were read in full. Forty papers were excluded: 22 papers did not contain data on resilience or coping; 15 papers did not focus on care home staff experience; and three papers were not qualitative research. As a result, 12 papers were included in the final review and thematic synthesis (see Figure 1). The reference lists of the 12 papers were checked for any appropriate references, but no additional relevant papers were identified and therefore this step is not represented in the PRISMA diagram.

All 12 papers included in the thematic synthesis are summarised in Table 1. Three studies were from the United Kingdom; four were from Canada; two were from Europe; two were from China; and one was from the Middle East. In terms of the profession of participants, six studies classified their samples as healthcare workers, four studies interviewed nurses, one study interviewed care aides and one study interviewed managers of care homes. A total of 10 studies were carried out in long-term or residential care homes, but these studies are unclear about the demographics of the residents that were being cared for. One study specifically collected data in a residential care home for people with learning disabilities, and one study focused on a dementia care unit. All studies were published between 2021 and 2022. Most studies collected qualitative data via individual interviews or focus groups, however, one study examined open-ended survey questions. In terms of the analytic approach, five studies used thematic analysis; two referenced grounded theory approaches; two used content analysis; one used narrative analysis; one used qualitative description analysis and one used a descriptive phenomenological method.

Quality Appraisal

The results of the quality assessment using CASP criteria are shown in Table 2. Overall, the quality of the papers varied. Many papers were rated as only partially meeting criteria due to a lack of information about analysis procedures and researcher input. The relationship between the researcher and participants was often not considered or discussed. Data analysis was often not clearly described, or the results lacked quotes from participants as evidence for their themes. In terms of ethical rigour, often papers did not mention how the purpose of the study was described to participants in detail or lacked a description of ethics procedures. In terms of the reliability of the quality appraisal, the second researcher agreed with 80% of the original CASP ratings (Appendix 2).

Figure 1

PRISMA Flow Diagram

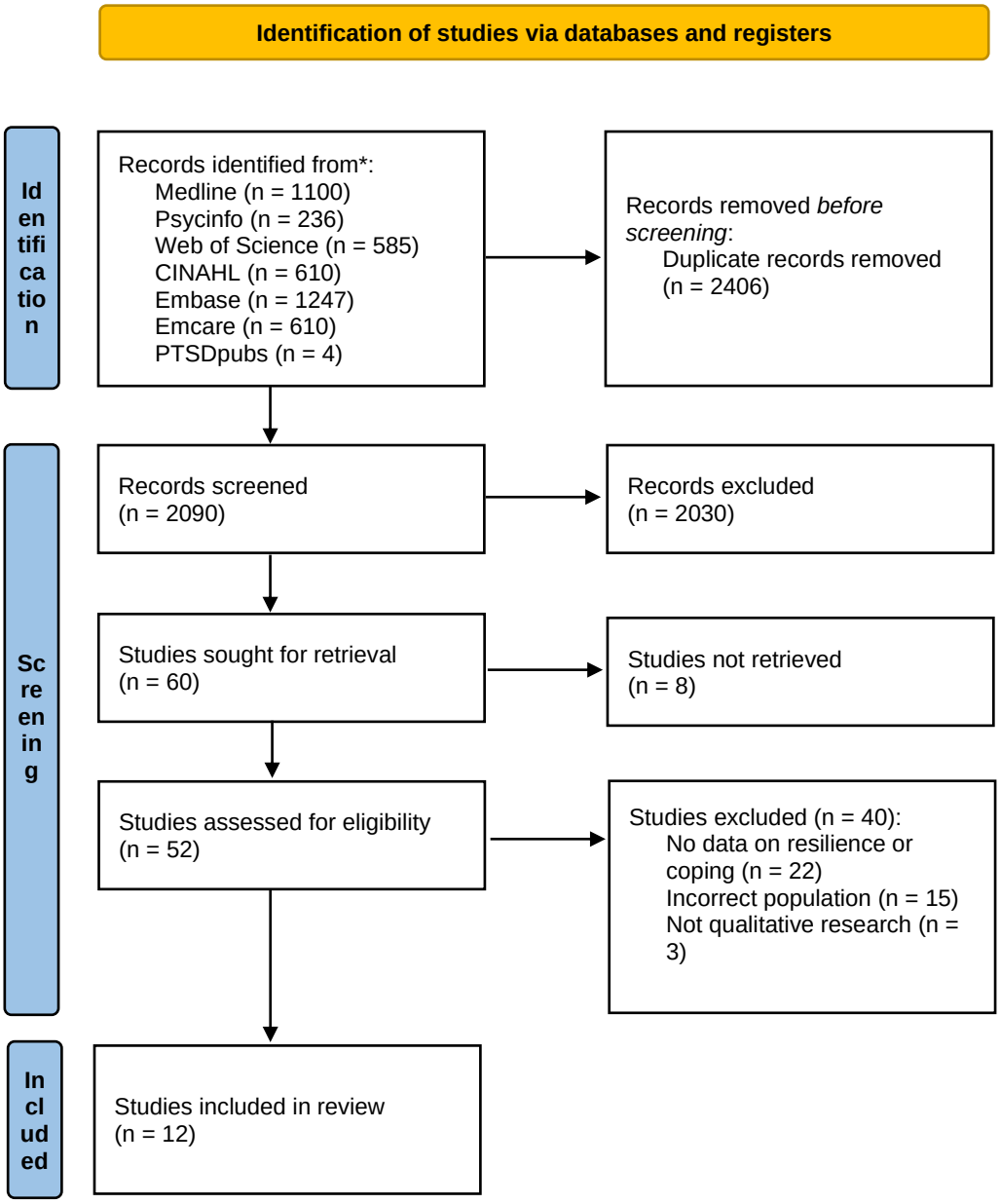

Table 1

Summary of Articles Included in Review

Author (Year)	Study Design	Analysis	Participants	Country	Main Findings
Beattie et al. (2022)	Mixed methods including individual interviews	Thematic Analysis	Healthcare Workers in Care Homes (*N* = 13)	Scotland	Staff coping was documented in three main themes: personal factors; organizational culture; safety and security.
Connelly et al. (2022)	Qualitative analysis of individual interviews	Grounded Theory	Registered Practical Nurses in Care Homes (*N* = 40)	Canada	Individual resilience was made up of four main themes: Dynamic Role of the Nurse', 'Preserving Self', 'Banding Together' and 'Sense of Leadership Support'. These four themes could both enhance or drain resilience.
Conolly et al. (2022)	Qualitative analysis of narrative individual interviews	Narrative Analysis: Case Studies	Nurse Manager of Care Home (*N* = 1)	United Kingdom	Taking pride in resilience, despite work-based stress due to system failings. Using distress to create change. The concept of resilience is used to question the abilities of employees.
Hung et al. (2022)	Qualitative analysis of individual interviews and focus groups	Thematic Analysis	Healthcare Workers in Care Homes (*N* = 30)	Canada	Four main themes were identified: We are Proud, We Felt Anxious, We Grew Closer to Residents and Staff Members, and The Vaccines Help

Lai et al. (2022)	Qualitative analysis of individual semi-structured interviews	Thematic Analysis	Healthcare Workers in Care Homes (*N* = 30)	Hong Kong	The theme "Developing Resilience" was made up of the following sub-themes: Experiencing Stress at the Onset of the Pandemic; Seeking Resilience in Adverse Circumstances; and Joining the LTC Sector in the Midst of the Pandemic.
Lev & Dolberg (2022)	Qualitative analysis of focus groups	Not explicitly stated but Grounded Theory referenced	Healthcare Workers in Care Homes (*N* = 21)	Israel	Staff coping strategies included: commitment to work despite risk; redefinition of their role; and taking responsibility and not relying on outside help.
Nuttall et al. (2021)	Qualitative analysis of individual semi-structured interviews	Content Analysis	Healthcare Workers in supported-living and residential services for people with learning disabilities (*N* = 14)	England	There were four main coping mechanisms and stress management strategies identified. These were: Communication and managerial support; celebrating achievements; peer support; and personal resources.
Ree et al. (2022)	Qualitative analysis of individual semi-structured interviews	Thematic cross-case Analysis	Managers of Care Homes (*N* = 13)	Norway	Several coping strategies were used by the managers. Being proactive and thinking ahead; sharing information; training staff in new procedures. Managers also encouraged togetherness and collaboration; were available as managers. Managers hired temporary staff and found new ways to organize work and activities.

Reynolds et al. (2022)	Mixed-method design. Qualitative analysis of open-ended survey questions	Thematic Analysis	Healthcare Workers in Long-term Care Homes (*N* = 70)	Canada	Five sub-themes were identified as part of the 'Coping with Stressors' Theme. These were: Embracing time away from work; Relying on support from colleagues: Practicing cognitive coping; Employing pandemic safety measures; and a contradictory sub-theme: Feeling stuck in stressful experiences and coping.
Scerri et al. (2022)	Qualitative analysis of individual semi-structured interviews	Descriptive Phenomenological Method	Nurses in Dementia Care Units (*N* = 9)	Malta	Two sub-themes were identified as part of the theme 'Building on personal and organisational resilience'. These were: Personal coping strategies and Organisational Resilience. One sub-theme was also around "positive emotions".
Titley et al. (2022)	Qualitative analysis of individual semi-structured interviews	Inductive Content Analysis	Care aides in Long-term Care Homes (*N* = 52)	Canada	Two sub-themes were identified as part of a main theme 'resilience and optimism'. These were 'strength in connection' and 'optimism'.
Zhao et al. (2021)	Qualitative analysis of individual semi-structured interviews	Qualitative Description Analysis	Nurse managers (*n* = 7) Registered Nurses (*n* = 7) and Nursing Assistants (*n* = 7) in Nursing Homes (Total *N* = 21)	China	Coping Strategies were reported for Nurse managers, Registered Nurses and Nursing Assistants.

Table 2

Quality Assessment of Each Study Included – CASP Criteria (2018)

	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Were the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration ?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Beattie et al. (2022)	✓	✓	✓	?	✓	✗	?	?	✗	✓
Connelly et al. (2022)	✓	✓	✓	✓	✓	?	?	✓	✓	✓
Conolly et al. (2022)	✓	✓	✓	✓	✓	?	?	✓	✓	✓
Hung et al. (2022)	✓	✓	✓	✓	?	✗	?	✓	?	?
Lai et al. (2022)	✓	✓	✓	✓	✓	?	?	?	?	✓
Lev & Dolberg (2022)	✓	✓	?	✓	✓	?	✓	?	✓	✓
Nuttall et al. (2021)	✓	✓	✓	✓	✓	?	?	✗	✓	✓
Ree et al. (2022)	✓	✓	?	✓	✓	?	?	?	✓	✓
Reynolds et al. (2022)	✓	✓	✓	✓	✓	✗	✗	✓	✓	✓
Scerri et al. (2022)	✓	✓	✓	✓	✓	✓	?	✓	?	?
Titley et al. (2022)	✓	✓	?	✓	✓	✗	?	?	?	?
Zhao et al. (2021)	✓	✓	✓	✓	✓	✓	✓	✓	?	✓

Note. Green (✓) represents "Totally Met"; Orange (?) represents "Partially Met"; Red (✗) represents "Not Met".

Thematic Synthesis

Table 3 outlines the three main themes and eight sub themes in the thematic synthesis.

Table 3

Themes and Sub-themes identified.

Main Themes	Sub Themes
Psychological	Occupational Identity
	Personality
	Cognitive Strategies
Social	Personal Relationships
	Work Relationships
	Leadership and Management
Practical	Practical Strategies at Work
	Practical Strategies at Home

Psychological

Psychological themes of coping and resilience and were found in all 12 studies on care home staff. Care home staff drew on different psychological factors to cope with the pandemic. These factors included their own occupational identity, their individual personality, and the cognitive strategies they used to cope with stress and emotion.

Occupational Identity. In nine studies, care home staff were described as having a strong occupational identity, which encompassed a sense of duty and purpose to care for residents which helped them to persevere during the pandemic. Overall, these nine studies were of good quality in terms of their analysis and

methodological rigour. As described by Beattie et al. (2022) “Inherent within participants’ values and beliefs was a strong sense of altruism and duty to their residents and job” (p. 697).

The pandemic heightened the importance of working in a care home. This was drawn upon by staff in Lev & Dolberg (2022) when facing adversity: “We chose this profession, everyone chose his profession and it’s impossible in a time of crisis . . . to just up and leave” (p. 13)

Staff who felt a sense of duty and committed to their roles also gained a sense of reward, “meaningfulness” (Lai et al., 2022, p. 11) and “pride” (Nuttall et al., 2021, p. 29), which bolstered their ability to cope:

> We thought they (residents) really couldn’t make it. Now, they’re out in the dining room being their normal selves again. It’s quite rewarding! ... It’s a really nice feeling thinking about how hard we worked for them, and… it actually worked (Hung et al., 2022, p. 4).

Personality. Another psychological concept that was described in four studies as a source of resilience was an individual’s personality. The combined studies that evidenced this theme, were of lower quality overall compared to other themes included in the results. Beattie et al. (2022) felt staff resilience was “linked to their individual personality traits, such as extraversion and conscientiousness” (p. 696). A participant in Conolly et al. (2022) also described her resilience as being a fixed personality trait that not everyone possesses: “…she said, “I cannot get over your resilience. Where do you get your resilience from?” I need to be mindful that that’s how I am, but everybody is not like that” (p. 9).

Optimism was another example of a personality trait that was related to staff coping. Titley et al. (2022) noted that care home staff "…tried to maintain positive attitudes, accepting current circumstances as transient and remaining hopeful for the pandemic's end" (p. 203).

A participant's own sense of agency or self-efficacy was a personality trait that was described as enhancing resilience. For example, Ree et al. (2022) described that "managers emphasized the importance of relying on their own competence and ability" (p. 12). Similarly, a manager in Conolly et al. (2022) highlighted the importance of her own sense of self-efficacy during the pandemic. She explained that her mantra was "you can't change something unless you do something about it" (p. 9).

Cognitive Strategies. A final psychological factor that was described in nine studies was participants' individual cognitive coping strategies that they used to manage stress and emotion. This theme was evidenced across seven good quality studies, as well as two studies with poorer quality methodologies. Cognitive strategies were internal, mental coping strategies, such as acceptance, present moment focus, avoiding emotion and compartmentalizing work.

Connelly et al. (2022) was explicit about the connection between acceptance and resilience: "for some [registered practical nurses] RPNs, being truly resilient may have meant accepting the limitations of their job and personal self" (p. 4228). A participant in Hung et al. (2022) was labelled as resilient when she described the pandemic as "something we can't control" (p. 4), demonstrating an acceptance of uncertainty.

Reynolds et al. (2022) highlighted that care home staff used the cognitive strategy of present-moment focus to cope with stress, by "dealing with changes one day at a time" and "taking each shift as it comes" (p. 618).

Mental strategies to cope with emotion also included staff avoiding or delaying emotion. Nuttall et al. (2021) described that care home staff "found that adopting a 'survival mode' – for example, by avoiding too much wishful thinking…relieved stress" (p. 29). However, this was not always thought of as an effective long-term coping strategy. A participant in Beattie et al. (2022) talked about existing emotion about the pandemic being placed behind "floodgates": "when it's all over… once the floodgates of this is opened it's going to be hard for some people" (p. 697).

Compartmentalising work was a particularly common psychological strategy that staff used to cope with stress. Connelly et al. (2022) explained that "when RPNs were able to compartmentalize to preserve their sense of self, this fuelled their individual resilience" (p. 4228). Nuttall et al. (2022) described that:

> "Participants believed it was important to compartmentalise their lives so that work would not intrude in their personal life and said switching off work phones and not checking work emails on days off was essential for preserving their mental well-being". (p. 29)

Social

Out of the twelve studies, eleven detailed how care home staff used their social connections to cope and build resilience throughout the pandemic. The most frequently discussed relationships were care home staffs' personal and professional relationships as well as their relationships with managers and leaders.

Personal Relationships. In seven studies, care home staff mentioned their personal relationships with friends and family as a source of support and an important way to cope during the pandemic. The quality of the studies that evidenced this theme were generally mixed, as both good quality and poorer quality studies reported on staff's personal relationships. Reynolds et al. (2022) found that "being with family and friends, whether seeking emotional support or distancing from work-related stress, was also reported by participants as a way to cope with current stress" (p. 617).

Participants' personal relationships were a source of positivity outside of their work. For example, a participant in Zhao et al. (2021) explained that keeping in touch with her family via social media was a source of support: "My husband often chatted with me on WeChat about pleasant things, such as stories about our son. . ." (p. 890).

Work Relationships. Eleven studies noted that care home staff relied on their team and other staff members to cope. This relationship provided individuals with a variety of benefits. Staff described camaraderie and strength against a shared challenge, which boosted their resilience: "We're all in this together and we're all feeling the same and facing the same" (Beattie et al., 2022, p. 699); "We're still standing up. And I think, standing stronger now!" (Hung et al., 2022, p. 4).

Care home staff often used their work relationships to cope emotionally and psychologically by talking and reflecting and using humour. Titley et al. (2022) described that staff "relied on each other to discuss feelings and bring humour into their work" (p. 203).

Due to the increased workload during the pandemic, teamwork was often mentioned by participants as an essential resource to draw on: “Teamwork is how you be resilient in this job” (Connelly et al., 2022, p. 4229).

Ree et al. (2022) described that the pandemic had resulted in improved relationships between staff members and that this was key for coping with the pandemic:

> Staff across different departments and services got to know each other, which again created a strong feeling of unity and team cohesion among the employees, as well as a greater flexibility and understanding of the necessity of everyone’s roles. Trusting and helping each other and being aware that everyone was in this together seemed to be one of the most important strategies in dealing with the pandemic. (p. 10)

Leadership and Management. Management staff were interviewed exclusively in two, good quality studies (Conolly et al., 2022; Ree et al., 2022). However, in seven studies, effective, positive leadership and managers were often mentioned as a key source of support for staff, which improved their ability to cope. This theme was evidenced in good quality studies. Firstly, managers were able to find solutions to problems for staff. Reynolds et al. (2022) explained that “being able to discuss concerns with management was also seen as a valued way of coping with stressors” (p. 617).

Ree et al. (2022) provided an account of a care home manager’s perspective on the importance of their presence on staff resilience: “There was almost a queue

outside my office all the time. People always had something to ask about. So, I think it was important to be a manager that was present" (p. 11).

Managers' presence alone led to staff feeling valued and resilient. As Connelly et al. (2022) described: "the physical presence of leadership with and amongst the RPNs in [long-term care] was an important factor that contributed to them feeling valued in the workplace, which consequently, fuelled their individual resilience" (p. 4231).

Practical

All twelve studies identified a range of practical strategies that care home staff used to cope and build resilience. At work, these practical strategies were often used to manage the increased workload caused by the pandemic. At home, practical coping strategies helped staff to unwind and relax.

Practical Strategies at Work. At work, care home staff had increased workloads, reduced staff numbers due to sickness, and increased pressure to perform to a high standard. All twelve studies documented a range of strategies that were employed by staff to cope with the unprecedented challenge.

Six studies reported on care home staff "getting on with it" (Beattie et al., 2022, p. 679). Care home staff used hard work to try to push through the pandemic: "resilience … means just keeping going with what you are doing, no matter what challenges you're facing" (Connelly et al., 2022, p. 4226).

Other care home staff used practical strategies such as prioritising, organizing, and planning ahead to mitigate the increased demands placed on the care home due to the pandemic. Ree et al. (2022) detailed what this looked like for care home managers: "This ranged from obvious important strategies like having

contingency plans and appropriate equipment, to smaller strategies like having updated lists of telephone numbers for next-of-kins" (p. 8).

Another practical strategy that was employed by care home staff was streamlining communication and information. The unprecedented nature of COVID-19 resulted in a large number of policy and procedural changes in care homes, which felt overwhelming for staff at times. Effective communication was described as the solution to this issue for both staff and residents. As Nuttall et al. (2021) explained:

> emails provided clear guidance and were therefore a source of support and/or stress-relief. Briefings and summaries of COVID-19- related guidance developed by managers were viewed as particularly helpful, since they were in easy-read and poster format to assist service users to understand the situation. (p.28)

Staff also reported that staying informed about the pandemic helped them to cope. A participant noted that "reading recent research articles on COVID-19" was one of their coping strategies (Reynolds et al., 2022, p. 618).

A practical strategy to cope for many care home staff was to follow the guidance around COVID-19. Guidance provided a structure and routine within a changing and chaotic environment. A participant in Zhao et al. (2021) explains that following guidance was a method for dealing with stress:

> I knew how to deal with it (stress). I paid more attention to COVID-19 prevention every day during the lockdown. . . I worked more carefully than I usually do, such as washing hands frequently and disinfecting strictly. I followed all instructions from management and registered nurses and I did my job well. (p. 891)

A practical factor at work that improved care home staff resilience was around job security, job development and financial compensation. This resulted in a lasting resilience that encouraged care home aides to continue their work. As Lai et al. (2022) explained:

> Participants suggested that population aging had increased the societal demands for healthcare workers in the long-term care sector, which in turn created plenty of job opportunities and provided stable income for them… they proposed that the sector's relatively promising career ladders that offered development opportunities… would also incentivize them to pursue a long-term career in the sector. (p. 12)

Practical Strategies at Home. Eight studies commented on the practical strategies that care home staff used to cope with the pandemic once they got home. The eight studies were of mixed quality overall, but six had good analytical and methodological rigour. Hobbies such as being outdoors, including walking and gardening were commonly discussed by studies as coping strategies that care home staff relied on (Nuttall et al., 2022). Exercise, music and creative hobbies such as knitting were also mentioned by participants: "I just go away up into the countryside just to clear the air." (Beattie et al., 2022, p. 698); "trying to exercise as much as possible" (Reynolds et al., 2022, p. 617); "I used to remain quiet for half-an-hour and listen to music" (Scerri et al., 2022, p. 6).

Substance use was also cited in three studies as a coping strategy that some care home staff relied on more frequently during the pandemic. Scerri et al. (2022) noted that: "one participant… indicated that her smoking habit increased" (p.6).

Perhaps due to the anonymous nature of Reynolds et al. (2022) survey, care home staff reported increased alcohol consumption: “Started drinking again” (p. 618); “Drinking when I get home” (p. 618).

Discussion

The aim of this review was to understand how care home staff coped and built resilience during the COVID-19 pandemic. A total of 12 papers were included in the thematic synthesis. The studies were heterogeneous in terms of location, job role and analysis method. Despite the heterogeneous nature of the studies, a clear set of themes were synthesised. Care home staff used psychological, social, and practical coping methods to remain resilient during the COVID-19 pandemic. Firstly, care home staff drew on three psychological factors to cope and build resilience: their occupational identity, their personality, and various cognitive strategies, which included acceptance, present moment focus, compartmentalising, and avoidance of emotion. The second theme found that care home staff used different social relationships to cope. This included their personal and work relationships, as well as positive leadership and management. Thirdly, care home staff used practical coping strategies to cope with demands at work and to relax at home. These three main themes will be examined within the context of existing literature.

Psychological

The first finding was that care home staff used psychological strategies to cope during the pandemic. Their occupational identity, in terms of a sense of duty and purpose, was one of these psychological strategies and was closely linked to building resilience. Reviews on healthcare staff resilience during the pandemic also

identified moral purpose and duty as a factor in resilience (Curtin et al., 2022). One explanation for this finding is using the transactional theory of stress and coping (Lazarus & Folkman, 1984). If care home staff viewed the pandemic through a sense of duty and purpose, the stress of the pandemic could be interpreted as a challenge and potential for growth, rather than a threat.

An occupational identity may also be a source of resilience because it is often experienced as a shared identity between care home staff. A shared social identity amongst colleagues is associated with lower levels of stress and higher job satisfaction (Haslam et al., 2005; Krug et al., 2021). The COVID-19 social distancing measures may have affected the occupational identity of care home staff as disrupted team processes, connections and rituals may have eroded a sense of "we-ness" (Jetten et al., 2020). Alternatively, COVID-19 could be seen as a "common fate" which activates a shared identity between care home staff as they share goals, and experience solidarity and validation (Drury, 2012). Therefore, in the current study, care home staff who reported an occupational identity as a source of resilience may be experiencing a sense of shared identity with their colleagues, providing access to collective resilience which protects against the impact of high organisational stress.

The review also found that the individual personality traits of care home staff were reported to be a factor in maintaining resilience. However, only four studies out of twelve found individual traits were part of care home staff resilience, and these studies were of lower quality. The results of the current study may reflect that resilience is often researched and discussed as an individual personality trait (Windle, 2011). As discussed, researching resilience as a trait is unhelpful, as it can be blaming if an individual is labelled as not possessing resilience (Luthar &

Cicchetti, 2000; Mohaupt, 2009). For example, healthcare staff were found to internalise the idea of resilience as a trait during the pandemic leaving them feeling "not resilient enough" (Conolly et al., 2022, p. 11). "Character" was also found as a factor in the resilience of healthcare staff during the pandemic (Curtin et al., 2022). However, Curtin et al.'s (2022) theme of "character" encompassed a broader definition, such as individual coping strategies, core values and emotional reactions. The findings of the current study suggest that although personality traits were identified as a factor in the literature on care home staff resilience, it should be considered with caution.

A final psychological factor that was identified in the results of this review was that care home staff used specific cognitive strategies to manage stress and emotion. These included compartmentalising their work, focusing on the present moment and accepting their situation. In wider literature, these processes fit with emotion-focused coping (Carver et al., 1989). Emotion-focused coping strategies are often used when an individual feels there is no option to use a problem-focused strategy to change the stressor. In the current review, some care home staff felt they had no control over the virus and therefore focused on acceptance and managing their emotions instead. However, one meta-analysis found that the use of emotion-focused coping strategies was associated with poorer physical and psychological health outcomes (Penley et al., 2002). More specifically, they found that the coping strategy of 'distancing', was associated with poorer health outcomes. 'Distancing' is conceptually similar to avoiding emotion and compartmentalizing work. Therefore, although care home staff used strategies to cope with emotion, it was not clear whether this had a benefit for care home staff in the long term.

Social

The second major theme was that care home staff used their social networks and relationships to cope with the pandemic. This theme was evidenced in almost all papers and particularly papers of higher quality. Care home staff relied on their personal relationships with friends and family to provide positivity and cope with stress. Care home staff also relied on their work relationships for emotional and practical support. Again, these findings are similar to wider healthcare staff where connections to both professional peers and family were found to be a factor in resilience (Curtin et al., 2022). In the current review, support from colleagues in terms of teamwork, camaraderie and use of humour were factors that helped care home staff to cope and remain resilient. These findings have also been found in qualitative studies on healthcare staff resilience during COVID (Rose et al., 2021; Soubra et al., 2023). One study in the review noted that the relationships between care home staff had been improved by the pandemic (Ree et al., 2022) and this fits with the theory of post-traumatic growth improving interpersonal relationships. However, other research on health and social care staff found that the pressure of the pandemic had strained healthcare staff relationships and providing peer support was sometimes experienced as a burden (Billings et al., 2021; Soubra et al., 2023).

The final relationship care home staff relied on for support was their management and leadership teams. In the current study this was identified in studies of higher quality. Increased visibility of management made care home staff feel valued and access to a manager helped staff resolve issues. These findings are similar to research on healthcare staff resilience. Curtin et al. (2022) found that management presence bolstered healthcare staff resilience by providing guidance as well as emotional support. Soubra et al. (2023) found that a lack of managerial visibility, support and empathy resulted in healthcare staff feeling abandoned,

dehumanised, and worsened their ability to cope. Both studies align with the results of the review as they reflect the important contribution that effective management has on staff resilience and coping.

The majority of studies included in the current review interviewed or surveyed individuals. Therefore, the results of the studies focused on resilience and coping from the perspective of individual staff. However, the COVID-19 pandemic added pressure to care homes on an organizational and systemic level. For example, COVID-19 resulted in increased work demands, lack of PPE and staff shortages for care home staff teams (Greene et al., 2021; White et al., 2021). Therefore, the theme of social support identified in care home staff resilience could relate to wider theory around systemic resilience. Ungar's (2018) principles of systemic resilience suggest that connectivity is a crucial part of a resilient system, as relationships can act as a buffer against the impact of a stressful environment. This theory is supported by a recent systematic review which found that social support had a significant positive relationship to resilience in nurses (Galanis et al., 2022). Furthermore, well connected communities have been found to be more resilient when facing collective stressors, such as an earthquake (Hikichi et al., 2016). This supports the argument that social support from colleagues and managers may be viewed as a systemic factor in resilient care home teams, rather than an individual factor. This finding aligns with the idea of resilience being an interactive process, through which individuals draw on collective social and environmental resources to be able to cope with increasing demands, rather than resilience being an individual trait.

Practical

The final major theme in the review was that care home staff used practical strategies to cope and maintain their resilience. When care home staff were at work, they used practical strategies to cope with the increased workload caused by the pandemic. These included a range of strategies, such as organizing work, communicating effectively, keeping informed and following guidance. These strategies could be seen as examples of problem-focused coping strategies (Carver et al., 1989). The use of problem-focused coping has been associated with improved psychological health, particularly for chronic stressors such as the pandemic (Penley et al., 2002). Curtin et al. (2022) found healthcare staff used similar strategies to maintain resiliency during the pandemic. This included clear communication and training on COVID-19 procedures which helped staff to feel safe.

When care home staff returned home after work, they continued to implement practical ways to manage the stress of the pandemic. This included engaging in hobbies and being outside. Other research on non-staff populations during the pandemic found that being in nature was associated with positive mental health outcomes and the use of hobbies was associated with lower depressive symptoms (Fullana et al., 2020; Soga et al., 2021). Additionally, in the current review, care home staff reported drinking and smoking more often when they got home. This is similar to Greene et al. (2021) who found in their survey that nearly a third of healthcare staff reported increased alcohol, cigarette, and substance use. A recent meta-analysis of healthcare workers found that hazardous alcohol consumption had increased during the pandemic compared to pre-pandemic levels (Halsall et al., 2023). However, this trend was also found outside of healthcare worker populations. A systematic review of substance use during the pandemic found that alcohol consumption increased across the population and that this was

observably linked to increased depression and anxiety (Roberts et al., 2021). This trend of increased alcohol consumption across the population during the pandemic could be an explanation for care home staff reporting an increase in alcohol and cigarette consumption. However, care home staff reported high levels of stress during the pandemic (Beattie et al., 2022) and chronic stress has been associated with increased alcohol consumption in animal and epidemiological studies (Becker et al. 2011, Keyes et al. 2012). Increased alcohol consumption was also associated with higher levels of reported stress and avoidant coping in healthcare workers during the pandemic (Beiter et al., 2022). Additionally, shift work, which is common in care home staff rotas, was associated with increased alcohol consumption (Richter et al., 2020). Therefore, this suggests that the increase in alcohol consumption reported by care home staff may have been an attempt to cope with the increased occupational stress of the pandemic.

Strengths and Limitations

To my knowledge, this is the first review of literature of care home staff coping and resilience during the COVID-19 pandemic. The review included a global sample of care home staff, which improves the generalisability of the findings. However, caution should be taken when applying these findings, as each country will have a unique health and social care system, as well as varied governmental responses to the COVID-19 pandemic. The current review also included studies on both long-term care of older adults as well as residential settings for those requiring long-term care or learning disabilities. Seven databases were searched, using a comprehensive search strategy, including searching the reference lists of relevant papers. Quality appraisal was conducted with two reviewers to minimise bias.

The quality of the papers included was generally adequate in terms of data collection and analysis, but the majority did not consider ethical issues and the influence of the researcher sufficiently. Furthermore, most of the participants included in the review were clinical staff. Care home managers were included, but other non-clinical staff who may be present in a care home, such as administrators or cleaners, were not included. Additionally, staff included in the studies were still employed by care homes, and staff who left their job during the pandemic were not included. As there is no data included on staff who left their job in a care home during the pandemic, there is no data on their experiences and reasons for leaving. Therefore, the care home staff included in this review may represent a biased sample of individuals. As the current sample of care home staff have continued to work, they may have experienced higher perceived or actual social, occupational or financial support which may have resulted in higher levels of resilience within this population and therefore biased the current findings.

The current review also has some limitations. The review was not pre-registered on PROSPERO due to time constraints. The review only looked at published research with results written in English and did not include grey literature. Therefore, results may have been liable to some publication bias.

Implications

Understanding how care home staff remained resilient and coped with an unprecedented stressor such as the pandemic, could protect care home staff from burnout in the future. Burnout in care home staff has been associated with greater job dissatisfaction and higher rates of staff turnover (CQC, 2022; White et al., 2019). Therefore, understanding how to support care home staff better could partially

resolve the major staffing crisis in UK care homes, by increasing staff retention (Skills for Care, 2022). Additionally, adequate staffing levels and low rates of staff turnover in care homes improves the quality of care that staff can provide for residents (Bostick et al., 2006). Therefore, supporting care home staff to cope and build resilience is not just important for their own mental wellbeing, but improves the quality of care that residents receive.

The findings of this review can be used to make recommendations for supporting care home staff. Firstly, effective management and leadership presence is crucial for the wellbeing of care home staff. Specifically, use of practical coping strategies such as planning, organizing and prioritizing tasks could be encouraged by management, as well as providing clear information, guidance and training for staff. Managers could also implement a space to discuss concerns and help staff to feel valued. Where relevant, managers and teams can elicit the occupational identity of care home staff which can be used as a source of resilience for staff facing adversity, particularly if this identity is shared between the team. Systemic resilience amongst teams can be maintained or promoted by encouraging positive work relationships between care home staff. As a result, caution should be taken when isolating staff from each other, for example when zoning a care home into separate areas or teams. If physical isolation of staff is necessary, increasing social ties between staff in alternative ways could help bolster staff resilience. In addition to positive working relationships, it is important that care home staff have adequate time off to engage in their own personal lives and relationships outside of work.

Future Research

The qualitative research in this review has examined care home staff views at different time points during the pandemic. However, the pandemic's course has been turbulent, and most countries experienced multiple waves of COVID-19. For care homes, changing guidance, the fluctuating threat from COVID and different pressures and issues may have resulted in care home staff using different coping mechanisms at different times. No qualitative research has been conducted on the experience of care home staff over the entire course of the COVID-19 pandemic, which may have resulted in different experiences, coping strategies and outcomes for staff. Future research may wish to examine the experience of care home staff during the pandemic as an entire narrative.

Conclusion

Despite the stressful and traumatic conditions of the COVID-19 pandemic, the results of this review indicate that care home staff have implemented many different strategies to cope and build resilience during the pandemic. These include psychological factors such as drawing on their occupational identity, inherent personality factors and cognitive coping strategies. Care home staff also relied on their social relationships, with friends, family, colleagues, managers and leaders. Care home staff also used practical strategies to cope with stress at work and then to rest and unwind at home. From the results of this review, resilience in care home staff has been discussed in terms of individual personality traits, however this was typically from lower quality studies. Higher quality studies discussed care home staff resilience as a process of developing and maintaining resilience systemically between staff, managers, wider teams, and personal relationships at home. Generally, the results of this review can be used to support care home staff in the future as they recover from the COVID-19 pandemic and continue to face new challenges.

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Part 2: Empirical Paper

The experience of care home staff during COVID-19: A narrative analysis

Abstract

Background

Care home staff have endured the chronic stress of the COVID-19 pandemic for several years. However, qualitative research on the experience of care home staff has mainly been conducted early in the pandemic during 2020.

Aims

This study aims to capture and explore care home staff's narratives of the entire COVID-19 pandemic.

Method

Interviews were conducted with six care home staff and transcribed. Narrative analysis was used to explore the participants' stories.

Results

An individual narrative account was created for each of the six participants. The cross-case analysis explored shared narratives across participants. Two shared narratives were identified. Firstly, participants experienced COVID-19 regulations to be double-edged: regulations were helpful, but also harmful to care homes. Secondly, participants compared social care and the National Health Service (NHS).

Conclusions

Care home staff narratives are discussed in terms of prior research on burnout, moral injury, occupational stigma, relationships and coping and resilience. Care home staff may require systemic and organisational support in order to recover from their experiences of the COVID-19 pandemic.

Introduction

Impact of COVID-19 on Care Homes and Care Home Staff

Globally, care homes have been greatly affected by the COVID-19 pandemic. During the first wave, 40-80% of all deaths from COVID were linked to long-term care facilities (Comas-Herrera et al., 2022; WHO, 2020). In the United Kingdom (UK), England and Wales experienced 27,000 excess deaths (deaths above a five-year average) in care homes during the first wave of the pandemic (Barrett, 2022). In addition to high death rates, care home staff endured additional pressures, including being short-staffed, and isolating residents from their families (Gordon et al. 2020; Xu et al. 2020). The impact of the pandemic has affected staff recruitment and retention, and staffing levels in UK care homes are now in crisis. Care homes now have an extra 55,000 staff vacancies compared to pre-pandemic figures, with a total of 165,000 vacancies (Skills for Care, 2022).

Working under these conditions has affected the psychological wellbeing of care home staff. Gray et al. (2021) reported a high prevalence of anxiety, depression, and post-traumatic stress disorder (PTSD) among care home staff. Care home staff have also experienced moral injury as a result of the pandemic (Laher et al., 2022). Moral injury is defined as witnessing or involvement in an event that violates an individual's ethical principles (Griffin et al., 2019). Moral injury also includes being betrayed or let down by leaders or those in a position of authority (Shay, 2014). Inadequate staffing levels are detrimental to the quality of care that residents receive. Understanding the experience of care home staff during the pandemic is crucial for understanding how to support care home staff to recover from this experience.

The experience of care home staff during the pandemic has been examined by a number of qualitative studies. Gray et al. (2021) reviewed eight qualitative studies and two mixed-method studies on the experience of care home staff during 2020 and 2021. They found that care home staff reported poor working conditions, a lack of Personal Protective Equipment (PPE) and COVID tests, as well as feeling underprepared and having a lack of skills and knowledge. Staff also reported being unable to find appropriate COVID guidance that was suitable and/or consistent. Staff also discussed struggling with their mental wellbeing, describing symptoms of anxiety, depression, exhaustion and burnout as well as being concerned about becoming infected with COVID. Staff reported feeling undervalued and abandoned by their organisation and/or government. Additionally, feeling undervalued was exacerbated by negative, blaming media coverage of care homes (Gray et al. 2021).

The review by Gray et al. (2021) identified key themes in the experience of care home staff during the COVID-19 pandemic. However, the review only included qualitative studies that collected data during 2020, whereas the pandemic has continued for several years, with many key policy changes and events happening after 2020.

Care Homes, COVID-19 and United Kingdom Policy

COVID-19 arrived in the UK in March 2020 and a national lockdown was declared on the 23rd of March. There were three waves of the virus, peaking in mid-April 2020, January 2021 and July 2021. The Omicron variant emerged in December 2021. Restrictions were lifted and reimposed several times. The vaccination programme began in the UK in December 2020. All national restrictions were lifted in February 2022.

During the pandemic, the government implemented several key policies that affected UK care homes (for a full account, see Daly, 2020). During the first wave, patients were quickly discharged from hospitals to care homes with the aim of reducing pressure on the National Health Service (NHS). Between March and April 2020, care homes received an estimated 25,000 patients who were discharged from hospital without being tested for COVID (National Audit Office, 2020). It is unclear the exact effect this had on COVID-19 transmission in care homes, however this decision by the government has been described as an "appalling error" in a parliamentary report (Public Accounts Committee, 2020). It was also later ruled as "unlawful" by the High Court (Gardner and Harris v Secretary of State for Health and Social Care, 2022).

On the 27th of March 2020, the government and Public Health England (PHE) announced COVID-19 testing for NHS staff (DHSC, 2020a). This was later extended to social care staff and residents on the 17th of April (DHSC, 2020b). PPE was provided to care homes via NHS Trust supply chains, but supply was directed towards health services. Care homes were only provided with a specific PPE supply route and guidance in May (DHSC, 2020c). Both COVID testing and PPE supply chains for care homes were implemented after NHS services.

Another COVID regulation that affected care homes and social care was the vaccine mandate. In June 2021, it was announced that all staff working in Care Quality Commission (CQC) regulated care homes would need to be fully vaccinated against COVID (DHSC, 2021a). In November 2021, care home staff who were not fully vaccinated lost their job. This was despite vacancies of approximately 110,000 in the sector at the time (Skills for Care, 2022). In November 2021, it was announced that the vaccine mandate would be expanded to include NHS staff, and

that they would need to be fully vaccinated by April 2022 (DHSC, 2021b). This decision resulted in considerable criticism from NHS staff (RCP, 2021; RCGP, 2021; RCN, 2022; RCM, 2022). The government revoked the vaccination as a condition of employment in March 2022 for all health and social care staff (DHSC, 2022). As a result, NHS staff did not lose their jobs in the way that social care staff did.

Narrative Analysis

As discussed, the pandemic has been a chronic stressor which care home staff have endured for a number of years. However, most of the qualitative literature on care home staff experiences of the pandemic has been conducted in 2020 and analysed thematically (Gray et al., 2021). Thematic analysis is not best for capturing an individual's story of a period of time, such as the pandemic, as it summarizes data by theme rather than presenting intact narratives. Narratives or stories often reveal how individuals have made sense of events and of their own identity in the context of social and cultural norms (Riessman, 1993). As a result, narrative analysis is often used to understand traumatic events (Crossley, 2007). Additionally, unlike thematic analysis, it can be used to understand experiences over a long period of time and capture changing moments within an individual's story. Therefore, narrative analysis is a useful approach for understanding how care home staff have made sense of the COVID-19 pandemic over time.

Aim

The aim of this study was to capture the narratives of care home staff looking back on the COVID-19 pandemic.

Method

Ethics

Ethical approval for this study was given by the University College London (UCL) Research Ethics Committee (Ethical approval number: 22133/001) (Appendix 3).

Participants

Sample Size

Sample size estimates for narrative analysis are typically small. Creswell and Creswell (2017) suggest one to two participants for narrative qualitative research. As narrative analysis requires intensive in-depth analysis of each interview a sample size above ten is considered too large (Esin, 2011; Sandelowski, 1995). Similar studies using narrative analysis used sample sizes of four to six participants (Marshall & Long, 2010; Newman et al., 2011; Yuen et al., 2019). Therefore, a sample size of six was considered adequate.

Recruitment

All participants were recruited using convenience sampling. Participants were recruited from private (non-NHS) care homes. A research poster was emailed by a supervisor of the project (MP) to colleagues in her professional network of managers of private care homes. Managers were asked to disseminate the research poster to all their staff. Interested participants emailed directly and then I confirmed their eligibility.

Eligibility criteria

Participants were eligible if they had worked in a care home in any role for six months or longer during the pandemic, which was defined as any time from February 2020 onwards. They also had to be able to take part in an interview in English. Participants were compensated £25 for their time.

Procedure

Participants were asked to read the participant information sheet (Appendix 4) and if willing to take part, sign and return the consent form via email (Appendix 5). Interviews were arranged online via videoconferencing software (Microsoft Teams). Participants were sent the Institute for Government (IfG, 2022) timeline of the COVID-19 lockdowns and government measures in the UK between March 2020 and December 2021 as a general overview of the pandemic and an optional memory aid (Appendix 6). Before each interview began, I checked the participant had read the participant information sheet. I explained the study and participants' right to withdraw and confirmed their agreement to record the interview. I asked if they had any questions before beginning the interview.

Interview Schedule

The interview schedule (Appendix 7) was developed in conversation with the wider research team. The research team consisted of myself, as well as three clinical psychologists (MP, JB and GC) who combined have experience with working with care home staff both before and throughout the pandemic, as well as experience of conducting narrative analysis. The interview schedule was designed to be semi-structured and applicable to any member of staff working in the care home. We decided to ask questions in chronological order, following the timeline of the pandemic to encourage a narrative from the participants whilst allowing space for

them to tell their story in their own way. The schedule included prompt questions to enquire about the participant's memories or feelings when describing a particular part of the pandemic. After the chronological questions, questions were included about the impact of the pandemic. At the end of the interview, some additional questions were included to capture participants' reflections on their experience of the interview itself.

Data Analysis

Narrative analysis was used to analyse the data. Narrative analysis focuses on capturing the stories that individuals tell and understanding how they make meaning of their experiences (Esin, 2011; Riessman, 1993). Rather than fragmenting individuals accounts into themes as in thematic analysis or grounded theory, narrative analysis aims analyse the narrative as a whole unit and retain the sequential and structural elements that are lost in other qualitative methods (Riessman, 2008). As a result, it is useful for understanding personal accounts of events, such as the COVID-19 pandemic (Crossley, 2007). Narrative analysis uses a realist epistemology, in that it appreciates the use of language to structure experiences and identity, but balances this with the idea that there is a 'real' or 'know-able' truth that can be found in a person's subjective account (Crossley, 2007).

In this study, narrative analysis was performed following the steps set out by Crossley (2007). In practice, there is wide variation in narrative analysis methods and often different approaches are combined depending on the aims and disciplines of the researcher (Riessman, 2005). Crossley's (2007) method was chosen as it focuses on the personal content of the narratives, rather than other narrative analysis methodologies which focus on how narratives may be performative, behavioural or

how discourse is used within narratives (Esin, 2011). Crossley's (2007) method also focuses on the linguistic elements to understand individuals' interpretations as well as the participants wider historical and societal context. As the aim of the study was to examine care home staff narratives of the COVID-19 pandemic, a focus on the content of what happened during this time, whilst capturing personal experiences and interpretations is useful for meeting the aims of the research. Firstly, similar to most qualitative methods, transcripts were repeatedly read to allow for immersion in the data. Secondly, the transcripts were coded (Appendix 8). Coding was done specifically looking for important concepts, which were: narrative tone, imagery and themes (McAdams, 1993). 'Tone' is a description of what the story contains, as well as the way that this story is told. 'Imagery' is important for understanding the individual, particularly in their own values and beliefs and the context of these within the culture where these images may have developed. 'Themes' are the patterns that weave through the narrative as a whole. The third step is to combine these concepts into a coherent, succinct story for each participant. A fourth step was added: conducting cross-case analysis of participant narratives, to highlight any similarities or differences across the individual stories.

Saturation, Plausibility and Validity

The idea of saturation is common in qualitative research, however as narrative analysis focuses on the completeness and coherence of individual narratives, saturation across interviews is not the aim of this analysis (Saunders et al., 2017). Instead, the aim of the analysis was to arrive at a "plausible and persuasive" narrative summary (Crossley, 2007). As narrative analysis involves the reflexivity of the researcher, the aim is not to produce certainty, but rather to produce an analysis that is convincing: consistent with the data, and meaningful to participants and the

research team (Polkinghorne, 1988). As a result, a few methods of validity checking were included in the analysis process. Firstly, two transcripts were analysed by a researcher (RS) outside of the research team, but who was familiar with research into care home staff experience of the pandemic. RS coded the transcripts with the aim of identifying themes, tone and imagery. This was then compared against the original coding. Discrepancies in coding between myself and RS were discussed and resolved. Once the summaries of each narrative had been written, member checking, also known as, respondent validity was used to improve the credibility of the analysis (Riessman, 1993). Participants were emailed the summary of their own narrative and asked to comment. They were asked three questions (Does this match your experience? Do you want to change anything? Do you want to add anything?). Four participants responded that their summaries fitted their experience, and they would not add or make any changes. Two participants did not respond. Additionally, a participant's narrative was presented to the research team to review the analysis process and results. The feedback from the team was that the method and analysis provided a convincing, rich narrative of the individual and their experiences.

Subjectivity Statement

As qualitative research is influenced by the researcher, I have included a statement around my own position to highlight my experiences, values and assumptions on this topic. I have attempted to bracket the following preconceptions throughout the development of the research, data collection, analysis and reporting of the results (Tufford & Newman, 2012).

I am a white British female trainee clinical psychologist in my late twenties. I have experience of conducting therapy sessions and discussing difficult topics with

others, particularly around their mental health. However, I was conscious that the interviews in this study should not be a therapy session. I tried to remain as neutral as possible during the interviews to avoid influencing participants.

I have conducted qualitative research once before on a different research topic (the identity of ex-smokers who now used e-cigarettes). In that study, I recruited and conducted interviews with participants, therefore I drew on that experience to conduct the current interviews. However, I was conscious that interviews with care home staff may be more emotive than the ones I conducted with e-cigarette users. I have conducted thematic analysis in the past, but this was my first experience completing narrative analysis.

In terms of my personal experience of the COVID-19 pandemic, I was considered a key worker as I was working in the NHS. I experienced the benefits that were offered to NHS staff during the pandemic, such as skipping queues at supermarkets. I have been COVID-positive on three occasions but did not experience any long-lasting physical issues. None of my relatives or friends were affected by COVID in any long-term capacity. I also was keen to be vaccinated against COVID and remain fully vaccinated, although I believe this should be an individual's choice and not affect their right to work.

My interest in this topic stems from my own experience of being a key worker in a clinical setting during the pandemic. I am curious about staff experience of the pandemic generally. I am particularly interested in care home staff as I believe they experienced many challenges during the pandemic as well as being under-researched in comparison to other frontline staff. I have never worked in a care home although I have visited residential care homes as part of my placements during my

training in clinical psychology. I have one relative who currently lives in a care home and has a diagnosis of dementia. My assumptions about care homes are likely to be influenced by wider, British cultural ideas about care homes being a normal part of the system in place to support older adults who need more care.

Results

During recruitment, 11 care home staff expressed their interest in the study and were sent a participant information sheet and consent form. Ultimately, six care home staff decided to participate in the research. The characteristics of each participant (pseudonym, gender, age, ethnicity, job role and length of time working within a care home) are detailed in Table 1. Interviews ranged from 55 minutes to 90 minutes long (average length: 75 minutes) and were conducted between September and November 2022. All interviews were recorded and transcribed verbatim.

Narrative Summaries

Each participant had a unique narrative. Table 2 summarises each participant's narrative, detailing the core narrative, themes, tone and imagery.

Table 1.

Participant Characteristics

Pseudonym	Gender	Age-range	Ethnicity	Job Title	Time Employed in a Care Home
Steve	Male	50-59	White British	Manager	30+ years
Bridget	Female	40-49	African Caribbean	Registered Manager	19+ years
Padma	Female	30-39	Sri Lankan	Training Administrator	10 months
Grace	Female	40-49	African	Team Leader	7 years
Harriet	Female	50-59	White British	Manager	15 years
Jessica	Female	40-49	White British	Manager	8 years

Table 2.

Participant Narratives

Pseudonym	Core Narrative	Themes	Tone	Imagery
Steve	In here vs. out there	• Regulation stifling and harmful, not COVID • Scepticism of rules but abiding regardless	Paternal Protective Frustrated Torn	Masculine Strength Force
Bridget	"Getting life back in the care home"	• Relationships are essential • Care homes had to focus on the basics	Proud	Signalling Sacrifice (Cinderella)
Padma	Isolation vs. Integration	• Experience of immigrating and being new to care homes	Bright	Trapped
Grace	Pulling through and pulling together	• Staff went above and beyond their duty • Regulation was helpful and followed	Fear Joy Relieved	Religious imagery
Harriet	"Their homes had been decimated"	• Agency was taken away • No one was thinking • Opportunity was missed	Frustrated Disappointed Exasperated Concerned	Destruction Rapid movement Dehumanising
Jessica	"We mustn't bring it in"	• Guilt if testing positive • Balancing risk with quality of life • Social care doesn't matter • Personal impact	Let down Vigilant	Battle Unseen Threat

Steve

"Steve" is a white British man in his late 50s. He had been working in social care for over 30 years and is currently the manager of a care home for adults with learning disabilities. He was the manager before the pandemic began and has remained in that role since then. Steve's core narrative of the pandemic consisted of being torn between being in the care home and the outside world: 'in here' versus 'out there'. Steve felt it was acceptable to think what you like about COVID when you're outside of the care home, but you had to follow the rules when you were inside it: "I don't really care what you think about this, outside of this door. When you're in this door, these are the rules that you abide by". Steve was sceptical about some of the rules imposed during the pandemic. However, he followed them regardless and encouraged his staff to do the same: "when you're in the service you had to make sure that everyone was following the rules… no matter how daft you thought some of it was".

The difference between 'in here' versus 'out there' was highlighted again when Steve described an experience with a family member who was frustrated about having to talk to his son through a window or outside the front door. Steve described his response to the family member: "I was like 'I know. I know. And I am honestly with you. If I could step outside of this door, I'd be having the same arguments with you. But I'm in here'". Steve's tone was torn as he empathised with the relative but also acknowledged that he worked "in here" therefore he had to follow the rules.

Another key part of Steve's narrative was that COVID regulation was more stifling and harmful to the care home than COVID itself. Steve discussed the vaccine mandate, and used imagery around force as he talked about human rights being

“thrown out the window”. He also used more imagery of force, describing that some people “stood fast” against the downward pressure to have the vaccine. His speech was clipped, and his tone became angrier as Steve explained that he had no choice but to sack staff who had worked hard through the pandemic: “We had to dismiss a load of staff. Just sacked. Staff who had worked… through the pandemic, have given all but… they were exercising their right to refuse and did not want to have that vaccination. So dismissed.” This left the home with the additional problem of a shortage of staff.

Steve described the lowest point in his narrative as “hell”. They experienced an outbreak of COVID and the washing machine broke. Steve’s tone was frustrated as he recalled “screaming… ‘Can you get someone out to do our machine?!’ And they were going ‘We can’t because… you have an outbreak in the service’… I was literally going ‘Look. I have got bags and bags of shitty clothes that need to be washed! It’s a health hazard!’” This story highlighted how Steve felt the restrictions impacted the home more than COVID itself.

Overall, Steve’s narrative had a protective, paternal tone. His role as a manager meant he focused on the wellbeing of staff and summarised this with a Richard Branson quote: “My staff look after my customers, and I look after my staff”. He also used a shepherding analogy when discussing his style with staff. Steve aimed to “bring people back into the fold”. This gave a protective, paternal image. He also used masculine imagery, around physical strength and force. For example, he described himself during the pandemic as feeling like Samson: “you got your hands on the pillars and you’re trying to keep that thing up”; or fighting in a world war: “like Blitz, like Second World War…it did feel a little bit like that”.

Bridget

"Bridget" is an African-Caribbean woman in her 40s. At the time of the interview, she had worked in care homes for over 19 years and was currently employed as a registered manager at a large care home. Bridget's core narrative is described as "getting life back in the care home". Bridget used this phrase when summarising her future aims for the care home, but it also captured how the pandemic eroded relationships (or "life") in the care home.

Throughout Bridget's narrative, there was a strong theme of relationships and their importance. At the beginning of the pandemic, Bridget talked about relationships existing between residents, staff and family members and that the care home was a "vibrant place to work", and "fun" with "lots of laughter". Bridget would walk around the home to "see the residents, speak to staff", and she had time to connect with others.

At the beginning of the pandemic, the care home was "rapidly changing" and staff were "panicking". Due to the increasing time pressures, Bridget and the care home began to solely focus on the "basics". Bridget described that "the clinical team… their focus was… preserving lives". Bridget compared this to attending an accident when "your adrenaline is at its highest and nothing else matters but the people you're supporting". Staff were focused on the basics of life preservation, and this consumed all available time and effort. Bridget also narrowed her focus to basic tasks and "didn't find myself leaving my office much". She had "never-ending" paperwork that she "couldn't even accomplish that at work. I had to bring things home". She described that once she got to work her "head is down and sometimes you even forget to eat". Bridget only had time for paperwork, or "the basics" and did

not have time to foster wider connections, relationships, or “life” within the care home.

As Bridget’s narrative continued, she again used relationships to highlight how the pandemic affected the care home. As the pandemic progressed, some newer staff lacked experience in building relationships as they “started to work during the time when there was no socialization, it was all task-oriented”. When it came to residents, Bridget talked about COVID “taking away…that love, that care” and that virtual communication with relatives lacked “the touch and the feel”. Residents were “dying from depression” because “loved ones… that they’ve known for their whole life… they weren’t able to visit”.

A key image that Bridget used in her narrative was around signalling to others. Bridget needed to “shout the loudest” to get what her team and residents needed during the pandemic. She “spoke out about the feelings of the staff” on the topic of the vaccine mandate. She also talked about “flying the flag” for registered managers and trying to get others to understand the role.

At one point, when Bridget summarised how social care staff felt, she said “We were the Cinderellas”. Using Cinderella invokes an image of self-sacrifice, unappreciated hard work and unfair treatment. Bridget highlighted the disparities between NHS and social care staff: that social care staff were “dumped” with the vaccine mandate and felt “like guinea pigs”. She also talks about a lack of wider public support: “everything was about NHS. Nobody thought about social care”. She gave examples of not being able to skip queues at supermarkets and the police asking her to return home as they did not recognise her as a key worker.

When she came towards the end of her narrative about the pandemic, Bridget's tone was optimistic as she talked about the "flurry of activities" in the care home. Bridget felt "people are pretty happy" and she aimed to "regenerate a lot of the laughter". She was looking forward to a staff party so that staff could build relationships and get "to know each other individually as well as a team". Bridget discussed that she's able to take time again to forge new connections: "I'm having a… daily walk around like I used to… despite the paperwork still being there. I kinda just say, you know what, it can wait for two days." This gave a sense that there was a shift towards regenerating "life" and away from the "basics" of COVID.

Padma

"Padma" is a Sri-Lankan woman in her early 30s who had been working in care homes for 10 months. During that time, she had a number of clinical roles and worked in two care homes. At the time of the interview, she was employed as a Training Administrator.

Padma's narrative is different from other participants. She had been working in a care home for a comparatively short time and had also immigrated to the UK during the "heat of the pandemic" with her husband. Her first job in a care home began two weeks after arriving in the UK.

Padma's core narrative was around isolation and integration. These two opposing themes were both discussed in Padma's personal narrative and her reflections on the care home. Padma was "new to the country" and when she and her husband arrived, they "felt isolated". This is true in a literal sense, as Padma quarantined at home after arriving and described her disconnection and disorientation: "We had nowhere to go. We didn't even know where we were, to be

honest". As a result, she felt she and her husband "missed out on our first year's experiences" because she "didn't get much chance to explore".

The theme of isolation continued when Padma discussed the care home. Padma often used the image of being trapped and stuck to discuss the pandemic restrictions in the care home for residents: "they were just stuck between four walls". Padma also discussed a lack of integration in the care home. COVID restrictions meant that "so many people couldn't visit… they couldn't do many activities and… they couldn't integrate with society." This resulted in isolation. Staff were isolated from each other: "we had to stick to our same floor". Padma felt trapped in her first job due to immigration rules: "I was in no position to quit. I had to do it. I had no choice".

Padma found it "really, really hard for me to wrap my head around" her "unfamiliar" caring role because they "don't have care homes back at home". Padma found it "sad to see that people actually grew old to the position where their lives are in the hands of complete strangers".

Padma also talked about the experience of other "overseas recruits", who arrived in the UK alone: "they're lonely, they cry on the unit". This was exacerbated as planned team activities for staff were cancelled: "stuff to get to know each other and things like that, to make friends or whatever. Those were cancelled as well… we have a lot of international recruits. I know they found it kind of isolating during that period of time". The lack of integration between team members resulted in new team members feeling isolated.

However, Padma then secured a new role at a different care home. Padma was invited to a Christmas party by her new boss "because I was new and it'll be

nice to get to know the other staff". Her tone was bright as she discussed feeling more integrated with the team: "I really enjoyed it. We had a really good time". She talked about her own way of coping with isolation, which was to "try to put ourselves out there". She found it "very difficult" to do this as there was a "cultural difference, where we're not as outgoing". However, she talked about tourism and exploration as a method of coping with isolation and a way to integrate: "we go to central London and explore… because it's new to us".

Throughout Padma's narrative, her tone generally remained bright, and she found silver linings in most of the difficult topics she talked about. She mentioned that "the pandemic has been a blessing in some ways" as she got to travel to different countries. She also discusses lessons she has learnt: "to be grateful for what we had, the lifestyle that we had, which 99% of the time, people take for granted". Even when discussing a remaining "major challenge" such as "wearing a mask for a 12-hour shift", Padma saw the positives: "the masks not only prevented COVID, but it prevented you from other diseases… I used to get sick like constantly. If someone in the bus sneezes, I catch it, you know? So with the mask, it has really prevented that".

Grace

"Grace" is an African woman in her late 40s. At the time of the interview, she was working as a Team Leader in a residential care home for older adults and had worked in care homes for seven years.

Grace's core narrative is described as pulling through and pulling together. Grace felt she "pulled through" the pandemic, despite it being "the most scary time in my life". When Grace discussed the initial phase of the pandemic, her tone was fearful. Staff were "anxious. Anxious is an understatement". She talked about a

memory of narrowly avoiding catching COVID from a positive patient but then having to return: “You’ve done (a) test. Yes, you didn’t catch it, but then you have to go back. So you are even going into a risky situation. You can’t stay away”.

When discussing times of fear, Grace used religious language, particularly around praying. Grace gave one example of prayer being used at a time when the team was scared, and it gave a sense of connecting the team together: “I remember one of… the managers had to say, ‘Let us pray’”. Grace also used prayer when she talked about a resident becoming unwell: the team were “praying ‘God let him pull through’”. This use of prayer highlighted that the team were hoping for a residents’ recovery in a desperate time, and that they were dealing with a life-or-death situation.

Grace gave many examples of her sense of duty. Particularly during the early stages of the pandemic, Grace felt she had to “brave up”. She described having an important job and could not let down the residents: “We have to do this thing for them”. As more staff became sick with COVID, Grace continued to come in: “If you stay away, who’s gonna do it?... most staff were off. At a point, it was only me”. However, when she spoke about this, she was proud: “I worked through. I didn’t take off one day”. Grace also spoke about her manager and other staff members’ sense of duty. Grace described her manager as having “this big heart for her residents, she just cannot stay away”. Her manager would be in regular contact with the care home: “She has worked hard… you send that text 2 AM, 3 AM, she will respond back… I guess she sleeps with her phone on her pillow”.

The narrative of staff “pulling together” is discussed by Grace: “the pandemic… made the staff pull stronger… it is (a) stronger force. We can do this”.

For example, if the care home was “short of staff, just need to call one or two people and they say ‘Yes, I’m fine, I will come’’’. She felt that the team has a “sense of togetherness, oneness, you know, ‘Together we stand’’’. As COVID cases began to rise again, the sense of “pulling through” and “pulling together” as a team continued: “my manager was reassuring us and we’re listening to the news, you know, like, ‘Oh, we’ll get there again, we’ll get there again’’’.

Throughout Grace’s narrative of the pandemic, she mentioned that the team “only follow strictly what PHE recommended” and they “went by the book”. She noted the reaction from family members: “they were not very pleased, but then they were happy that their loved ones are fine, are alive”. When discussing current COVID testing protocols, Grace said that some external staff found the testing regime difficult, but Grace described this positively as the care home was “just being protective” as COVID “hits so hard on the care home”.

As Grace’s narrative moved towards 2021, she discussed the arrival of the vaccine. She discussed that some staff left, but her tone was steadfast as she explained “they had to leave, although they were good, good staff. We can’t compromise”. Her tone was more relaxed as she discussed that “gradually everybody got vaccinated. Everything went back to normal again. Oh, it’s has taken time, but it’s no more scary”.

Grace’s tone changed to joyful and thankful as she described that the care home had “pulled through”. She recalled residents going on a trip: “they go out now and they are happy. Oh my God!”. Grace described looking at the photos of the trip: “Now if you see the photos! [kisses] They love it, they love it! ...it’s nice to see them like that”. She also talked about the first resident reaching 100 years old and the

celebratory atmosphere: “and then he made hundred… we all happy, pleased he pulled through”. At the end of Grace’s narrative, along with joy, she had a more relived, thankful tone: “I’m happy I pulled through, I’m happy I went through that time and I’m telling the story”.

Harriet

“Harriet” is a white British woman in her mid-50s. She had worked in adult social care for 15 years. Throughout the pandemic and at the time of the interview, her role was a manager. Her core narrative is summarised by a phrase she used to describe the impact of COVID on care homes: “their homes had been decimated”. This was linked to imagery she often used around destruction or chaos. For example, she described the pandemic as “a disaster” and that “lives were turned upside down”. This contrasted with Harriet’s description of care homes before the pandemic as “freer”. She used imagery of rapid movement to describe the “roller coaster” of emails backtracking on initial guidance: “You will do this now. No, no. We’ve changed our mind. You’ll do this, you’ll do this. Oh no, no, we’ve changed our mind’”.

Throughout Harriet’s narrative of the pandemic, she described that people’s agency was taken away. Harriet’s own “skills and knowledge… were absolutely taken from me and I was made to feel paralyzed”. She described that “lots of things were dictated to us about how we do things”. Her tone was frustrated as she described the “utter madness” of being asked to zone care homes in the same way as hospitals: “This is people’s homes… you can’t flippin’ zone the home… it totally distresses them, disorientates them”. She also talked about family members’ agency being taken away during the pandemic. Harriet had always tried to “encourage

relatives to keep a lot of that control" of looking after their relative in the care home. Harriet described this relationship as "really beneficial" and felt relatives are "another set of eyes that help you see things that you might not see". However, during the pandemic, "that was taken from (relatives) and… they'd already lost so much".

Harriet's tone was exasperated as her story focused on the chasm between policy makers' understanding and the reality of a care home: "So how on earth do you do it, that you meet what your local authority, your clinical commissioning group, the government are saying, but actually none of them are sitting here… with a woman of 90, sobbing her heart out outside and the husband of 92 in his bed, screaming and hitting and saying, where's my wife?". Harriet often summarized this theme as "nobody was thinking".

The lack of thinking was described by Harriet in multiple contexts. Along with the policy makers and local authority, Harriet noted that the "doctors and the nurses within the acute sectors were just exhausted". As a result, "they couldn't think. They were having lots of deaths and they just needed to get people out" of hospital. Harriet provided an explanation: "to think, would maybe cause more distress". The "pressure" of the pandemic meant staff de-humanised patients: "no one was thinking about people as individuals and people with rights… it was very much just like, 'Right. That's a body' … you know, 'This one's alive. That one's dead'".

Harriet talked about the speed of the pandemic taking away "time to grieve between deaths… before you would have been able to go to the funeral… but… it was happening so quickly". This impacted care home staff who "are really pretty

traumatized and they need a lot of support". Harriet's noted cultural differences "compounded" on care home staff trauma: "their role in a lot of their countries was, is that you must look after your older generation, no matter what. And actually what we've successfully done is we allowed a whole load of them to die". As a result, Harriet recognized that "lots of these people do have lots of trauma and that they're not coming forward with any of it". This changed staff behaviour towards residents: "people are… more short-tempered…people are more angry" and she hypothesized that "I think that you've probably got more carers who are being a bit rougher… because they're so knackered". Harriet explained the change in staff behaviour: "I would say that people still cared, but I wonder if they cared as much… because they weren't being cared for, really".

Harriet described how trauma and pressure on the care home prevented thinking. Again, she noticed that "people were… not able to think about doing anything meaningful with their residents. Not because they didn't want to. They didn't have the mental capacity to do it". To tackle this, Harriet set up some meaningful activities ("art classes and music") with residents, family members and staff and "it was the best thing we ever did and it made huge differences to people".

Although Harriet often discussed the ideas and innovations that did happen during the pandemic, overall, she felt frustrated that opportunities have been missed: "We saw what worked well. We saw what didn't work so well. We now need to change it. That takes money and that money isn't forthcoming because they're not interested". Her tone was disappointed as she reflected on staffing issues: "we've just missed the window of opportunity in my view, to get more people into the care sector" and that "the care sector could have been shown in an amazing light… if local authorities and government had given much more decision making to (care

homes)". Harriet discussed that "there's people who are making policy procedure in government all the way down, who've never stepped into a home" and that this is "wrong".

As Harriet's narrative turned towards the upcoming winter, she was concerned: "there's a bit of a worry about how an earth we're gonna get through this… winter". Harriet was also frustrated as she felt an opportunity was missed: "the pieces of work that…worked really well. If we had been doing that now for the past year, we'd be in a very different position now for winter". In contrast to Harriet's wish to have more agency during the pandemic, when talking about the future, her tone was more passive: "now I suppose we're all sitting, waiting to see what new rules and regulations will come out". This gave a sense that in some ways she still felt paralyzed.

Jessica

Jessica is a white British woman in her 40s. Throughout the pandemic, she worked as a manager of a care home. Her core narrative was summarized by a quote from her interview: "it all goes back to that fear of 'we mustn't bring it in'". Jessica discussed multiple times the fear of bringing COVID into the care home. She described that at the beginning of the pandemic, although "we all really knew it was COVID, everybody referred to it as 'it'". The imagery of an unseen threat was used throughout her narrative.

When Jessica discussed the beginning of the pandemic, she talked about "adrenaline running" and the staff feeling "'We're all gonna beat this' and 'We're all in it together'". She used imagery of battling or fighting a shared enemy: "generally morale wasn't too bad because it was everybody against COVID". However, as

Jessica discussed the progression of the pandemic beyond the early months, she continued to use imagery of battles: “it was almost easier… when COVID was in the home because we knew it was there and we were fighting it and all the rest of it. Whereas from then even till now… it’s that constant vigilance… defending your home against something unseen”. Jessica noted the courage needed to face this battle: staff were “looking after people with ‘it’… they were really courageous”.

Jessica spoke about staff becoming “tired” as they continued to be vigilant. Jessica highlighted that “a lot of my staff…really modified their lifestyle, stuck to the rules” outside of the care home. Jessica linked this to “that guilt feeling that the staff have if… they test positive”. Jessica also noticed this in herself: “I’m the manager, I shouldn’t be the one to bring it in the home” and she described being more “careful”. Jessica made it clear that her concern was “not about me getting sick. It’s about if I… get it and bring it in”. Jessica herself had a strong sense of personal responsibility as a manager. She explained that if COVID was brought into the home, she might ask herself “have I failed in keeping the home safe?”.

Jessica described staff guilt and vigilance around COVID and linked this to “the fear of being blamed all the time. That if, if we got COVID in, it was somebody’s fault”. Jessica felt the sense of blame came from both relatives and organisational bodies. Relatives questioned “why are the staff bringing it in?” In terms of organisational bodies, Jessica “worried about…being penalized by CQC”. She gave an example that “there was a big list published with care homes and how many people they lost”, highlighting how CQC publicly named and shamed care homes.

Jessica's tone was "let down" when she described her disappointment with "those who are meant to be supporting the care home". This theme was summarised as "social care doesn't really matter" and this ran throughout Jessica's narrative. In the early months of the pandemic, Jessica described "arguing with public health" about lack of testing. She recalled an incident when there was a discrepancy between what was being said in the media, versus the reality in the care home: "I'm on the phone to public health and I'm saying to them, 'But that lady on the television… has just stood there and said you're testing people from care homes, but you're not giving me any tests'". She felt that "someone is lying" and that PHE were "not being straight with people". When discussing the vaccine mandate, Jessica described social care as being the "poor relation" in comparison to the NHS: "when it was gonna happen in the NHS and they were going to lose staff all of a sudden it became more important to keep the staff… it was all right for us to have to cope". She discussed that "we don't really matter in terms of support needed" and that this was "unfair".

Jessica reflected that the efforts to avoid COVID coming into the care home were successful: "for a long, long time, we didn't have outbreak at all amongst the staff". The care home continued to test visitors on entry and when a person tested positive, Jessica felt that this "validates what we're doing". However, she talked about the difficulty of "how do we balance keeping people safe against, as you might say, quality of life?". Balancing risk with quality of life was a theme that arose when Jessica discussed some of the activities that the care home were able to restart but that they are "measuring everything against what is safe to do with COVID ". She talked about some relatives encouraging the care home to "keep doing what you're doing. You need to be really careful". However, other relatives were "unhappy that

we're restricting people". Jessica summed up her position on this by stating "death is a very final restriction".

Jessica talked about the lasting impact that the pandemic had on her. Just as the care home was trying to balance risk and quality of life, Jessica had to do the same in her personal life. Jessica described trying to "live life a bit more normally" but that this was a challenge. She talked about her vigilance around COVID spoiling her enjoyment of activities: "We would go out for a meal and I would find it hard to enjoy it because… my COVID antenna is up". Jessica's tone was sad as she reflected that "it's quite upsetting when you actually think… about the impact it had on had on my life and had I been in a different job, would I worry so much? Probably not".

Comparison of Narratives

The six summaries aim to provide an independent account of each participants' narrative. Despite their individuality, there are common and contradictory themes between each narrative. The first is a comparison of participants' narratives around COVID regulation, and whether it was helpful or harmful. The second looks at how participants compared social care to the NHS in their narratives.

Regulations as either Harmful or Helpful

All participants' narratives of the pandemic involved some discussion of a change in regulations and rules. The word "regulation" encompasses guidance passed down from higher regulatory bodies during the pandemic and includes changes in PPE and infection control, restriction of visitors, lockdown of homes, the vaccine mandate, COVID testing, CQC inspections and extra paperwork. All participants used changes in regulation to mark out their narrative of the pandemic in

some way. However, some participants described regulations as being important and helpful, whilst others felt it was stifling or harmful.

For example, Steve's narrative was defined by following regulations, but at the same time feeling as though they were "daft" or a "faff". He was particularly angry about the vaccine mandate as it left them with staffing issues, which was harmful rather than helpful for the home: "So then on top of working through the pandemic, we were having to manage staffing issues as well, so it's just like 'Here you go. Here's another thing.'"

Steve's quote gave a sense of being given another problem by regulatory bodies. This closely aligns with Harriet's narrative about local authority governance taking away the opportunity for innovation or adaptation within the home, leaving her feeling "paralyzed", thus regulation being more harmful than helpful. Bridget mentions being "dumped with the idea that we were the only ones that were meant to have (vaccinations)". The word "dumped" indicates that this was a problem given from the top down. Steve felt that care homes had to "close our eyes to certain abuses. By that I mean… the right to refuse and people being forced to have vaccinations, I mean that wasn't right." Harriet was also frustrated that regulation was not thought about and she could "see how we can make things different and how we can change things, but nobody really wants to listen".

However, Padma, Grace and Jessica discussed regulations as a helpful way to keep people safe. Padma discussed that masks were "one of the challenges the staff face to date" but also followed this with their importance: "the masks not only prevented COVID, but it prevented you from other diseases". Grace was more resolute about following regulations "by the book" and that the regulations were part

of the care home being "protective" of residents. For example, when Grace described lateral flow tests (LFT) for visitors she said "we have vulnerable people here…you have to do that before you come in. That's number one." Similarly, Jessica described feeling validated when a visitor's LFT came back positive. Additionally, she talked about "for a long, long time, we didn't have an outbreak at all amongst the staff" and put this down to staff being careful outside of work. These themes amongst the narratives indicate that Padma, Grace, and Jessica felt following regulations had ultimately been helpful during the pandemic.

Whether regulation was helpful or harmful also resulted in similar connected themes in participants' narratives. For example, Jessica and Grace both described regulations as helpful for protecting themselves and others, but both focused on issues around a lack of supplies at the beginning of the pandemic. Jessica described feeling "so let down" at the lack of testing, and angry that this is different from what was being promised on TV: "I've had the call back from PHE and they're saying 'No' to testing. But 10 minutes earlier, someone else on the TV's promised it. It's such lies." Grace's early narrative also stressed her concern about the lack of PPE "There was nothing! Nothing! No PPE. Nothing!".

Comparison of Social Care with NHS

All participants discussed that care home staff were not recognised enough for the work they were doing, and five directly compared social care to the NHS in some way. Padma was the only participant not to compare social care to the NHS, potentially because she was not in the UK at the beginning of the pandemic. Other participants noticed the treatment and recognition that the NHS was receiving in the

early stages of the first lockdown. For example, Grace, Bridget and Steve talked about NHS receiving preferential treatment at supermarkets:

> "if you was an NHS worker, you got priority in supermarkets, you had times that you could go in. That wasn't for care homes. Care homes didn't get priority." (Steve)

> "…the queues whereby an NHS staff could show their ID card and get past the lines, my staff weren't allowed to do that." (Bridget)

> "…you go to supermarket, you see NHS staff are given preferential treatment to do shopping first…. I remember going to Morrisons and (they) say 'Ohh no, but it's NHS', I said but 'Yeah. I'm not NHS but I'm a carer as well'…the guy rolled his eyes like, 'OK come in then but you are not NHS.'" (Grace)

The lack of recognition for care home staff in the wider public was echoed by Padma, who acknowledged that care staff are not given enough recognition for the "hard job" they do. Jessica noted that "on the news… care homes are not really important". Additionally, Steve felt that the work that care staff did during the pandemic was "not really recognised". Steve and Bridget mentioned that social care was not recognised by the wider public in comparison to the NHS, particularly around the 'Clap for Carers'.

> "…you don't hear people talking about social care at all do you? You hear people talking about the NHS tonnes. People were going out and clapping for the NHS, as daft as that was… But the NHS got an awful lot of recognition, but social care didn't." (Steve)

> "During the first part of the pandemic where there were awards, clap for the NHS, it was, you know, everything was about NHS. Nobody thought about social care". (Bridget)

Jessica and Harriet made comparisons between the treatment of social care and NHS staff during the vaccine mandate. Both made it clear that social care lost staff despite concerns being raised. However, when the NHS resisted the vaccine mandate, this was taken more seriously by the government.

> "So social care had it mandated, we lost staff. And when it was gonna happen in the NHS and they were going to lose staff, all of a sudden it became more important to keep the staff. So social care doesn't really matter." (Jessica)

> "…then the government said that adult social care all had to be vaccinated, and then they changed their mind and then it went to the NHS and then the NHS all kicked up" (Harriet)

All participants highlighted that social care staff were not recognized for their hard work, but this became unfair in the context of the wider public and governmental show of support for the NHS during the pandemic. This has left a lasting sense for participants that social care is not seen as important as the NHS, or as Jessica described it "the poor relation", despite social care being a crucial part of the wider healthcare system. Jessica summarised her hopes for parity and recognition alongside the NHS:

> "I think what a lot of people want, myself included, is to be recognized as equal…we're not better than anybody else. We're not worse than anybody else…we do a difficult job like lots of other people do. But it needs to be recognized." (Jessica)

Discussion

This study explores the narratives of care home staff who worked during the COVID-19 pandemic. The analysis allowed for participants' stories to retain their individuality but also to compare shared narratives across participants. The shared narratives were (a) COVID regulations being both helpful and harmful and (b) the comparison of social care to the NHS. The results of this study will be reviewed in the context of wider theory on burnout, moral injury, occupational stigma, relationships and resilience and coping.

Burnout

In the current study, some participants discussed narratives which could align with the concept of burnout. Burnout is defined as emotional exhaustion; detachment from the role expressed as cynicism or depersonalization; and a sense of personal ineffectiveness (Maslach & Leiter, 2016). Jessica's narrative emphasised the continued and prolonged personal impact that COVID-19 had on her, which aligns with the concept of emotional exhaustion. Harriet described the lack of thinking and resulting de-humanising of patients by staff, which reflects depersonalization. Harriet also discussed feeling "paralyzed" and a lack of agency, which may reflect the concept of low personal effectiveness. Burnout has been associated with the experience of care home staff during the pandemic in existing qualitative research (Giebel et al., 2022; Gray et al., 2021; White et al., 2021). However, other participants also discussed concepts which challenged the theory that care home staff felt burnout. For example, Grace's narrative theme outlined how staff went above and beyond during the pandemic. Most participant's narrative reflected a deep sense

of pride about their work, as well as care for staff, residents and their relatives, which suggests they did not feel detached from their role or emotionally exhausted.

Conceptually, burnout may not be the best explanation for the narratives of the participants in this study for multiple reasons. Firstly, this study may not have identified many experiences of burnout as it may be less pertinent to care home staff populations. A large longitudinal survey conducted before the pandemic with 2062 UK care home staff found low burnout rates overall (Costello et al., 2019). Despite low overall rates of burnout in care home staff, they found that staff who were younger, male and spoke English as a second language, experienced higher rates of burnout. However, this study was conducted before the COVID-19 pandemic began. Care home staff have since endured increased workloads and demands since March 2020 therefore results on burnout may be considerably different. Additionally, Costello et al. (2019) did not examine how staffs' years of experience affected burnout. A meta-analysis by Brewer and Shapard (2004) found that staff age and years of experience were negatively correlated with burnout, suggesting that being older and more experienced could be protective against burnout. The majority of the current sample were managers with many years of experience. Therefore, if younger staff with less experience were interviewed, the narratives may have had stronger themes of burnout.

Furthermore, the concept of burnout has been critiqued in relation to understanding healthcare worker distress, as it highlights an individual's lack of coping and focuses on rest and relaxation as the cure (Dean et al., 2019; Vaughn et al., 2021). Additionally, burnout has become a "catch-all" term for any occupational distress, which obscures any systemic and organisational factors (Kopacz et al., 2019). The narratives in the current study reflected systemic and organisational

challenges, as care home staff felt isolated, betrayed and abandoned. These experiences may therefore align more closely with theory and research on moral injury.

Moral Injury

Participants highlighted that COVID-19 regulations were harmful for staff and residents' wellbeing. More specifically, Steve, Harriet and Padma outlined the distress caused to residents by visiting restrictions. This theme has been found in other qualitative research into care home staff experiences during the pandemic. Briggs et al. (2021) identified that although COVID-19 was seen as responsible for resident deaths, visitor restrictions were seen by staff as contributing to the rapid decline in some residents.

Participant experiences of systemic factors such as strict regulations preventing care home staff from doing what they felt was beneficial, is an example of moral injury (Griffin et al., 2019; Shay 2014). More specifically, these experiences fit with the definition of betrayal-based moral injury. Betrayal-based moral injury is the betrayal of what is right in a high-stakes situation by someone in a position of authority, whereas perpetration-based moral injury is an unethical act by an individual that results in guilt (Shay, 2014). Most participants expressed a sense of anger and frustration with COVID-19 regulations, including the vaccine mandate which was viewed as harmful leadership from local and government authorities. This theme of government and organisational betrayal has also been found in qualitative research on healthcare worker experiences of moral injury during the COVID-19 pandemic (French et al., 2022; Hegarty et al., 2022).

Additionally, Marshall et al. (2021) also found that care home managers felt deprioritised by the government and that regulations impaired their decision making.

However, some participants also found COVID-19 regulations to be helpful. Padma, Grace and Jessica explained that following regulations was important for saving lives and protecting the care home. This replicates findings from other qualitative studies, that identified that following COVID-19 guidance was used as a method to cope with the stress of the pandemic (Zhao et al., 2021). However, moral injury does still align with some of these participant's experiences. Jessica expressed that she and other staff felt responsible and guilty for catching COVID-19 and "bringing it in" and as a result causing harm, which aligns more closely with perpetration-based moral injury.

The current results align with prior research that care home staff and healthcare staff have experienced moral injury during the pandemic (Briggs et al., 2021; Laher et al., 2022). Additionally, these findings align with results from Mantri et al. (2021) who found that experiences of moral injury in healthcare workers have increased over the course of the pandemic, but burnout did not similarly increase. However, as the current study captured longitudinal narratives of the pandemic, this study adds to the existing literature by demonstrating that care home staff have experienced cumulative moral injuries. Many qualitative studies looking at care home staff experience of the pandemic had been conducted prior to the vaccine mandate, therefore may only have identified moral injuries that occurred in the first year of the pandemic (Gray et al., 2021). The current participants highlighted that the feeling of being let down and undervalued persisted after the early months of the pandemic, particularly in reference to the vaccine mandate, which could be an additional moral injury. The vaccine mandate may be particularly pertinent as a

moral injury in care home managers as it could be experienced as both a betrayal-based moral injury and a perpetration-based moral injury, given that managers had to dismiss their own staff even if they felt this decision was unnecessary. The effect of cumulative moral injuries experienced during the pandemic could impact care home staff wellbeing and retention, as cumulative moral injuries are correlated with poorer psychosocial functioning, depression, anxiety and career abandonment in healthcare workers (Borges et al., 2021; Sert-Ozen & Kalaycioglu, 2022: Wang et al., 2022). Additionally, a meta-analysis by Coimbra et al. (2024) identified a significant association between betrayal-based moral injuries and mental health difficulties in healthcare staff during the pandemic. Therefore, as the narratives identified in this study suggest that care home staff have experienced cumulative betrayal-based moral injuries, their wellbeing and mental health may have also been impacted.

Occupational Stigma

One cross-participant narrative that was identified in this study was that care home staff often compared their experience to the NHS during the pandemic. This emphasized how participants felt their work went unrecognized and unappreciated by the government, press and public. Participants in the current study recalled experiences from early in the pandemic, such as clap for the NHS as well as NHS staff being able to skip supermarket queues. This narrative was also strengthened when care home staff discussed the vaccine mandate being enforced for social care staff but not NHS staff. Care home staff feeling undervalued, abandoned, stigmatized, and blamed by wider society in comparison to healthcare or hospital staff has also been found in multiple qualitative studies conducted early in the pandemic (Gray et al., 2021; Sarabia-Cobo et al., 2020; White et al., 2021). This suggests that the feeling of social care being “the poor relation” in comparison to

NHS staff is a key part of the care home staff narrative of the pandemic and has persisted.

The narrative outlining a lack of recognition and blame that participants discussed may also be associated with long-standing occupational stigma associated with working in a care home. Aged-care work has been negatively perceived and socially devalued by healthcare staff outside of the care sector as well as by friends and family of care home staff (Clarke & Ravenswood, 2019; Manchha et al., 2022b). Care home staff also perceived their occupation to be stigmatized and that this was predictive of staff psychological distress (Manchha et al., 2022a). Therefore, the narrative identified in the current study concerning staff feeling undervalued and unrecognized in comparison to NHS during the pandemic, may reflect wider stigmatization of the care home staff role.

Isolation and Relationships

A unique narrative that participants emphasised in this study was that care homes are primarily "homes" and therefore positive relationships between staff, residents and their families were essential. This aligns with results from a prior systematic review by Bradshaw et al. (2012) which found that a "home-like environment" and connectedness with others was important for living well in a care home. Participants also emphasised the difference between care homes and hospitals. Harriet discussed that isolating residents to reduce infection may have been appropriate for hospitals but was inappropriate for care homes. Steve, Bridget and Padma described residents and families experiencing loneliness and extreme distress as a result of being disconnected from their loved ones. Concern over the effect of isolating residents has been found in existing qualitative research on care home staff

experiences of the pandemic (Briggs et al., 2021; Giebel et al., 2022; Laher et al., 2022; White et al., 2021).

The current study found that narratives of isolation extended beyond residents being isolated from loved ones. For example, PPE stopped staff from engaging in methods of connection with residents such as physical touch. Harriet discussed that the beneficial relationship between staff and family members was disrupted during the pandemic. When infection rates improved and lockdowns were lifted, participants reflected on their relationship with residents and reported experiencing pride or joy when seeing them recover or reconnect with family. This finding may be linked to prior research which indicates that providing person-centred care is associated with higher job satisfaction in care home staff (Edvardsson et al., 2011). Therefore, care home staff narratives may have focused on the impact of COVID-19 restrictions on relationships because person-centred care is a central aspect of job satisfaction for care home staff.

Another theme around isolation was how staff discussed the impact of being isolated from one another. For example, participants described working on separate floors and opportunities for staff socialising were cancelled. Padma also reflected on her experience of being new to the UK and struggling with the isolation during the lockdowns. The narrative around isolation changed when participants' discussed care homes recovering after the lockdowns. For example, Bridget's pandemic narrative was constructed around the initial disruption of relationships and regeneration after the pandemic was focused on building new connections. The finding that relationships between staff were central to care home staff narratives aligns with wider theory on the importance of cohesion and connection within care homes and healthcare teams. Team social cohesion amongst care home staff has been positively

associated with job satisfaction and resilience (Marshall et al., 2021; Öhman et al., 2017). Outside of care home staff, group cohesion has been positively correlated with nurses' intention to stay in their post (Cowden et al., 2011). This research suggests that care home staff narratives focused on the impact that COVID-19 regulations had on staff relationships because they are important for care home staff job satisfaction, staff resilience and wellbeing.

Resilience and Coping

Although the narrative themes in this study illustrate the difficulty and stress of the pandemic, the participants also described examples of resilience and coping. Parallels can be drawn between the narratives identified in this study and prior qualitative literature on care home staff coping and resilience during the pandemic. Occupational identity is a factor identified in care home staff resilience (Beattie et al., 2022; Connelly et al., 2022), and a sense of duty was found in participants' narratives to residents and their families, colleagues, and their employees. Prior research has also indicated the importance of relationships and social support as a coping mechanism used by care home staff (Beattie et al., 2022; Hung et al., 2022; Reynolds et al., 2022; Titley et al., 2022). In terms of relationships, participants in this study highlighted that their manager's support was essential during the pandemic. Leadership and management support has also been found in prior qualitative research to be an important source of resilience (Beattie et al., 2022; Connelly et al., 2022; Nuttall et al., 2021; Ree et al., 2022; Zhao et al., 2021). Furthermore, research on moral injury has found that a supportive work environment can help protect staff from moral injury (Hines et al., 2021). This may explain why some narratives had a bright and joyful tone, as those participants described being supported by their teams and managers.

Limitations

One limitation of this study is the sample of participants was homogenous in terms of job role within the care home. The original aim was to interview a variety of staff in terms of clinical, domestic, administrative and managerial staff. However, five out of six participants labelled themselves as managers and had been working for more than 7 years. There was one participant who was not a manager, but she also did not have a direct clinical role. Therefore, the results generally reflect the voices of established management in care homes, rather than all care home staff. As discussed, managers within care homes in this study described experiences that aligned with moral injury. Other care home staff, particularly those with more clinical roles, may have experienced more direct experiences of managing residents' and their families' isolation, distress, or death. Managers may have also discussed more around the difficulties of managing COVID-19 protocols and staff wellbeing, compared to other care home staff who may have different views and experiences on how the guidance and protocols affected them. Additionally, managers may be more financially stable and established in their careers than other members of staff within a care home. Only Padma discussed the isolation of staff who had recently moved to the UK to work in care homes. Recent figures suggest 40,000 care home staff were granted visas to work in the UK in 2023 (Home Office, 2023). This suggests that a considerable proportion of care home staff will be experiencing recent immigration and new careers in UK care homes: their experiences were predominantly unexplored in this study.

There are many possible explanations for why other members of staff did not wish to participate in this study including a lack of time, fear, or unwillingness to discuss the pandemic due to mental health difficulties. Another explanation could be

that the recruitment strategy used a convenience sampling method via email. Managers may be more likely to have access to digital communication methods such as email and videoconferencing software, compared to other staff. The method of recruitment also relied on managers passing on the study details to all staff. Additionally, as participants discussed, there was a sense that organizational bodies such as the government, CQC or PHE let down care homes and at times were punitive. The participants were aware that this research was being conducted by a student at UCL and this may have represented another untrustworthy organization, which may have prevented some care home staff from engaging with the research. Managers may have felt in a more powerful, secure position in their role to defend care homes compared to staff in other roles.

Future Research

Findings suggest that care home staff may have narratives that align with moral injury as a result of their experiences of the pandemic. There are some unique experiences in UK care homes, such as the vaccine mandate and treatment of care home staff in comparison to the NHS. However, as the current study was qualitative and therefore the focus was exploration of experiences, future research could investigate the prevalence of moral injury amongst a wider sample of care home staff. Additionally, the impact of these experiences on care home staff, particularly moral injury, could be researched in terms of longitudinal outcomes such as staff wellbeing and staff turnover**.**

Implications

In this study care home staff raised how policy affected their ability to work during the pandemic. They expressed a loss of trust in organizational and regulatory

bodies such as the CQC and PHE. A perception of a lack of responsibility taken by senior management or leadership for morally injurious events, is a risk factor for staff developing moral injury (Williamson et al., 2020). This can be rectified within care homes, by ensuring any potential morally injurious events are discussed openly and accountability is taken, as forgiveness and apologising can aid moral repair (Cole, 2008). Additionally, at an organisational level, devolving decision-making to a care home level could allow managers to adapt policy to best suit their own staff and residents. Any future policy making could be improved by greater involvement of care home staff, residents, and families, to ensure it is relevant and applicable to care homes. For example, in the UK, relative groups such as Rights for Residents (RfR, 2023) and the Relatives & Residents Association (R&RA, 2023) campaign for their views on care to be heard by regulatory bodies and the government. At a governmental level, the current UK-COVID Inquiry may act as a way to learn from the events of the pandemic and repair trust, if responsibility is taken and lessons are learned for the future (Rabin et al., 2023).

A further implication of this study is highlighting the effect the pandemic has had on the individual wellbeing of care home staff. The quality and safety of care provided to patients relies on a content workforce (De Lima Garcia et al., 2019). This study showed that three years after the pandemic, care homes and their staff are still managing the emotional and practical impact of this unprecedented event. Currently, there is no evidence-based treatment for moral injury (Williamson et al., 2020). However, Murray and Ehlers (2021) suggested as part of cognitive therapy for moral injury, reading others' stories of morally injurious events can help clients feel less isolated. Sharing the stories of care home staff in this study may help current staff who might be struggling with their psychological wellbeing.

A supportive work environment has been correlated with lower rates of moral injury (Hines et al., 2021). Therefore, ensuring that care home staff feel that their mental health and wellbeing is valued, particularly by senior management, and embedded into organizational culture, is crucial to heal moral injuries. One suggested method to alleviate moral distress within teams is to incorporate regular reflective practices or Schwarts rounds (Flanagan et al., 2019; Litam & Balkin, 2021; Rabin et al., 2023; Whitehead et al., 2021). Additionally, poorer social support after a morally injurious event is likely to lead to a moral injury (Williamson et al., 2020). As some participants discussed, relationship building was part of their narrative of recovery from the pandemic, therefore focusing on team cohesion and building relationships between staff, residents and relatives may buffer any future moral injuries for care home staff. As moral injury is related to job dissatisfaction and career abandonment, addressing moral injury could improve staff retention in care homes (Sert-Ozen & Kalaycioglu, 2022).

Care homes are a key part of the functioning of our wider health care system, but staff in the current study often felt like the “poor relative” in comparison to the NHS. If staff continue to feel undervalued, the current staffing crisis in care homes is unlikely to resolve (Skills for Care, 2022). Continuing staff shortages will have a detrimental impact on the quality of care that existing staff can provide to residents (Bostick et al., 2006). Social care staff are already difficult to attract and retain when other jobs such as the NHS, provide better pay and conditions (CQC, 2022). Supporting our care home staff and recognizing their contributions alongside the NHS during the pandemic is essential for a healthier and happier care home workforce moving forward.

Conclusions

In this study, care home staff talked about the challenges of enduring the entire COVID-19 pandemic. Each participant had a unique story about their time working in a care home, but the participants also shared narratives about the pandemic. They felt that their sacrifices and hard work went unrecognized, and they were repeatedly treated unfairly, in comparison to the NHS. They also talked about COVID-19 regulations being double-edged, in that regulations were helpful to protect the lives of residents, but also harmed the care homes by creating staffing issues and causing psychological harm to residents by separating them from their loved ones. The moral injuries that the participants described throughout their narratives will need to be resolved before care homes and care home staff are able to recover from the pandemic.

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Part 3: Critical Appraisal

Introduction

The following critical appraisal explores my experience of undertaking this research project. Firstly, I discuss my background and the selection of the thesis project. Then, I reflect on conducting a narrative analysis, with reference to the interview and analysis process. I expand on the findings of the empirical paper in the context of literature on post-traumatic stress disorder (PTSD) as well as how the findings have changed my own understanding of care homes and care home staff.

Background and Project Selection

Before clinical training, I worked for three years in an Increasing Access to Psychological Therapy (IAPT) Service as a Psychological Wellbeing Practitioner (PWP). When I came to begin my doctoral research, I felt more comfortable in a clinical setting rather than conducting research. My research experience involved a quantitative analysis of an existing dataset from a randomized control trial of antidepressant medication during my Masters. I also completed a qualitative piece of research as part of my undergraduate degree where I looked at the identity of ex-smokers who had moved to e-cigarettes, and I used thematic analysis as part of that project. I had experience of both quantitative and qualitative research before choosing my doctoral research, and this guided me to what project I wanted to choose. Although I did find the statistics in quantitative research quite reassuring, the clinician within me enjoyed speaking to people about their experiences and so I chose a project that would ultimately broaden my experience with qualitative methodology.

I joined the doctorate in September 2020, whilst the COVID-19 pandemic was still ongoing. When it came time to choose a project, I already felt saturated and

overloaded with discussions of COVID and was really looking forward to a time when COVID would no longer be a daily part of life, so I wondered whether a project on COVID would be too intense. However, I was interested in occupational trauma and PTSD. Therefore, conducting research with care home staff and their experiences of the pandemic seemed timely, valuable, and worthwhile.

Narrative Analysis

Interviews

As discussed, I have conducted qualitative research before with e-cigarette users, but this was my first time using narrative analysis. The topic of e-cigarette use is arguably less emotive that the experiences of care home staff during the pandemic. I was acutely aware that the research with care home staff felt more serious, and I wanted to be more sensitive as participants could potentially discuss traumatic events and/or their mental health. I naturally wanted to rely on my clinical skills to manage any participant distress, but this was conducting research interviews rather than holding a therapy session, and as a result I felt a little out of my depth. I relied on the guidance of my supervisors when thinking about how to ask questions about the experience of the pandemic, trying to draw out narratives and allow participants to tell their story as they wished. This was different from my prior experience of qualitative research, as I asked e-cigarette users a greater number of direct questions. As a result, I felt nervous entering the interviews with care home staff as I worried that participants would not have enough questions to answer. However, the interviews with care home staff turned out to be very rich, and much longer than the interviews I had conducted with e-cigarette users. Participants generally took a little time to "warm up" during the interviews, and the first question "Can you tell me

what it was like to work in a care home before the pandemic began?" often was met with quite a short response from participants. However, participants had much more to say when discussing the start of the pandemic. This could be because the arrival of the pandemic was unusual and unprecedented, therefore people may remember it well as a type of "flashbulb memory" (Brown & Kulik, 1977).

We asked questions in the interview chronologically (e.g. Can you tell me what it was like to work in a care home during the first year of the pandemic [2020]?). This was to aid participants to think about the whole pandemic and to try to capture the fluctuations across the years in the participants' narratives. However, participants often did not tell their story chronologically and would naturally jump between events as they were looking backwards in time. I wonder whether the chronological questions gave participants the incorrect impression that they needed to tell me what happened in the correct order and remember exactly when an event took place. For example, at one point during his interview, Steve asked me if he could return to discussing 2021 and I explained that he could tell his story in any way that he wanted to. I think because the questions focused on chronological time points, this potentially got in the way of participants telling their story naturally (i.e. not in perfect chronological order). If I was to conduct narrative analysis again in the future, I may consider writing the interview questions to allow the participants more flexibility and freedom to tell their narrative in any order they wish.

One potential way to resolve this issue about the chronological narrative interview and could be a future direction for research would be to examine the narratives that participants tell each other about the pandemic. Holding focus groups could be richer in terms of natural stories that care home staff share about the pandemic. Guest et al. (2017) found in a randomised trial that sensitive disclosures

were more likely to occur in focus groups than individual interviews. Coenen et al. (2012) suggested that focus groups of peers may provide an environment that encourages disclosure of sensitive topics, in comparison to the participant-interviewer relationship. However, I think in the context of care homes, individual interviews did allow participants to be more honest about their experiences. Perhaps the presence of peers in a focus group would cause care home staff to feel uncomfortable expressing their true experience of the pandemic, particularly experiences of moral injury. Describing your involvement with an act that you feel goes against your values, or being let down by managers, leaders or organizations may be difficult to do with peers of a more junior or senior position in the room.

Whilst conducting the interviews, I was reminded of the literature on narrative therapy, which emphasises that stories require an audience (Denborough, 2014; White, 2007). I was the "audience" in this study, and on reflection, I did feel that participants were responding to me as an outsider. They were aware that I came from University College London (UCL) as a researcher in the psychology field, therefore I may have represented a threatening or penalising organisation. As discussed in the paper, some participants were sceptical and had lost trust in the organisations that claimed to help them. As a result, some participants may have depicted a rosier view of the care home than reality, due to feeling worried about being penalised. For example, Bridget asked me "I just wanted to ask though, as part of this research, what are they trying to achieve with the research and where would the research be taking UCL in terms of the outcomes etc?". I also suspect that the "audience" in the participants' minds was organisational bodies such as the Care Quality Commission (CQC), the government and the general public and that this resulted in their expression of frustration and disappointment.

Analysis

The narrative analysis process was also a new skill I learned as a result of this research. Unlike the thematic analysis I have completed in the past, the narrative analysis process involved a more reflexive stance. When I conducted thematic analysis, I followed the method set out by Braun and Clarke (2006), which suggests that interpretative analysis of the data should begin to happen when developing themes after coding. However, when I was coding the transcripts of the care home staff, as part of the narrative analysis process I had to interpret narrative "tone". This involved reflection on my own interpretation of their words and their expression in a deeper way. I also re-listened to the interviews when I was coding the transcripts, to hear the way a participant had spoken about a certain experience to try to better elicit my thoughts on the tone. At this point, I drew on my experience as a clinician, as understanding what someone might be feeling whilst they describe an event is a skill I have already developed in that setting. Overall, when conducting the narrative analysis, I found I had to be much more reflexive and detailed whilst coding compared to coding a thematic analysis.

The idea of a narrative analysis is to ultimately arrive at a coherent, "plausible" summary of a participant's narrative (Crossley, 2007). I found writing the narrative summaries to be a powerful and intense process. I wrote the participant narrative summaries relatively quickly after transcribing and coding each interview as I wanted to remember the way in which a participant had spoken about an event and write a summary that reflected the tone of their interview. Again, this process involved some reflexivity, but I tried as much as possible to put myself in the shoes of the participant. I was conscious that the narratives were my interpretation of their story, and my own experiences were influencing the narratives I was writing,

particularly in terms of my clinical experience and background in psychology. My experience is working within the NHS with individuals experiencing mental health difficulties, therefore participant narratives around these topics were naturally of interest to me. As the interviews continued, I felt a sense of responsibility to do justice to their stories and capture participants' stories accurately. I felt concerned that because I was taking a spoken story and turning it into a written story, I was losing some of the inherent tone and emphasis, and that this would not translate in the way the participant had originally meant it. I feel this also came from a sense of "imposter syndrome" about feeling as though I did not understand the experience of care homes during the pandemic well enough as they are not a service I have ever worked in.

Reflexivity can be practiced at the level of researcher and data but can also be collaborative between researcher, data and participants in the form of member checking (Olmos-Vega et al., 2019). My anxieties about the narrative summaries being biased by my own experiences of the NHS and COVID-19 were reduced when I conducted some of the validity checks. When I sent the individual narrative summaries back to the participants, I felt very nervous. I did not want the participants to feel misunderstood by me, as they had already been let down many times. In total, four participants responded to their narrative summaries and that I had accurately captured their story. One participant even noted that she felt emotional reading it, therefore I felt satisfied that I had captured the emotion in her narrative well enough. Furthermore, no participant wanted to change or adapt their narrative summary. Additionally, I shared the process with a wider research team, and they also felt the narrative summary captured the participants' story and tone

well. As a result of these checks, I felt more confident that my summaries were plausible summaries of participant narratives.

If I was to conduct narrative research in the future, I would draw upon the experience I have gained from conducting this research. Specifically, due to the length of the interviews and the intensity and depth of the analysis process, conducting a narrative analysis with six participants provided enough data and richness. In the future, I would be wary of recruiting more than six participants for a narrative analysis, as this could result in an overwhelming level of data. I would carefully consider the interview schedule in terms of the order of questions, and I would consider whether a focus group or individual interviews could be more applicable. Additionally, I have learnt how important validity checks are to provide confidence and ensure that the analysis of participants' narratives are "plausible".

Overall, learning and conducting narrative analysis for the first time has been an enjoyable process. As discussed previously, thematic analysis breaks down individual participant stories into their codes and then builds back into themes that are evidenced across the data set. I felt that the narrative analysis process was ultimately a richer way to capture the experiences of individuals over a period of time, such as the pandemic.

Experiences of Post-Traumatic Stress Disorder

Throughout the research process, the research team and I discussed whether we would have any participants reporting on experiences of trauma or post-traumatic stress disorder, as this has been found in care home staff populations during the pandemic. For example, Greene et al. (2021) found that care home staff had significantly higher levels of PTSD symptoms compared to other staff in community

settings. However, it was not something we specifically set out to find in the study, and none of the participants in the study reported experiences that fit PTSD. Instead, participants' narratives were more closely aligned to the theory around moral injury. There may be an explanation for why participants did not recount any experiences of PTSD.

PTSD and moral injury are both potential outcomes after a traumatic event. Existing literature on trauma highlights that an individual's appraisal or sense-making of a traumatic event is important in both PTSD and moral injury. An individual's appraisal of an event is theorized as a key element in the development of PTSD after a traumatic event (Ehlers & Clarke, 2000). Negative appraisals of a traumatic event have been found to be significantly correlated with PTSD symptoms (De La Cuesta et al., 2019). Furthermore, Farnsworth (2019) argued that the distinction between PTSD and moral injury is related to the appraisals of the event. In PTSD, the appraisals are descriptive of the event itself, or "what is". In moral injury, the appraisals are prescriptive, in that they are about the moral meaning of the event and the culpability of the self or others, or "what ought to have happened". The participants' narratives often focused much more on what ought to have happened and who was ultimately responsible for failings throughout the pandemic.

One explanation for why I found experiences of moral injury instead of PTSD could be that I interviewed managers, who may have fewer experiences of direct care for residents. Staff who have less experience of directly caring for residents may have lower exposure to traumatic experiences that could result in PTSD. Additionally, managers may have more experiences of moral injury, as care home managers had no choice but to follow guidance as well as encourage staff to follow too, even if they felt this to be ultimately harmful to residents and/or staff.

My Perspective of Care Homes

Narrative therapy discusses the idea of the "outsider witness practice" where an outsider, typically with lived experience of a difficulty, will join a patient and therapist in therapy and listen to, or "witness" the patient's story. In the typical format, the outsider witness then re-tells the story they have heard (White, 2007). This is done to "deal with the problems of invisibility and marginality; they are strategies that provide opportunities for being seen and in one's own terms, garnering witnesses to one's worth, vitality, and being" (Myerhoff, 1986, p. 267). As discussed, care home staff feel invisible and marginalised by the government and the public in comparison to their NHS colleagues.

Through the process of interviewing, analysing and creating narrative syntheses for care home staff experiences of the COVID-19 pandemic, I feel aligned with the position of an outsider witness, although as discussed, I have no experience of working in a care home myself. White (2007) emphasises that outsider witnesses do not only re-tell the story but outsider witnesses express what they might have been drawn to in an individual's story, what resonated, what was evoked emotionally, or how the outsider witness has been changed by witnessing of the story. As I have already created the narrative syntheses for care home staff, I feel I have already re-told their stories from my perspective. However, I have not yet elaborated on how the stories of care home staff changed me.

Before I carried out this project, I did not think of care home staff often, and being an NHS member of staff, I was much more aware of the challenges that NHS staff faced during the pandemic. Care homes felt "far away" in a temporal sense as I do not have to think about them as a place for myself or my immediate family. I also

was not very aware of how care homes had experienced the pandemic, apart from perhaps being aware of resident isolation via photos published of residents and family members speaking through care home windows. As a result of conducting this research, care homes are much more in my focus. I have become much more aware of the unfair treatment that care homes received during the pandemic, compared to my own experience as an NHS member of staff. I have also been very moved by the commitment, passion and joy that care home staff expressed about their roles and their residents. I was not expecting participants to describe care homes as "fun" or "lively" places, but they did and described the richness of their relationships with residents, families, and colleagues. I now have a better understanding that a good care home is much more than a clinical service, but more similar to a home where residents and staff have the potential to flourish. As a result, I feel a greater sadness and anger when I think of the current climate that care homes face, in terms of the continued lack of social care funding and potential ongoing staffing issues. These issues could erode the quality of care that care home staff strive so hard to provide. As a result, I am more concerned about what the future holds for our care homes. I have found myself already talking about the results of this study with others, describing how care home staff have been affected and what needs to be done to support them. Overall, I feel this research has changed my own understanding of care homes, care home staff and the challenges they continue to face.

Conclusions

Conducting this thesis has been challenging but I am glad I chose such a valuable and worthwhile topic. I have built on my experience of conducting research, particularly gaining an understanding of conducting thematic synthesis and narrative

analysis. I have learnt broadly about how staff have been affected by the chronic stress of the pandemic. Finally, I have gained a greater understanding and appreciation of care homes and care homes staff.

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Appendix 1

Full Search Terms

OVID: Embase

exp coping behavior/
OR
psychological adjustment/
OR
psychological resilience/
OR
social adaptation/
OR
("post-traumatic growth" or "posttraumatic growth" or "stress-related growth").tw,kw.
OR
(positiv* adj1 (adapt* or adjust*)).tw,kw.
OR
(psychol* adj1 (adapt* or adjust*)).tw,kw.
OR
(resilien* or hardiness*).tw,kw.
OR
(cope or coping).tw,kw.
OR
((withstand* or overcom* or resist* or recover* or thriv* or adapt* or adjust* or bounc* back) adj5 (stress* or trauma* or advers*)).tw,kw.

AND

exp health care personnel/
(health* adj3 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
OR
(medical adj3 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
OR
(clinical adj2 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
OR
(care adj2 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
OR
(NHS adj2 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
OR
(doctor* or physician* or general practitioner* or (primary care adj2 practitioner*) or surgeon*).tw,kw.
OR
(nurse*1 or nursing).tw,kw.
OR
((hospital or ambulance) adj1 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
OR
(allied health* adj2 (personnel* or profession* or worker* or practitioner* or

provider* or staff)).tw,kw.
(psychologist* or psychotherapist* or psychiatrist* or mental health clinician* or mental health profession* or mental health worker*).tw,kw.
OR
(paramedic* or medic*).tw,kw.
OR
((first or emergency) adj1 (response or responder*)).tw,kw.
OR
(professional adj (caregiver* or care-giver*)).tw,kw.
OR
(physical therapist* or physiotherapist* or occupational therapist* or recreational therapist* or music therapist* or art therapist* or dietitian* or nutritionist* or ((speech and language) adj1 therapist*) or speech pathologist* or audiologist* or exercise physiologist* or osteopath* or sonographer* or radiographer* or radiotherapist* or ((radiology or radiation) adj1 (therapist* or technician* or technologist* or assistant* or scientist*)) or respiratory therapist* or ((anesthesia or anesthesiologist) adj1 (technician* or assistant*)) or dental hygienist* or (surgical adj1 (technician* or technologist*)) or orthotist* or orthoptist* or podiatrist* or perfusionist*).tw,kw.
OR
counsel?or*.tw,kw.
OR
((nursing or medical or premedical or paramedic or psychology or physical therapy or occupational therapy) adj2 student*).tw,kw.
OR
((nurs* adj1 graduate*) or (nurs* adj1 education) or (medic* adj1 train*)).tw,kw.

AND

exp coronavirus disease 2019/
OR
(2019 nCoV or 2019nCoV or 2019-novel CoV).tw,kw.
OR
(coronavir* or corona virus*).tw,kw.
OR
COVID 19.tw,kw.
OR
(COVID19 or COVID 2019).tw,kw.
OR
(nCov 2019 or nCov 19).tw,kw.
OR
(“SARS-CoV-2” or “SARS-CoV2” or SARSCoV2 or “SARSCoV-2”).tw,kw.

AND

exp qualitative research/
OR
exp interview/
OR

(qualitative or interview* or “thematic analysis” or “narrative analysis” or “grounded theory” or “interpretative phenomenological analysis” or “mixed method*”).tw,kw.

OVID: Emcare (1995 to present)

exp coping behavior/
OR
psychological adjustment/
OR
psychological resilience/
OR
social adaptation/
OR
(“post-traumatic growth” or “posttraumatic growth” or “stress-related growth”).tw,kw.
OR
(positiv* adj1 (adapt* or adjust*)).tw,kw.
OR
(psychol* adj1 (adapt* or adjust*)).tw,kw.
OR
(resilien* or hardiness*).tw,kw.
OR
(cope or coping).tw,kw.
OR
((withstand* or overcom* or resist* or recover* or thriv* or adapt* or adjust* or bounc* back) adj5 (stress* or trauma* or advers*)).tw,kw.

AND

exp health care personnel/
OR
(health* adj3 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
OR
(medical adj3 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
OR
(clinical adj2 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
OR
(care adj2 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
OR
(NHS adj2 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
OR
(doctor* or physician* or general practitioner* or (primary care adj2 practitioner*) or surgeon*).tw,kw.
OR
(nurse*1 or nursing).tw,kw.

OR
((hospital or ambulance) adj1 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
OR
(allied health* adj2 (personnel* or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
(psychologist* or psychotherapist* or psychiatrist* or mental health clinician* or mental health profession* or mental health worker*).tw,kw.
OR
(paramedic* or medic*).tw,kw.
OR
((first or emergency) adj1 (response or responder*)).tw,kw.
OR
(professional adj (caregiver* or care-giver*)).tw,kw.
OR
(physical therapist* or physiotherapist* or occupational therapist* or recreational therapist* or music therapist* or art therapist* or dietitian* or nutritionist* or ((speech and language) adj1 therapist*) or speech pathologist* or audiologist* or exercise physiologist* or osteopath* or sonographer* or radiographer* or radiotherapist* or ((radiology or radiation) adj1 (therapist* or technician* or technologist* or assistant* or scientist*)) or respiratory therapist* or ((anesthesia or anesthesiologist) adj1 (technician* or assistant*)) or dental hygienist* or (surgical adj1 (technician* or technologist*)) or orthotist* or orthoptist* or podiatrist* or perfusionist*).tw,kw.
OR
counsel?or*.tw,kw.
OR
((nursing or medical or premedical or paramedic or psychology or physical therapy or occupational therapy) adj2 student*).tw,kw.
OR
((nurs* adj1 graduate*) or (nurs* adj1 education) or (medic* adj1 train*)).tw,kw.

AND

exp coronavirus disease 2019/
OR
(2019 nCoV or 2019nCoV or 2019-novel CoV).tw,kw.
OR
(coronavir* or corona virus*).tw,kw.
OR
COVID 19.tw,kw.
OR
(COVID19 or COVID 2019).tw,kw.
OR
(nCov 2019 or nCov 19).tw,kw.
OR
(“SARS-CoV-2” or “SARS-CoV2” or SARSCoV2 or “SARSCoV-2”).tw,kw.

AND

exp qualitative research/
OR
exp interview/
OR
(qualitative or interview* or “thematic analysis” or “narrative analysis” or “grounded theory” or “interpretative phenomenological analysis” or “mixed method*”).tw,kw.

OVID: MEDLINE(R) ALL (1946 to January 10, 2023)

Resilience, Psychological/
OR
Social Adjustment/
OR
Adaptation, Psychological/
OR
Posttraumatic Growth, Psychological/
OR
Emotional Adjustment/
OR
(post-traumatic growth or posttraumatic growth or stress-related growth).tw,kf.
OR
(positiv* adj1 (adapt* or adjust*)).tw,kf.
OR
(psychol* adj1 (adapt* or adjust*)).tw,kf.
OR
(resilien* or hardiness*).tw,kf.
OR
(cope or coping).tw,kf.
OR
((withstand* or overcom* or resist* or recover* or thriv* or adapt* or adjust* or bounc* back) adj5 (stress* or trauma* or adversit*)).tw,kf.

AND

exp Health personnel/
OR
(health* adj3 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kf.
OR
((medical care adj3 (personnel or profession* or worker* or practitioner* or provider* or staff)) or (medical adj3 (personnel or profession* or worker* or practitioner* or provider* or staff))).tw,kf.
OR
(care adj1 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kf.
OR
(“care home” adj1 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kf.
OR
(doctor* or physician* or general practitioner* or (primary care adj2 practitioner*)

or surgeon*).tw,kf.
(nurse* or (nursing adj3 assistant*) or (nursing adj3 staff)).tw,kf.
OR
((hospital or ambulance) adj1 personnel).tw,kf.
OR
((intensive adj2 care) or ICU or (intensive adj2 care adj2 unit adj3 personnel*)).tw,kf.
OR
((allied health*) adj2 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kf.
OR
(psychologist* or psychotherapist* or psychiatrist* or (mental health adj2 clinician*) or (mental health adj2 profession*) or (mental health adj2 worker*)).tw,kf.
OR
(paramedic* or ambulance or medic* or ((first or emergency or disaster) adj1 (response or responder*))).tw,kf.
(professional adj1 (caregiver* or care-giver*)).tw,kf.
OR
((physical therapist*) or physiotherapist* or occupational therapist* or recreational therapist* or music therapist* or art therapist* or dietitian* or nutritionist* or ((speech and language) adj1 therapist*) or speech pathologist* or audiologist* or exercise physiologist* or osteopath* or sonographer* or radiographer* or radiotherapist* or ((radiology or radiation) adj1 (therapist* or technician* or technologist* or assistant* or scientist*)) or respiratory therapist* or ((anesthesia or anesthesiologist) adj1 (technician* or assistant*)) or dental hygienist* or (surgical adj1 (technician* or technologist*)) or orthotist* or orthoptist* or podiatrist* or perfusionist*).tw,kf.
OR
counsel?or*.tw,kf.
OR
((nursing or medical or premedical or paramedic or psychology or physical therapy or occupational therapy) adj2 student*).tw,kf.
OR
((nurs* adj1 (graduate* or education)) or (medic* adj1 train*) or (student adj1 nurse*)).tw,kf.
OR
(clinical adj2 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.
OR
(NHS adj2 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw,kw.

AND

exp Coronavirus/
OR
exp Coronavirus Infection/
OR
(2019 nCoV or 2019nCoV or 2019-novel CoV).tw,kf.
OR

(Coronavir* or corona virus*).tw,kf.
OR
COVID 19.tw,kf
OR
(COVID19 or COVID 2019).tw,kf.
OR
(nCov 2019 or nCov 19).tw,kf.
OR
("SARS-CoV-2" or "SARS-CoV2" or SARSCoV2 or "SARSCoV-2").tw,kf.
OR
exp COVID-19/

AND

exp qualitative research/
OR
exp interview/
OR
Interviews as Topic/
OR
grounded theory/
OR
(qualitative or interview* or "thematic analysis" or "narrative analysis" or "grounded theory" or "interpretative phenomenological analysis" or "mixed method*").tw,kf

OVID: PsycInfo (1806 to January Week 2 2023)

"resilience (psychological)"/
OR
"adaptability (personality)"/
OR
emotional adjustment/
OR
coping behavior/
OR
posttraumatic growth/
OR
protective factors/
OR
emotional processing/
OR
psychological endurance/
OR
(post-traumatic growth or posttraumatic growth or stress-related growth).tw.
OR
(positiv* adj1 (adapt* or adjust*)).tw.
OR
(psychol* adj1 (adapt* or adjust*)).tw.

OR
(resilien* or hardiness*).tw.
OR
(cope or coping).tw.
OR
((withstand* or overcom* or resist* or recover* or thriv* or adapt* or adjust* or bounc* back) adj3 (stress* or trauma* or advers*)).tw.

AND

exp health personnel/
OR
exp therapists/
OR
exp clinicians/
OR
exp counselors/
OR
home care personnel/
OR
rescue workers/
OR
(health* adj3 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw.
OR
(medical adj3 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw.
OR
(care adj1 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw.
OR
("care home" adj1 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw.
OR
(NHS adj1 (personnel or profession* or worker* or practitioner* or provider* or staff)).tw.
OR
(doctor* or physician* or general practitioner* or (primary care adj2 practitioner*) or surgeon*).tw.
OR
(nurse*1 or nursing).tw.
OR
((hospital or ambulance) adj1 personnel).tw.
OR
((intensive adj2 care) or ICU).tw.
OR
(allied health* adj2 (personnel* or profession* or worker* or practitioner* or provider* or staff)).tw.

OR
(psychologist* or psychotherapist* or psychiatrist* or mental health clinician* or mental health profession* or mental health worker*).tw.
OR
(paramedic* or ambulance or medic*).tw.
OR
((first or emergency or disaster) adj1 (response or responder*)).tw.
OR
(professional adj (carer* or caregiver* or care-giver*)).tw.
OR
(physical therapist* or physiotherapist* or occupational therapist* or recreational therapist* or music therapist* or art therapist* or dietitian* or nutritionist* or ((speech and language) adj1 therapist*) or speech pathologist* or audiologist* or exercise physiologist* or midwi?e* or osteopath* or sonographer* or radiographer* or radiotherapist* or ((radiology or radiation) adj1 (therapist* or technician* or technologist* or assistant* or scientist*)) or respiratory therapist* or ((anesthesia or anesthesiologist) adj1 (technician* or assistant*)) or dental hygienist* or (surgical adj1 (technician* or technologist*)) or orthotist* or orthoptist* or podiatrist* or perfusionist*).tw.
OR
counsel?or*.tw.
OR
(clinical adj1 (technician* or technologist* or assistant* or scientist*)).tw.
OR
((nursing or medical or premedical or paramedic or psychology or physical therapy or occupational therapy) adj2 student*).tw.
OR
((nursing or medical or midwifery or premedical or paramedic or psychology or physical therapy or occupational therapy) adj2 student*).tw.
OR
((nurs* adj1 graduate*) or (nurs* adj1 education) or (medic* adj1 train*)).tw.

AND

exp COVID-19/
OR
(2019 nCoV or 2019nCoV or 2019-novel CoV).tw,
OR
(Coronavir* or corona virus*).tw
OR
COVID 19.tw.
OR
(COVID19 or COVID 2019).tw.
OR
(nCov 2019 or nCov 19).tw,
OR
(“SARS-CoV-2” or “SARS-CoV2” or SARSCoV2 or “SARSCoV-2”).tw,

AND

exp qualitative methods/
OR
interviews/
OR
(qualitative or interview* or “thematic analysis” or “narrative analysis” or “grounded theory” or “interpretative phenomenological analysis” or “mixed method*”).tw,

Web of Science

TS=(resilien* or hardiness*)
OR
TS=(“post traumatic growth” or “posttraumatic growth” or “stress related growth”)
OR
TS=(positiv* near/1 (adapt* or adjust*))
OR
TS=(psychol* near/1 (adapt* or adjust*))
OR
TS= ((withstand* or overcom* or resist* or recover* or thriv* or adapt* or adjust* or “bounc* back”) near/1 (stress* or trauma* or advers*))

AND

TS=((nursing or medical or premedical or paramedic or psychology or “physical therapy” or “occupational therapy”) NEAR/2 student*)
OR
TS=(counsellor* or counselor*)
OR
TS=(anesthetist* or anaesthetist* or audiologist* or “dental hygienist*” or dentist* or dietitian* or “midwi*e*” or nutritionist* or pathologist* or physiologist* or physiotherapist* or therapist or osteopath* or sonographer* or radiographer* or radiotherapist* or ((radiology or radiation) NEAR/1 (technician* or technologist* or assistant* or scientist*)) or ((anesthesia or anesthesiologist) NEAR/1 (technician* or assistant*)) or (surgical NEAR/1 (technician* or technologist*)) or orthotist* or orthoptist* or podiatrist* or perfusionist*)
OR
TS=(professional NEAR/1 (caregiver* or care-giver*))
OR
TS=((first or emergency or disaster) NEAR/1 (response or responder*))
OR
TS=(paramedic* or para-medic* or ambulance)
OR
TS=(psychologist* or psychotherapist* or psychiatrist* or “mental health clinician*” or “mental health profession*” or “mental health worker*” or “social worker*”)
OR
TS= (“allied health*” NEAR/2 (personnel* or profession* or worker* or practitioner* or provider* or staff))
OR
TS=((intensive NEAR/2 care) or ICU)

OR
TS=((hospital or ambulance) NEAR/1 (staff or personnel))
OR
TS=(nurse* or nursing)
OR
TS=(doctor* or physician* or general practitioner* or (“primary care” NEAR/2 practitioner*) or surgeon*)
OR
TS=(care* NEAR/1 (personnel or profession* or worker* or practitioner* or provider* or staff))
OR
TS = (NHS NEAR/1 (personnel or profession* or worker* or practitioner* or provider* or staff))
OR
TS=(medical NEAR/3 (personnel or profession* or worker* or practitioner* or provider* or staff))
OR
TS=(health* NEAR/3 (personnel or profession* or worker* or practitioner* or provider* or staff))

AND

TS=(2019 nCoV or 2019nCoV or 2019-novel CoV)
OR
TS=(Coronavir* or corona virus*)
OR
TS= COVID 19
OR
TS= (COVID19 or COVID 2019)
OR
TS= (nCov 2019 or nCov 19)
OR
TS= (“SARS-CoV-2” or “SARS-CoV2” or SARSCoV2 or “SARSCoV-2”)

AND

TS=(qualitative or interview* or “thematic analysis” or “narrative analysis” or “grounded theory” or “interpretative phenomenological analysis” or “mixed method*”)

CINAHL Plus

(MH “Hardiness”)
OR
(MH “Social Adjustment”)
OR
(MH+ “Adaptation, Psychological”)
OR
(MH “Coping”)

OR
TI (“posttraumatic growth” OR “posttraumatic growth” OR “stress-related growth”) OR AB (“posttraumatic growth” OR “posttraumatic growth” OR “stress-related growth”)
OR
TI (positiv* N1 (adapt* OR adjust*)) OR AB (positiv* N1 (adapt* OR adjust*))
OR
TI (psychol* N1 (adapt* OR adjust*)) OR AB (psychol* N1 (adapt* OR adjust*))
OR
TI (resilien* OR hardiness*) OR AB (resilien* OR hardiness*)
OR
TI (cope OR coping) OR AB (cope OR coping)
OR
TI ((withstand* OR overcom* OR resist* OR recover* OR thriv* OR adapt* OR adjust* OR “bounc* back”) N5 (stress* OR trauma* OR adversit*)) OR AB ((withstand* OR overcom* OR resist* OR recover* OR thriv* OR adapt* OR adjust* OR “bounc* back”) N5 (stress* OR trauma* OR adversit*))

AND

(MH+ “Health Personnel”)
OR
TI (health* N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff)) OR AB (health* N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff)) OR SU (health* N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff))
OR
TI (“medical care” N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff*)) OR AB (“medical care” N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff*)) OR SU (“medical care” N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff*)) OR TI (medical N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff*)) OR AB (medical N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff*)) OR SU (medical N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff*))
OR
TI (care N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff*)) OR AB (care N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff*)) OR SU (care N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff*))
OR
TI (doctor* OR physician* OR “general practitioner” OR (“primary care” N2 practitioner*) OR surgeon*) OR AB (doctor* OR physician* OR “general practitioner” OR (“primary care” N2 practitioner*) or surgeon*) OR SU (doctor* OR physician* OR “general practitioner” OR (“primary care” N2 practitioner*) or surgeon*)
TI (nurse* OR (nursing N1 assistant*) OR (nursing N1 staff)) OR AB (nurse* OR (nursing N1 assistant*) OR (nursing N1 staff)) OR SU (nurse* OR (nursing N1 assistant*) OR (nursing N1 staff))

OR
TI nursing OR AB nursing OR SU nursing

TI ((hospital OR ambulance) N1 personnel) OR AB ((hospital OR ambulance) N1 personnel) OR SU ((hospital OR ambulance) N1 personnel)
OR
TI ((intensive N1 care) OR ICU OR (intensive N1 care N1 unit N1 personnel*)) OR AB ((intensive N1 care) OR ICU OR (intensive N1 care N1 unit N1 personnel*)) OR SU ((intensive N1 care) OR ICU OR (intensive N1 care N1 unit N1 personnel*))
OR
TI ((allied N1 health) N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff)) OR AB ((allied N1 health) N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff)) OR SU ((allied N1 health) N1 (personnel OR profession* OR worker* OR practitioner* OR provider* OR staff))
TI (psychologist* OR psychotherapist* OR "mental health clinician*" OR "mental health profession*" OR "mental health worker*") OR AB (psychologist* OR psychotherapist* OR "mental health clinician*" OR "mental health profession*" OR "mental health worker*") OR SU (psychologist* OR psychotherapist* OR "mental health clinician*" OR "mental health profession*" OR "mental health worker*")
OR
TI (paramedic* OR ambulance OR medic* OR ((first OR emergency OR disaster) N1 responder*)) OR AB (paramedic* OR ambulance OR medic* OR ((first OR emergency OR disaster) N1 responder*)) OR SU (paramedic* OR ambulance OR medic* OR ((first OR emergency OR disaster) N1 responder*))
OR
TI (professional N1 caregiver*) OR AB (professional N1 caregiver*) OR SU (professional N1 caregiver*)
OR
TI ((physical N1 therapist*) OR physiotherapist* OR (occupational N1 therapist*) OR (recreational N1 therapist*) OR (music N1 therapist*) OR (art N1 therapist*) OR dietitian* OR nutritionist* OR ((speech and language) N1 therapist*) OR (speech N1 pathologist*) OR audiologist* OR (exercise N1 physiologist*) OR osteopath* OR (sonographer* OR radiographer* OR radiotherapist*) OR ((radiology OR radiation) N1 (therapist* OR technician* OR technologist* OR assistant* OR scientist*)) OR (respiratory N1 therapist*) OR ((anesthesia OR anesthesiologist) N1 (technician* OR assistant*)) OR (dental N1 hygienist*) OR (surgical N1 (technician* OR technologist*)) OR orthotist* OR orthoptist* OR podiatrist* OR perfusionist*) OR AB ((physical N1 therapist*) OR physiotherapist* OR (occupational N1 therapist*) OR (recreational N1 therapist*) OR (music N1 therapist*) OR (art N1 therapist*) OR dietitian* OR nutritionist* OR ((speech and language) N1 therapist*) OR (speech N1 pathologist*) OR audiologist* OR (exercise N1 physiologist*) OR osteopath* OR (sonographer* OR radiographer* OR radiotherapist*) OR ((radiology OR radiation) N1 (therapist* OR technician* OR technologist* OR assistant* OR scientist*)) OR (respiratory N1 therapist*) OR ((anesthesia OR anesthesiologist) N1 (technician* OR assistant*)) OR (dental N1 hygienist*) OR (surgical N1 (technician* OR technologist*)) OR orthotist* OR orthoptist* OR podiatrist* OR perfusionist*) OR SU ((physical N1 therapist*) OR physiotherapist* OR (occupational N1 therapist*) OR (recreational N1 therapist*) OR (music N1 therapist*) OR (art N1 therapist*) OR dietitian* OR nutritionist* OR

((speech and language) N1 therapist*) OR (speech N1 pathologist*) OR audiologist* OR (exercise N1 physiologist*) OR osteopath* OR (sonographer* OR radiographer* OR radiotherapist*) OR ((radiology OR radiation) N1 (therapist* OR technician* OR technologist* OR assistant* OR scientist*)) OR (respiratory N1 therapist*) OR ((anesthesia OR anesthesiologist) N1 (technician* OR assistant*)) OR (dental N1 hygienist*) OR (surgical N1 (technician* OR technologist*)) OR orthotist* OR orthoptist* OR podiatrist* OR perfusionist*)
OR
TI counsel?or* OR AB counsel?or* OR SU counsel?or*
OR
MH+ Counselors
OR
TI ((nursing OR medical OR premedical OR paramedic OR psychology OR (physical N1 therapy) OR (occupational N1 therapy)) N1 student*) OR AB ((nursing OR medical OR premedical OR paramedic OR psychology OR (physical N1 therapy) OR (occupational N1 therapy)) N1 student*) OR SU ((nursing OR medical OR premedical OR paramedic OR psychology OR (physical N1 therapy) OR (occupational N1 therapy)) N1 student*)
OR
TI (college N1 student*) OR AB (college N1 student*) OR SU (college N1 student*)
OR
TI (nursing N1 (graduates OR education)) OR AB (nursing N1 (graduates OR education)) OR SU (nursing N1 (graduates OR education)) OR TI (medical N2 train*) OR AB (medical N2 train*) OR SU (medical N2 train*) OR TI (student N1 nurse*) OR AB (student N1 nurse*) OR SU (student N1 nurse*)

AND

(MH “COVID-19”)
OR
(MH “COVID-19 Pandemic”)
OR
(MH “SARS-CoV-2”)
OR
TI (“2019 nCoV” OR “2019nCoV” OR “2019-novel CoV”) OR AB (“2019 nCoV” OR “2019nCoV” OR “2019-novel CoV”)
OR
(Coronavir* OR “corona virus*”) OR AB (Coronavir* OR “corona virus*”)
OR
(“COVID 19” OR COVID19 OR “COVID 2019”) OR AB (“COVID 19” OR COVID19 OR “COVID 2019”)
OR
(“nCov 2019” OR “nCov 19”) OR AB (“nCov 2019” OR “nCov 19”)
OR
(“SARS-CoV-2” OR “SARS-CoV2” OR SARSCoV2 OR “SARSCoV-2”) OR AB (“SARS-CoV-2” OR “SARS-CoV2” OR SARSCoV2 OR “SARSCoV-2”)

AND

(MH “Qualitative Studies+”)

OR
(MH “Interviews+”)
OR
(MH “Thematic Analysis”)
OR
TI (qualitative or interview* or “thematic analysis” or “grounded theory” or “Interpretative Phenomenological analysis” or “mixed method” or “mixed methods”) OR AB (qualitative or interview* or “thematic analysis” or “grounded theory” or “Interpretative Phenomenological analysis” or “mixed method” or “mixed methods”)

PROQuest PTSDPub

MAINSUBJECT.EXACT(“Positive Effects”)
OR
MAINSUBJECT.EXACT(“Resilience”)
OR
MAINSUBJECT.EXACT(“Coping Behavior”)
OR
MAINSUBJECT.EXACT(“Adaptability”)
OR
(“post-traumatic growth” or “posttraumatic growth” or “stress-related growth”)
(resilien* or hardiness*)
OR
(cope or coping)
OR
((withstand* or overcom* or resist* or recover* or thriv* or adapt* or adjust* or “bounc* back”) near/1 (stress* or trauma* or advers*))

AND

MAINSUBJECT.EXACT.EXPLODE(“Medical Personnel”)
OR
MAINSUBJECT.EXACT(“Health Personnel Attitudes”)
OR
MAINSUBJECT.EXACT.EXPLODE(“Mental Health Personnel”)

((nursing or medical or premedical or paramedic or psychology or “physical therapy” or “occupational therapy”) NEAR/2 student*)
OR
(counsellor* or counselor*)
OR
(anesthetist* or anaesthetist* or audiologist* or “dental hygienist*” or dentist* or dietitian* or “midwi*e*” or nutritionist* or pathologist* or physiologist* or physiotherapist* or therapist or osteopath* or sonographer* or radiographer* or radiotherapist* or ((radiology or radiation) NEAR/1 (technician* or technologist* or assistant* or scientist*)) or ((anesthesia or anesthesiologist) NEAR/1 (technician* or assistant*)) or (surgical NEAR/1 (technician* or technologist*)) or orthotist* or orthoptist* or podiatrist* or perfusionist*)

OR
(professional NEAR/1 (caregiver* or care-giver*))
OR
((first or emergency or disaster) NEAR/1 (response or responder*))
OR
(paramedic* or para-medic* or ambulance)
OR
(psychologist* or psychotherapist* or psychiatrist* or “mental health clinician*” or “mental health profession*” or “mental health worker*” or “social worker*”)
OR
(“allied health*” NEAR/2 (personnel* or profession* or worker* or practitioner* or provider* or staff))
((intensive NEAR/2 care) or ICU)
OR
((hospital or ambulance) NEAR/1 (staff or personnel))
OR
(nurse* or nursing)
(doctor* or physician* or general practitioner* or (“primary care” NEAR/2 practitioner*) or surgeon*)
(care* NEAR/1 (personnel or profession* or worker* or practitioner* or provider* or staff))
(NHS NEAR/1 (personnel or profession* or worker* or practitioner* or provider* or staff))
(medical NEAR/3 (personnel or profession* or worker* or practitioner* or provider* or staff))
(health* NEAR/3 (personnel or profession* or worker* or practitioner* or provider* or staff))

AND

(2019 nCoV or 2019nCoV or 2019-novel CoV)
OR
(Coronavir* or corona virus*)
OR
COVID 19
OR
(COVID19 or COVID 2019)
OR
(nCov 2019 or nCov 19)
OR
(“SARS-CoV-2” or “SARS-CoV2” or SARSCoV2 or “SARSCoV-2”)

AND

(qualitative or interview* or “thematic analysis” or “narrative analysis” or “grounded theory” or “interpretative phenomenological analysis” or “mixed method*”)

Appendix 2

External Reviewer CASP (2018) Ratings

	Paper 1 (Zhao et al., 2021)			Paper 2 (Reynolds et al., 2022)		
CASP Rating	Original Rater	Second Rater	Agreement?	Original Rater	Second Rater	Agreement?
1	✓	✓	Y	✓	✓	Y
2	✓	✓	Y	✓	✓	Y
3	✓	✓	Y	✓	?	**N**
4	✓	✓	Y	✓	✓	Y
5	✓	✓	Y	✓	?	**N**
6	✓	?	**N**	✗	✗	Y
7	✓	✓	Y	✗	?	N
8	✓	✓	Y	✓	✓	Y
9	?	?	Y	✓	✓	Y
10	✓	✓	Y	✓	✓	Y

Note. Green (✓) represents "Totally Met"; Orange (?) represents "Partially Met"; Red (✗) represents "Not Met".

Overall: 20 ratings, 16 agreements, 4 disagreements = 80% agreement

Appendix 3

Ethical Approval

UCL RESEARCH ETHICS COMMITTEE
OFFICE FOR THE VICE PROVOST RESEARCH

22nd June 2022

Dr Jo Billings
UCL Division of Psychiatry

Cc: Victoria Cannon

Dear Dr Billings

Notification of Ethics Approval with Provisos
Project ID/Title: 22133/001: Stories from Care Home Staff about the COVID-19 Pandemic - A Narrative Analysis

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 **22nd 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.

[redacted]

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 4

Participant Information Sheet

RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

PARTICIPANT INFORMATION SHEET

Study Title: Stories from Care Home Staff about the COVID-19 Pandemic - A Narrative Analysis

Department: Clinical, Educational & Health Psychology

Researcher: Victoria Cannon (Trainee Clinical Psychologist) [redacted]

Principal Researcher: Dr Jo Billings [redacted]

Data Protection Officer: Alexandra Potts [redacted]

Ethical Approval Number: 22133/001

What is this study?

You are being invited to take part in a research study that aims to understand care home staff's experience of the COVID-19 pandemic.

Before you decide whether to take part, please read the information below carefully to understand the purpose of the research and what it will involve. Please contact us using the information at the end of the sheet if there is anything that is unclear. Thank you for taking the time to read this.

Why are we doing this study?

Research has shown that COVID-19 has affected the mental health of frontline healthcare staff in different ways, but there is only a small amount of research on care home staff. Our research is trying to understand the experience of care home staff during the COVID-19 pandemic, via the stories they tell about this time.

Who is invited to take part in this study?

We are inviting staff who have worked in a care home for at least six months during the COVID-19 pandemic to take part. They can be involved with caring directly for care home residents or have any other role in the care home such as admin or management. Individuals wanting to take part must also be able to speak a sufficient level of English to be able to take part in a 60 – 90 minute interview.

Do I have to take part?

No. It is your choice whether to take part in this study. If you do take part, you are free to withdraw at any time up to two weeks after the interview without giving a reason and without consequences. After two weeks, the information you have given in the interview may be difficult to remove from the other data in the research. If you decide not to take part or withdraw from the study, this will not affect your employment in any way, now or in the future.

What will I have to do if I take part?

If you are interested in taking part in the study, we invite you to email the researcher Victoria Cannon at [redacted] with any questions you might have about the research. If you are still interested, you will be sent a consent form to sign. You will be sent a copy of the signed consent form along with this information sheet to keep.

Victoria will then set up a time for an interview which takes approximately 60 – 90 minutes. This interview will be done online via a videoconferencing software. There is also an option to do an in-person interview on UCL campus. You will be asked some questions about your experience of working in a care home during the COVID-19 pandemic. An example question would be "Can you tell me what it was like to work in a care home before the pandemic began?". You have the right to refuse to answer certain questions if you wish.

Will I be recorded and how will the recording be used?

Victoria will record the conversation to ensure that your story is captured accurately. This will be audio-recordings if the interview is in person, and video recording if done online via Microsoft Teams. The recording will be turned into a written transcript by the researcher, and then the recording will be deleted as soon as it has been turned into a written transcript. We will remove any personal, identifying information (such as names or places) from the transcript of the conversation so that people reading the transcript will not be able to identify you. Written quotes from the recordings will be used in the write-up of the study to illustrate certain themes, but these will be kept anonymous.

No one outside the study will be able to access the recordings. The recordings will not be used for any other purpose unless your written permission is given.

What if I don't want to be recorded?

Unfortunately, you cannot take part in the study. We want to use transcripts of what people have said so that the study can accurately explore people's experiences. Taking notes might not accurately capture everything that was said in the interview.

Are there any risks in taking part in this study?

We feel there are no major risks in taking part in this study. Taking part in this research will potentially involve you talking about upsetting or difficult memories of the pandemic, however if you feel uncomfortable or distressed during the conversation, we can stop at any time. There will also be time after the conversation to discuss how you are feeling and how to access support if necessary. Interviews will remain confidential unless a participant reports any risks to themselves or to someone else. In this case, local safeguarding procedures would be followed, after the researcher has a discussion with the study's supervisors. This is to ensure the safety of the individuals involved.

Are there any benefits to taking part?

We hope that this research will bring attention to care home staff's experience and story of the COVID-19 pandemic, as well as the effects on care home staff's mental health and wellbeing. This may inform how best to support care home staff as well as other frontline healthcare workers.

You will be compensated for your time and paid £25 in cash or via bank transfer as a thank you for taking part after the interview has been completed.

Who is organising and funding the research?

The study is part of Victoria Cannon's Doctoral Clinical Psychology studies at University College London (UCL). The research will be sponsored and funded by UCL.

What other information about me will you collect?

We will also collect some personal information about you including your age group, gender, ethnicity, and job role. This is to help provide some background information about the individuals who took part. This information will be made anonymous – it will be attached to a code so that nobody apart from the researchers will be able to identify you from the data we keep.

What happens to the information you collect and I stay in the study?

All the information you give will be treated as confidential and stored securely (see Data Protection Privacy Notice below). Confidentiality may be limited by the researcher's duty of care to report to the relevant authorities possible harm/danger to the participant or others. We will keep your interview data for up to 5 years after the study is finished. After this time all information will be destroyed. Your personal data will be deleted after the study is completed. If you decide that you want to stop taking part in the study your information can be destroyed if requested by contacting Victoria Cannon or Jo Billings.

Who can I contact for more information?

The study researchers Victoria Cannon and Jo Billings are happy to discuss any thoughts or questions you might have. Please email at [redacted]

Data Privacy Notice

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

Your personal data will be processed as described in this information sheet. The data that will be collected includes: ethnicity, gender, age bracket, length of employment in the care home and job role within the care home. The lawful basis that will be used to process your personal data are: 'Public task' for personal data (gender, age, length of employment in care home and job role within care home) and 'Research purposes' for special category data (ethnicity).
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.

Your data will be stored in password-protected files on a secure UCL server. Your data will be labelled with a numbered code and kept in a separate from your name and contact details. Only researchers directly involved in the study have access to your name and contact details. Anonymised data may be shared with other researchers at UCL or with collaborators at other institutions, to help answer new research questions, but they will never be given your name or contact details. Once names and contact details are no longer required for the research project, they will be deleted, and all data will be fully anonymised.

If you are concerned about how your personal data is being processed, please contact UCL in the first instance at data-protection@ucl.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are

available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

How will the study findings be shared?

We will write a report of the findings of the study, and what care home staff have said. We will use written quotes of what care home staff have said during their interview, but this will not identify you in any way. We will not include your name in the report. The study results will be presented as scientific papers, published in peer reviewed journals and at conferences, as well as in student dissertations. You will not be able to be identified with any reports, publications, talks or media.

If you would like a copy of the report, please let Victoria know and one will be provided when available.

What if something goes wrong?

If you wish to raise a complaint, then please contact Jo Billings (the Principal Investigator for the study) at [redacted] you feel that your complaint has not been handled to your satisfaction, you can contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk. If something happens to you during or following your participation in the project that you think may be linked to taking part, please contact Victoria Cannon and Jo Billings.

Thank you for reading this information sheet and considering taking part in this research study.

Appendix 5

Participant Consent Form

PARTICIPANT CONSENT FORM

Study Title: Stories from Care Home Staff about the COVID-19 Pandemic - A Narrative Analysis

Department: Clinical, Educational & Health Psychology

Researcher: Victoria Cannon (Trainee Clinical Psychologist) [redacted]

Principal Researcher: Dr Jo Billings [redacted]

Data Protection Officer: Alexandra Potts [redacted]

Ethical Approval Number: 22133/001

This study is a doctoral research study at University College London.

	Please put your initials here
I confirm that I have read the participant information sheet for the above study, and I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time up to two weeks after the interview without giving any reason and without it affecting me by telling the researchers that I wish to withdraw.	
I understand that I have the choice to have either an in-person interview or an interview using videoconferencing software (Microsoft Teams)	
I understand that I do not have to answer all the questions in the interview if I do not want to.	
I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers.	

I understand that all data will be kept confidential, and that no personal identifying information will be disclosed in any reports on the project.	
I understand that what I say in my interview will remain anonymous and confidential unless a disclosure is made that could affect the safety of someone else. In this case, this information will be passed on to the relevant organisation to ensure the safety of the individuals involved.	
I agree that my interview with the researcher will be recorded (video recorded if using Microsoft Teams; audio-recorded if interviewed in person).	
I understand that quotes of things I have said during the interview may be used in reports, but I will not be able to be identified from these quotes.	
I understand that I will receive a payment of £25 for taking part in the study.	
I consent to taking part in the above study.	

Full Name: _____

Signature: _____ Date:

_____

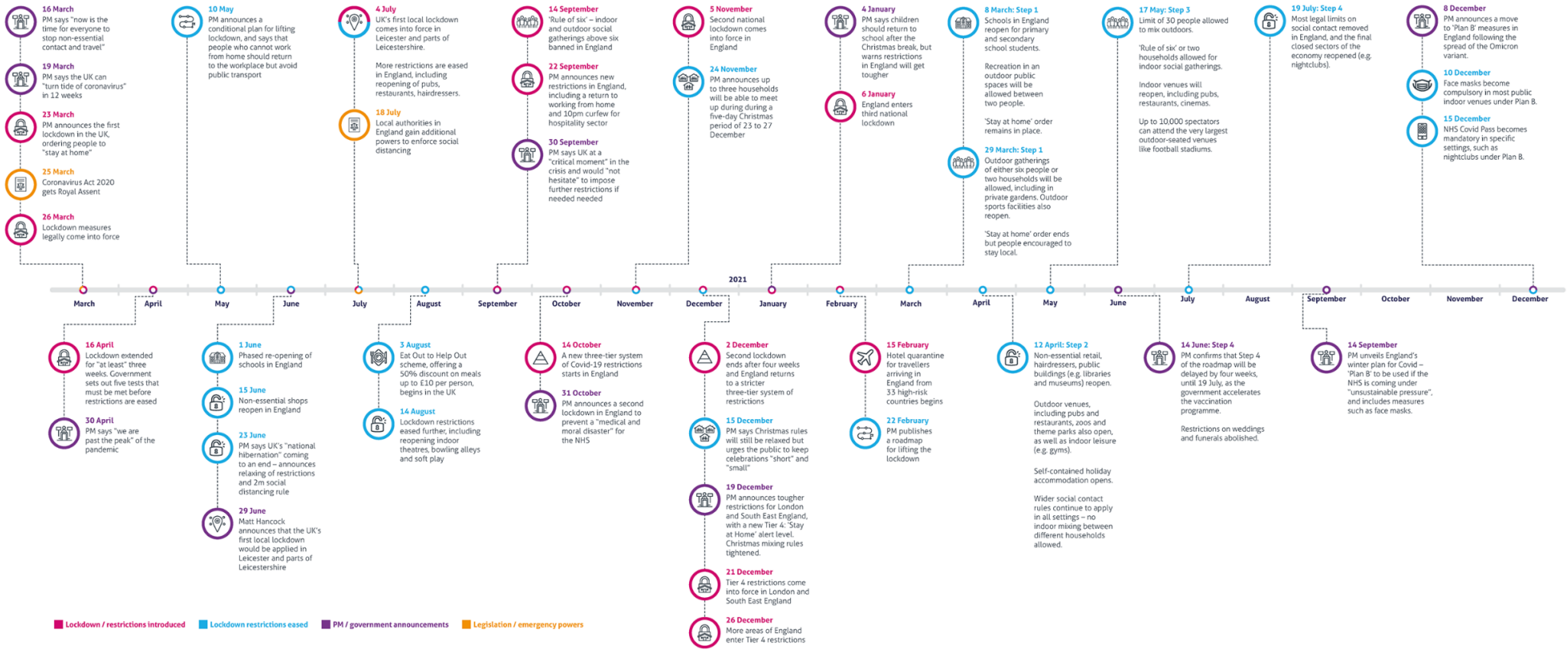
Name of Researcher: _____

Signature of Researcher: _____

Appendix 6

Timeline of COVID-19 Events

Timeline of UK government coronavirus lockdowns and measures, March 2020 to December 2021



Source: Institute for Government analysis.

Appendix 7

Interview Schedule

Interview Schedule: Stories from Care Home Staff about the COVID-19 Pandemic - A Narrative Analysis

Pre-interview demographic questions

1. What was your role in the care home during the pandemic?
2. How long have you been working in a care home?
3. What is your gender?
4. What is your ethnicity?
5. How old are you?

Interview Questions

I will be asking you some questions about your experiences of working in a care home during different points of the COVID-19 pandemic. Please feel free to look at the timeline of COVID pandemic events if you need to (see below). I am interested in any events or moments that you can remember that feel important, but feel free to answer the questions in any way you want and take as long as you need.

1. Can you tell me what it was like to work in a care home before the pandemic began?

2. Can you tell me about what it was like working at the care home when the pandemic first started?
    a. Are there any significant moments that stand out or memories you have of that time?
    b. How did you feel when that (if they mentioned a specific event) happened?
    c. Can you give me an example of (something they mentioned)?

3. Can you tell me what it was like to work in a care home during the first year of the pandemic (2020)?
    a. What about during the summer of 2020?
    b. What about leading up to the first Christmas (2020)?

4. Can you tell me what it has been like to work during the second year of the pandemic (2021)?

5. (If still working in a care home) Can you tell me what it is like to work in a care home in the last few months?
    a. How has the pandemic changed your work in the care home?

Thank you for telling me about your experiences of working in a care home during the pandemic. In the next few questions, I will be asking you to tell me about the impact of these experiences.

6. Looking back on the pandemic and the events that happened whilst you worked in a care home, how have these events impacted you personally, mentally and/or emotionally?
    a. How did you manage (to cope with) this?

7. Reflecting on the pandemic as a whole, how do you think the pandemic has affected other care home staff or residents?
    a. Can you give me an example of (something they mentioned)?
    b. Why do you think (something they mentioned) happened?

8. Is there anything you have learnt from the experience of working in a care home since the pandemic began (or the last 2 and a half years)?

<u>Ending Questions:</u>

1. How was the interview for you?

2. Is there anything you would like a chance to talk about or would like to add?

Appendix 8

Extract of Analysed Transcript

Transcript from "Steve"	Coding
P: (looking at timeline) Yeah, first lockdown. Yeah the 23rd of March, yeah first lockdown. Yeah, yeah, yeah, yeah, yeah. Yeah so, no one	
really knew what that kind of meant,	No one knew what lockdown meant.
really. [Int: Yeah] Do you know what I mean? I'm like 'Oh right OK, so what? What? What does that actually mean?' And then, and then during	What does it actually mean? Confusion around lockdown Questioning meaning
that period as well (coughs), excuse me, I think people started getting letters as well about, staff were	Letters about staying home
getting letters about them having to stay at home [Int: Yep] Cor, I can't remember what we called them now… um not isolate umm, well some staff	
were having to stay at home because they had disorders that, that that might adversely affect them [Int:	Staff isolating
Yeah] So all of a sudden, because we had a few staff, they got these	Suddenly a few staff
letters, all of a sudden we're we're in a staffing crisis, know what I	Staffing crisis (desperation)
mean. And then it was, it was quiet and because, because of all the,	Quiet
the, the stuff around hands, face, space, it was difficult, it was kind	Regulations
of difficult, sort of managing that with staff then, because everybody	Difficult managing
had different points of view on it, as we know everyone has different points of view on it, I still do have quite different points of view on it, and so managing what people (I'm talking about staff really here because the people we support were just like 'Well why are we stuck in our house? Why can't we go out? Why can't we do anything?') whereas the staff were coming in and coming out. And then we weren't, you know, we weren't allowed to have visitors and we were managing and families' expectations as well because they	Different points of view (then and now) Stuck in our house – questioning Not allowed visitors Managing expectations (of family)

were saying well 'why can't we come in? Your staff are coming in? Your staff are coming in, going home to their families and still coming into work, why can't we come in?' and trying to explain, trying to explain that was really difficult. And then, umm yeah, and then, and then also there was that balance like I say, with staff around saying 'Right, look, I don't really care what you think about this, outside of this door. When you're in this door, these are the rules that you abide by' and that was very difficult for some staff. You have the other end of the spectrum where people were really like, sort of, over the top about it, you know. Int: Mmm, yeah. Do you have any examples of that kind of incident? Any memories in particular of managing that? P: Yeah, you know, we, we we had, you know, like people who were saying 'Oh Why? Why?' You know, 'Why have we gotta do all this cleaning?' You know, 'All this cleaning why have we gotta clean every, every hour?' You know 'We're the only ones in here! We cleaned him once! You know what I mean? Why we gotta clean it again every hour? You know, Why can't we just every shift? [Int: Mmm] And, and it made sense, but we had this high risk cleaning schedule that we had to learn, you know, cleaning all the, all the handles and you know the touch spaces and stuff like that and I kind of, I kind of got what they were saying but erm, the rules as we had it that	Questioning guidance – frustration Difficult explanations Inside vs. outside Thinking vs. doing Tough on rules Over the top reactions from others Questioning why Rule challenging Agreeing with staff but following rules regardless Top down rules imposed

was fed down from the local authority and and and from the government was that we had to do what these things. So that caused a lot of friction. We had to manage that. And then you had other staff who were going 'Ooh, you know, you must do the cleaning you know, there's a pandemic going on, you know, people could die' and all this sort of stuff, You know? So it was, it was managing… At the very start, it was more… and throughout actually when I think about it, really more about managing the staff than it was managing the people we provide support for. I think another better way of putting it just some kind of got on with it, you know what I mean?, accepted the fact that their routine had changed. I mean, we did see a lot of things change with the people support, as as the time went on, a lot of people, few people became, became more withdrawn, were spending a lot of time just in their bedrooms, beds, watching telly, just wandering, walking down the hallways. [Int: Mmm]	Friction Split in staff team on importance of cleaning More about managing staff than residents Getting on with it Accepting routine change Lots of change for residents Residents withdrawn Loss of activity (Sad, lonely imagery)