8 CARING FOR OLDER ADULTS IN RESIDENTIAL LONG-TERM CARE DURING COVID-19 IN THE UNITED STATES AND SWITZERLAND

Balancing Protection and Social Isolation

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Reflections on a Cross-Cultural Experience during the Pandemic, by Megan Davies

I had been living in Switzerland for just over a year when COVID-19 lockdown procedures were introduced. On 16 March 2020, I began a journal to try to make sense of what was happening. Reading my early entries brings it all back: "Day 1: . . . Just heard Switzerland is going into a partial lockdown—everything but supermarkets and pharmacies closed. I don't know what this all means. . . No lockdown in the UK yet. They don't seem to know what's going on."

Before moving to Switzerland, I worked as a nursing assistant on an older person's medical ward in the UK, so watching the UK from afar was really hard, particularly as things were getting stricter and feeling much more serious here in Switzerland. I became obsessed with reading global news while trying to focus on work, wondering why the UK wasn't reacting in the same way as some other countries. "Day 3: The UK still doesn't seem to be getting this. They are not in any sort of lockdown yet. I wish they would take this more seriously." The UK did not impose the same level of lockdown as other countries in Europe until almost a week after Switzerland on 23 March 2020. I was already being updated by a close friend who is also a registered GP in my hometown to try to understand the situation beyond news reports. On 15 March 2020, she contacted me about the hospital I had worked at: "one person is now confirmed . . . sorry to let you know." It became harder to be away, knowing that if I was

in the UK I could help. On Day 9, I wrote: "I'm starting to feel guilty for being here and not in the UK where I could be working at the hospital." On 29 March 2020 (Day 14), an update from my friend included: "got a letter from the government asking to do more," which was sent to all NHS staff at this time. People were even being asked to come back early from maternity leave to boost staff numbers. The guilt of not being there to help was really hard to deal with.

In Switzerland, as the first wave ended, I began data collection in a care home. A week later, that care home had its first COVID-19 case among its residents. This rapidly went from bad to worse, but fortunately we were able to continue visiting the care home to observe and interview residents and staff. Different areas of the care home were sectioned off for isolation as cases spread. I began simultaneously researching global incidents of COVID-19 in care homes within my PhD work. I read about residents being abandoned, staff and residents catching COVID-19 one by one, and in the UK, care homes and the NHS functioning with skeleton staff who were working around the clock risking their health and sacrificing time with families to provide care. I could see firsthand in Switzerland how COVID-19 could rip through a care home and the impact it had on staff and residents. This care home had more staff than I was used to seeing in the UK and better resources, including PPE, which they had access to earlier in the pandemic. There were procedures in place to ensure staff would not take potentially contaminated items such as uniforms home with them. It was hard not to feel angry and upset about the situation in the UK. I felt like staff and residents were being let down. I felt like I was letting them down. While I spent my days in this care home observing residents and staff and interviewing with a research team to support me, the ward I used to work on was turned into a designated COVID ward, and my old colleagues were working tirelessly to provide care with little support.

As part of my PhD, I was originally due to begin comparative research in the UK in Autumn 2020, but this eventually began in August 2021, just after care homes in the UK had started allowing in-person visits again after more than a year of lockdown. The general population in the UK went in and out of lockdown throughout this time, but care homes were instructed to remain isolated for the duration. I didn't know what to expect going in. Part of me felt it couldn't be as bad as watching the devastation in a care home firsthand, but mostly I knew that it could be worse.

The UK care home itself had managed the last year amazingly with very little support. Unlike in Switzerland, staff in this care home had little PPE early on. Management had to source and buy what they could along with the rest of the general public. Where in Switzerland PPE while deal-

ing with COVID cases consisted of goggles, FFP2[1] masks, shoe covers, gloves, and aprons covering the full uniform, in the UK they had small polyethylene aprons, gloves, and surgical masks, some needing to be reused. In Switzerland, staff could change out of their uniform before leaving the building, which was industrially cleaned for them. In the UK, staff took their uniforms home with them to wash themselves. I was provided more protection as an observer in the care home in Switzerland than staff had been provided while caring for residents with COVID-19 in the UK. Staff here were angry, and I was angry for them.

Observing this situation from a distance has been devastating, but comparatively easy. Knowing you can help but not being able to while others suffer is awful, but is nothing compared to what UK care staff went through. I am angry about the way things have been handled, but I'm in awe of the way care providers kept going. They deserve more, and this should not be forgotten.

Introduction

Across the globe, COVID-19 has disproportionately impacted the older population in terms of morbidity and mortality, particularly those living in residential long-term care.[2] Over 40 percent of COVID-19 related deaths globally have occurred in residential long-term care, with figures as high as 80 percent in some higher-income countries according to the World Health Organization (2020). In the United States, residential long-term care residents account for 41 percent of overall mortality. In Switzerland, over 50 percent of COVID-19-related deaths have been linked to residential long-term care residents since the start of the pandemic, with actual figures varying from canton to canton (equivalent of state to state). To date, the Swiss population aged over eighty years has been most vulnerable, accounting for the highest number of deaths countrywide. As a result, concerns for resident safety led to extensive isolation of people living in residential long-term care since the beginning of the COVID-19 pandemic (Chu et al. 2021). In the United States, residential long-term care communities were locked down in the early days of the pandemic and reopened slowly to families, friends, and other caregivers. Switzerland took a more liberal approach and, except for an initial six-week visitation ban, have allowed family and friends to visit, reinforcing stricter rules only during an outbreak. Both approaches have costs and benefits. In this chapter, we present perspectives of residential long-term care staff in the US and Switzerland in addressing the overwhelming challenges faced during the pandemic. A primary focus is staff perception of social isolation and the tension between physical protec-

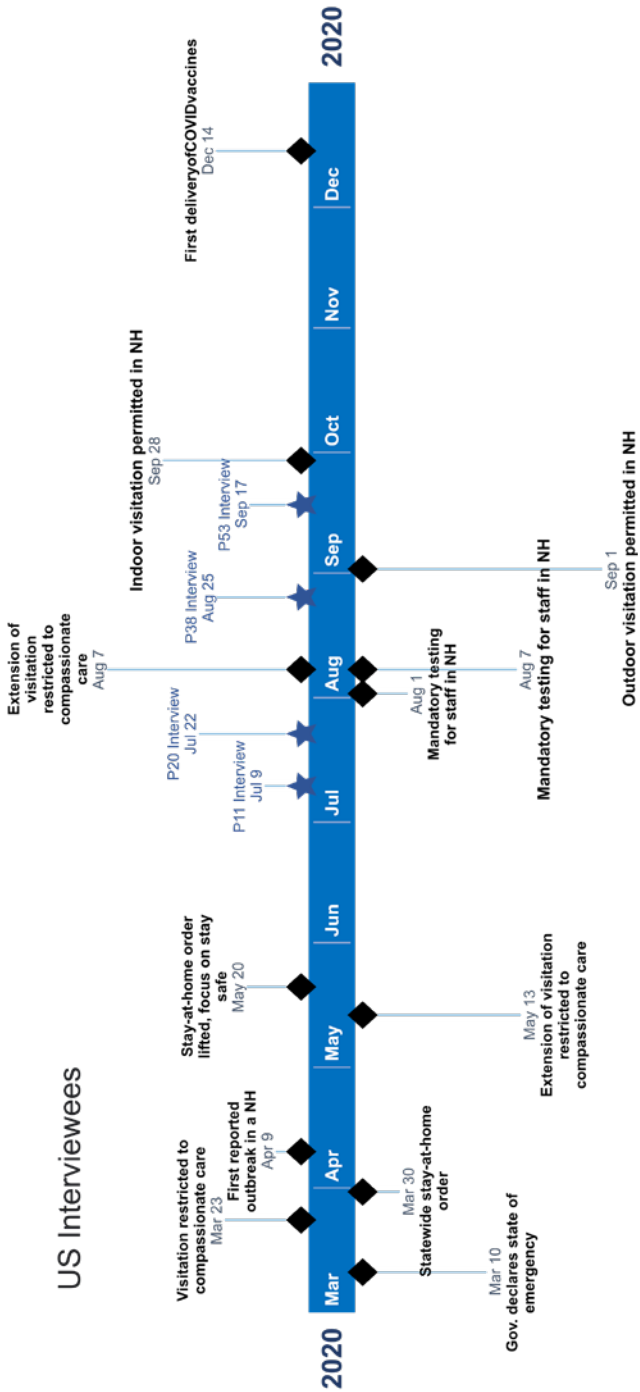

Figure 8.1. Timeline of US Interviews Quoted in Chapter 8.

tion and quality of life of residential long-term care residents. In their daily care of residents, staff had to balance safety measures and infection control with preserving the quality of life of a social group considered high risk.

A Swiss team and our team working in the US conducted independent qualitative appraisals of frontline workers in residential long-term care during COVID-19. In the following section, we focus on the perceptions of residential long-term care staff who navigated caring for residents in these different settings. We report on our findings, drawing on interviews with frontline residential long-term care workers, which illuminate the ongoing tensions between the need to physically protect residents while also providing adequate quality of life, which is defined as "individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (Peel, Bartlett, and Marshall 2007). We examine staff perceptions and experiences including 1) their fear and anxiety in relation to the risk of COVID-19 infection; 2) navigating provision of care during the pandemic; 3) implementing limited and evolving policies and guidelines; and 4) supporting engagement and quality of life for residents amid ongoing isolation.

Models of Residential Long-Term Care: Between Medicalization and Person-Centered Care

Due to the nature of the medical emergency and the differential mortality of older adults, in the US the focus has been predominantly on protection rather than quality of life. In Switzerland there has been a similar culture change in residential long-term care, with a shift in focus from a medical to a social model, which intends to provide a home environment rather than focusing solely on physical care. This updated concept of care focuses more on a person-centered approach, emphasizing overall well-being and quality of life for residents (Nolan 2001). Person-centered care has led to a change in care planning and decision-making in residential long-term care in Switzerland, with more involvement from relatives and residential long-term care residents themselves in the decision-making process. It is difficult to say whether all residential long-term care in Switzerland has succeeded in implementing full person-centered care, but it is clear that the aim is to provide a home with accessible care, taking into account the individual preferences of the resident moving in, rather than a place of care with a bed (McCance, McCormack, and Dewing 2011).

During the COVID-19 pandemic, even in Switzerland, the level of person-centered care provided was restricted by protection guidelines and dif-

ficult decisions made by management teams. The need to protect residents, particularly during an outbreak, caused residential long-term care staff to move further and further from their usual person-centered care approach. The increased need for care and infection control procedures led to a shift back toward a medical model of care to accommodate higher care demands and lower resources.

Impact of Social Isolation and Increasing Loneliness

It is already known that well-meaning policies and decisions intending to protect residential long-term care residents from COVID-19 have inadvertently caused social isolation (Chu et al. 2021). As discussed in chapter 4, social isolation is a significant risk factor for loneliness, which is a subjective feeling or desire for greater contact with social partners (Xie et al. 2020). Although social isolation and loneliness do not always co-occur (e.g., one can feel "alone in a crowd"), both are significant risk factors for negative health outcomes (Cacioppo and Cacioppo 2014; Courtin and Knapp 2017; Hayashi et al. 2020; National Academies of Sciences, Engineering, and Medicine 2020). Care staff were faced with taking on extra responsibilities and trying to respond to the social isolation of residents while dealing with an already heavy workload increased further by COVID.

In the US, loneliness and social isolation became volatile topics in terms of the ways in which federal, state, and local policies, as well as individual residential long-term care communities, restricted visitation to prevent exposure to the virus (Freidus and Shenk 2021). The primary focus was on the physical health of older Americans, which illuminates the failures of a medical model to address the social needs of residential long-term care residents. The medical model focuses on physical care and safety in the context of a complex health emergency and does not recognize residents as having agency to determine particular levels of risk in an effort to maintain their quality of life.

In Switzerland, contact with relatives and friends is encouraged following a move to residential long-term care. For example, some homes encourage relatives to stay for the first meal following a move to make the transition smoother for the resident. In addition, activity coordinators and frontline staff facilitate interactions between residents with similar interests. This is a key element in providing a person-centered approach and contributes to resident quality of life. This continuity is particularly important for people living with dementia. Restrictions imposed during the COVID-19 pandemic caused group activities to be halted and at times full social isolation to be implemented, due either to local lockdowns or residents exhibiting symp-

toms or testing positively for the virus. The lack of contact with specific people and a reduced wider network caused by this can create "emotional loneliness," which increases risk of morbidity and "all-cause mortality" in older adults (Gordon et al. 2020). Residential long-term care staff were forced to provide care in an environment described in the media as "prisonlike," while disputing decisions and practices that could increase social isolation (Peduzzi and Staudacher 2020).

Implementing Protection Measures

In order to slow the spread of COVID-19 to vulnerable older adults in the US, the federal Centers for Medicare & Medicaid Services (CMS), which sets the standards for nursing homes, issued strict guidelines shuttering the homes to everyone besides essential staff and residents on 13 March 2020 (Centers for Medicare & Medicaid Services 2020). CMS standards followed Centers for Disease Control and Prevention (CDC) guidelines and were then implemented at the state and local levels and followed for assisted living communities as well. The North Carolina governor restricted visitation of all visitors and nonessential healthcare personnel in residential long-term care communities (see Figure 0.3 in Introduction). An exception was made for specific compassionate care situations—for example, those involving end-of-life care (Executive Order 120 2020) (see chapter 2 for discussion of compassionate care guidelines). The state Department of Health and Human Services (NCDHHS) promptly canceled all communal activities in residential long-term care, including group meals, with any infractions subjected to state and federal regulatory processes. (NCDHHS 2020).

Many residential long-term care residents rely on family care for social support and to maintain health, well-being, and safety, and therefore need to stay connected to their families (Hado and Feinberg 2020). As the toll on residents increased due to lack of visits and communal activities, staff implemented creative visitation solutions, including the use of window visits and outdoor visits utilizing plexiglass dividers. The task of deciphering and implementing guidelines from federal, state, and county agencies was left to individual residential long-term care corporations and communities. With the pandemic ongoing after a year, compassionate care situations were expanded to include residents who were grieving after a friend or family member recently passed away, those experiencing weight loss or dehydration, or those experiencing emotional distress, seldom speaking, or crying more frequently. Overworked staff were directed to use a person-centered approach to identify the need for compassionate care visits.

In Switzerland, the Federal Office of Public Health recommended restricting residential long-term care visits from 16 March 2020 and introduced social distancing of two meters within residential long-term care. At the beginning of April, a full visitation ban was imposed; however, these were guidelines rather than law (Federal Office of Public Health 2020). Legally, each Swiss canton was responsible for deciding how residential long-term care visits should be regulated, although in practice, responsibility of how to handle visits was mostly delegated to individual residential long-term care homes. During this time, all external activity groups were prohibited, and internal activity groups were restricted by individual residential long-term care homes. Additional care, such as physiotherapy (physical therapy), was stopped in line with federal guidance on 16 March. The strict lockdown protocol early in the pandemic created a period of isolation for residential long-term care residents (Gordon et al. 2020). By the end of April, many residential long-term care homes in Switzerland installed plexiglass panels to enable safe visits in accordance with national rules; however, in-person visits and contact remained prohibited. On 6 June 2020, the Swiss visitation ban was lifted across many cantons, including Basel-Landschaft, where this research was conducted. Individual residential long-term care homes were left to decide how to proceed with minimal guidance, yet had to submit a protection concept and have it approved by the cantonal health authorities.

Methods

The US case study was conducted by our three-member research team. We interviewed a purposive sample of thirty-one staff caring for residents in fifteen congregate care sites in central North Carolina between June and October 2020 (female: n=25, male: n=6) as discussed in chapter 2. They included workers in continuing care retirement communities (CCRC), nursing homes, assisted living communities, adult care homes, and memory care for people living with dementia. Participants included dining staff, housekeepers, chaplains, marketing staff, certified nursing assistants (CNAs), medical technicians (med techs), activities staff, nurses, nurse practitioners, and administrators. In addition, follow-up focus groups were held in February and March 2021, along with media and policy analysis.

Interviews were video recorded using a web-based platform and were transcribed verbatim. Semi-structured interviews ranged from twenty-three minutes to two and a half hours, for a total of twenty-seven hours. We asked these workers about the overall impact of the pandemic on their daily provision of care as well as their key concerns and experiences. The

team implemented a grounded approach that avoided the use of preexisting codes (Freidus, Shenk, and Wolf 2020a, 2020b).

The Swiss case study "Tri-National Ethnographic Multi-Case Study on Quality of Life in Long-Term Residential Care," which aims to look at the concept of person-centered care and resident quality of life in long-term care took place in a purposefully selected long-term care home that purports to use person-centered care, in Basel-Landschaft, Switzerland. The site was selected in conjunction with CURAVIVA Schweiz, a care association working with long-term care communities to provide innovative care in Switzerland.

Ethnographic interviews, observations, and informal conversations were conducted by a four-member research team. Twenty-one healthcare staff (female: n=18, male: n=3)—including nursing staff, activity coordinators, physiotherapists, physicians, cleaning staff, catering staff, administrative and management team members, and hairdressers—were included in the study. Data collection took place from October 2020 to March 2021, during the peak of the second wave of COVID-19 as it affected this long-term care community. Data collection took place while the long-term care home coped with risk and uncertainties during the COVID-19 pandemic, allowing us to observe the situation firsthand and interview staff during and after the most challenging times of the second wave. Interviews were audio recorded and transcribed verbatim, and fieldnotes were made throughout. During the data collection period, we also shadowed staff members during daily tasks and while they coped with and recovered from outbreaks of COVID-19 in the residential long-term care home.

Collectively, both the US and Swiss teams generated a master list of themes. This allowed for an inductive process driven by the narratives of the participants to capture their unique perspectives. Both studies received individual Institutional Review Board (IRB) approval.

Findings

Fear and Anxiety While Navigating Risk of COVID-19 Infection

Residential long-term care staff in both the US and Switzerland recounted extensive fear and anxiety in their efforts to care for residents and keep them safe. This fear took on many forms, especially during the early days of the pandemic, when little was known about the virus, transmission, and how to prevent its spread. Staff expressed concerns about becoming infected themselves, infecting residents, as well as potentially infecting their own families. This was especially true for staff also caring for older relatives in their home or with small children. For example, Grace, the US participant

that we met in the introductory chapter, who works at a CCRC that suffered a major outbreak leading to the deaths of several residents explained: "I didn't sleep well that first month, maybe six weeks . . . , because every night I would lay in bed and think, 'Oh my gosh, have I brought this virus home to my mom?' 'Cause my husband's working from home, and my mom was at home and we did have some caregivers coming into the house, but it was me that was out among the people." (P38)

Similarly, in Switzerland, care staff were scared of becoming infected while working in residential long-term care, or that they would unknowingly bring the virus into residential long-term care from outside. Some used strategies to deal with this fear, including isolating themselves from others in their household, sleeping in separate rooms from their family, and making use of regular free testing provided by the residential long-term care home. Many staff members spoke of their ambivalent feelings toward WhatsApp and social media groups established within the facility; on one hand, they were glad to be informed about what was going on, but they also found it challenging to be constantly confronted with new positive cases, uncertainty, and their colleagues' fears.

News media in the US, as well as in Switzerland, often placed blame for residential long-term care outbreaks on care staff. Residential long-term care staff carried this additional burden of anxiety about being "vectors" introducing the virus into residential long-term care, which threatened the lives of residents. This fear and anxiety created more stress and pressure on already overwhelmed staff, who were being asked to provide additional services while also putting their own lives and the lives of their loved ones at risk. In an effort to cope in this environment, one participant explained: "How I actually made it through is I just shut down. . . . I disconnected. I was like, 'This is what doctors have to do, this is what people have to do.' To do your job every day, you have to just. . . You can't feel anymore" (P23).

This situation became increasingly difficult with "chronic" overburden, as highlighted by a senior team member in the Swiss case study, who explained: "They are minimally staffed at the moment, . . . Then there are also employees, who have now been burdened for a very long time, who want to go on holiday, or want some time off, . . . everyone is prepared to work for a certain time above average . . . but then when it becomes chronic, it becomes difficult. . . . There has to be a change, a relief." A Swiss care team member echoed this sentiment during an informal conversation, explaining that staff felt contracting COVID-19 would "at least mean they get to rest."

Findings from both the US and Switzerland suggest that residential long-term care staff struggled to maintain their own physical, mental, and emotional well-being during the COVID-19 pandemic, while also be-

ing responsible for maintaining the physical, mental, and emotional well-being of their residents. This pressure was exacerbated by older adults being identified as a group with the highest risk of both morbidity and mortality, as well as knowing the rapid physical and mental deterioration that can impact older adults in isolation.

Providing Care during Isolation

Residential long-term care staff in both countries reported facing many challenges in ensuring all resident needs were being met during the COVID-19 pandemic. Staff had to take on additional tasks that family and friends visiting their loved ones had previously assisted with. This included helping with feeding, laundry, and socializing with residents. Respondents discussed the challenges of increased labor on an already stretched and stressed team. A nurse in the Swiss case study explained how she became an intermediary between residents and relatives, also reassuring some anxious relatives during the isolation phase: "I experience telephone calls from outside, from relatives. . . . Question time has increased in the morning, e.g.: 'Have the biscuits/chocolates/photos arrived?'; 'My mother became a great-grandmother, for the ninth time'; '—and then you start looking and at the end of the service [shift] you try to call everybody to say 'I found it/It's there/She was happy.'"

Staff in both the US and Switzerland also explained the need to constantly adjust their planning, which not only caused additional work but also required them to be prepared for anything that could occur. For example, a Swiss nursing team member described: "Sometimes I come to work in the morning and I already have to reschedule because someone is not here, or I have to send someone home if they have a sore throat, fever. Just these symptoms—that's quite new. . . yes. I have to go and measure temperature for all the residents. I have to notice and feel everything."

In some residential long-term care homes in the US, meals were still being served individually to the residents' rooms eleven months into the pandemic. Some communities were able to establish split meal schedules or otherwise serve residents sitting at physically distanced individual tables. This depended on the size and layout of the specific residential long-term care community, but arrangements had been made particularly for those who require assistance with eating. These arrangements all required adaptation and increased the workload of the staff, as summarized by a CCRC Campus Director of Culinary and Nutrition Services: "Once we made the call [in March] that we were shutting down dining services, we opened the next day with a full delivery program [to residents' rooms]. And that deliv-

ery program was for every single resident on campus twice a day. And we're putting everything into this styrofoam takeout container" (P53).

Similarly, in Switzerland, no overall rules regarding mealtimes were enforced. During the time of the study, residents were mostly permitted to dine together in a communal restaurant designed for residents from all floors to meet, while maintaining physical distance. However, when residents tested positively for COVID-19, specific floors had to be isolated. During this time, isolated floors were restricted to dining either in the "café" area on the floor (only residents who tested negatively) or in their room (residents testing positively). Residents required to quarantine due to direct contact with a confirmed COVID-19 case or testing positively were isolated in their room for a minimum of ten days, and the remainder of that floor became isolated. For care staff on isolated floors, this meant mealtimes became an additional daily task when ordinarily catering staff would serve and clear resident meals. In addition, to enter an isolated room, full PPE was required and all PPE had to be disinfected or discarded afterward. The additional protective measures added a minimum of fifteen minutes per room on each entry. Staff had additional concerns because during non-pandemic times, many residents dined with relatives and would therefore desire more staff interaction than usual.

In the US, care staff pivoted to scheduling and facilitating family "visits" through phone calls, FaceTime and Zoom, window visits, and porch visits. These visits had to be monitored to ensure proper infection control protocols were being followed because many family, friends, and residents were tempted to touch, hug, and physically console each other. One staff member explained that these visits were emotionally difficult to witness:

> We have set up a window visit area and made it really special for them to be able to come through one of our gates into the playground courtyard, and then we have the residents come to the window for them to be able to visit with them. We have our cellphone in place, we have headsets in place for them to use. . . . And we, of course, we monitor, we stay there with them. . . . It has been a challenge, and when we first started that, yeah, it was really hard, really hard." (P11)

In the Swiss case, having to monitor visits was equally challenging while visitation was restricted.

In the US, end-of-life care proved particularly difficult. There were times when care staff were the only available physical and emotional support for residents because family and friends were too fearful to visit or were not able to get to their loved ones in time. One CNA explained how difficult this was as they sat with a resident dying of COVID-19: "Like I said, it was just

a very hard thing to be with people that didn't have their loved ones there holding their hand or putting the washcloth on their forehead, that sort of thing. That's the worst part of everything that was, I don't ever want to do that again" (P20).

These frontline workers demonstrated great resilience in confronting the monumental tasks of physically protecting residents as well as providing them emotional and social support. For example, US activities coordinators and dining staff were able to quickly pivot to serve the needs of residents. Staff developed such creative activities as in-room bingo, hallway bowling, water balloons and water guns outdoors, and family car parades to celebrate residents' birthdays.

In Switzerland, staff credited their ability to adapt during times of restrictions to a sense of camaraderie that enabled staff to empathize with each other. Staff on isolated floors became a unit, and together with the residents a family. In discussions following the reopening of isolated floors, several nursing staff highlighted the unity felt over the negative experiences with a sense of pride. They were not only proud of surviving the experiences during isolation, but of uniting as an interdisciplinary team from assistant personnel to the leadership team and many others between. The care team described interactions with the leadership team as being able to "let off steam for a short time" or "bitch and moan" (*auskotzen*) while they tried to stay strong for their coworkers.

Frontline workers in the US who were the focus in chapter 2, who experienced a major nursing home outbreak and volunteered to work on a sealed COVID unit, expressed similar feelings of closeness to other members of the team, but talked about feeling ostracized by other staff outside the unit.

Implementing Evolving Policies and Guidelines

The uncertainty surrounding the novel coronavirus was particularly evident in the ways policies and guidelines were ever changing as new information about COVID-19 emerged. Additionally, the unforeseen length of the pandemic led to the evolution of policy and programming as new concerns arose. This created a difficult terrain for governments at all levels as well as individual residential long-term care homes to navigate in their efforts to both protect and provide appropriate care for residents.

Switzerland and the US experienced the creation and implementation of policy in varied ways that can be tied to the different conceptualizations of care that emerged in response to the pandemic. US government policy emerged alongside policy focused on healthcare facilities to quickly shut their doors to all but the most essential staff needed to care for residents. As the pandemic progressed, residential long-term care communities were

given some leeway in terms of what kinds of access was allowed to family members. This was the case more so in Switzerland where, aside from an initial "full lockdown" period, the residential long-term care home made their own decisions on lockdown procedures, taking into account resident needs as well as cantonal guidelines. This required care staff to juggle both the implementation of changing policy and programming coming from government policies as well as administration and corporate offices, in addition to acting as conduits of information to anxious families concerned about their loved ones. One participant explained:

> In the beginning, based on the things that I've observed, and some of the family members that I've spoken with, they were glad that the administrator put into place immediately, no visitors, which includes family members. Again, we try to stay in tune and communicate with our family members, and have residents communicate with their family members. . . and making sure that they know their family member's in the best hands, that they are safe, still. (P16)

This additional labor was draining on care staff. Many participants reported exhaustion and fatigue associated with navigating their work under constantly changing conditions as well as uncertainty that decisions being made and implemented were the correct ones. This created a tenuous work environment as staff were aware that repercussions of ill-informed policy could be devastating to both workers and the residents in their care. Remember Grace who expressed: "You make a decision and it's the right thing, and then you make the decision and it's the wrong thing. And it's just been building the plane while you're flying it" (P38). Staff regularly talked about rules changing daily: "So every day is different. . . Literally every day, there's a new policy, a new procedure, and we're just. . . That's sort of a joke, our ongoing joke, like, 'What could possibly go wrong today?' And just figuring it out" (P13).

In the Swiss case, the long-term care home, which had to make most decisions, developed constant feedback loops between the "crisis team" who met daily and all other staff members. They were in constant contact by phone, email, and WhatsApp groups. This meant information from the leadership team could be communicated more quickly and clearly. At the same time, the "crisis team" learned from new instances and staff uncertainty. Several staff members explained that despite the uncertainty and constant new situations, they did not feel alone as they could ask for help from the leadership team or other senior staff at any time, day or night: "I just come to work and take it forward. . . because. . . how I have to act, I am guided. I can read that at home, [the information] from the crisis team. . . . I'm already prepared. . . with all this knowledge of how I have to act. If

I'm unsure, I can already sit at the computer. . . at 7 a.m. and write 'I'm unsure.'"

The US experience varied between different residential long-term care communities and also compared to that of Switzerland. In the US, administrators and managers met frequently to respond to executive orders and guidelines at the state, local, and corporate levels. Some nonmanagerial staff felt they had little to no voice in decision-making regarding how to handle the pandemic as well as the needs of residents and were responding to constantly changing rules. They were also faced with negative reactions in the community and pushback from families, due in part to negative media reports. In this context, many direct care workers felt anger, frustration, and helplessness.

Meanwhile, Swiss long-term care homes were largely given freedom to decide how to balance protecting residents while maintaining access to family and friends, and included staff and in some cases relatives in the decision-making process. During the peak of the second wave, when cases were at their highest, the Swiss long-term care home was still able to lockdown on a floor-by-floor basis. Floors with positive cases went into isolation, but residents and staff on floors with zero cases were able to move freely around non-isolated areas of the home while wearing masks. In addition, visitors were allowed in designated communal areas throughout this time, and in-room visits were permitted under special circumstances, which were decided on a case-by-case basis and permitted on compassionate grounds. During this time, residents could not go offsite but had as much contact with family and friends as the "crisis team," who at this point were in daily contact with the cantonal GP, felt safe. This site evolved between the first and second waves of the COVID-19 pandemic, gradually learning how to function effectively to protect resident quality of life, while negotiating guidelines from cantonal authorities to keep residents safe.

Balancing Isolation with Quality of Life

Throughout the evolution of the ongoing pandemic, staff struggled with balancing protecting the residents from COVID-19 and the negative effects of social isolation. One US administrator expressed:

> I want them to be able to have these experiences and not be secluded, so the best thing for the resident is for families to be in here, and so I want that. If I had to pick one or the other. What I have been told is I've been the most aggressive with the outdoor visitation compared to the other administrators in our region, and I actually, I was told to back it off just a little bit. . . the last thing I wanna do is have another outbreak, so you're. . . I'm torn between the two. (P56)

The long-term care home observed in the Swiss case study is perceived in Switzerland as having strict protection measures. However, the leadership team constantly strived to provide a level of resident freedom alongside restrictive safety measures. Resident quality of life was factored into decisions surrounding isolation, as this staff explanation demonstrates:

> What we do in here actually should have the same effect as when we close completely. . . . We no longer do room visits, we stopped that two or three weeks ago. . . . In the end you can ask yourself, if someone dies because of COVID, or because of "grief" or "wasting away" or "being alone" or simply no longer have the will to live . . . then I have to ask myself, or we just ask ourselves, "What has been gained?" . . . These are such ethical questions, or, there is no right and wrong. I maintain that if we and everyone stick to the protection concepts we have, it would work. But it doesn't work because not everyone sticks to it. . . . And then there is always the question: Do we punish everyone now?, and it is perceived as punishment [when they are not allowed to have visitors].

In the US, the majority of participants acknowledged that the social isolation was profoundly affecting residents, both physically and emotionally. At the same time, they expressed fear and anxiety about allowing families into the residences. Recognizing the cost to some residents, they questioned the wholesale shuttering of communities and were concerned that residents and families were not given any agency in this process. One administrator observed: "I have residents every day who say, 'It's not worth living like this.' So it's a fine line trying to decide what is right. And honestly, just because I feel depressed and wanna see my family, is it worth exposing the whole facility to that? It's really about what's best for the group. So, I'm really torn." Another staff member shared that residents were "in a pit of sadness" and that was too high a price to pay for the protection provided by the lockdown. They were supportive of the expansion of compassionate care visits. They went on to say that after the residents' families were allowed to visit, "It was amazing. And they [residents] would cry and cry afterwards and saying how that just felt like years to them, they haven't seen their family" (P31).

Discussion

Care staff found themselves navigating the physical risk of COVID-19 to their residents, self, and families while also being responsible for the quality of life of their residents who were experiencing isolation. Some of their responses related to fear of the disease and the potential repercussions. The

fear and anxiety experienced are responses to challenges faced in caring for isolated residents, such as enforcing infection control policies, providing emotional support while families are absent, and dealing with PTSD after watching residents suffer. These experiences and perceptions shape care staff's ideas about how to address further isolation while balancing quality of life. Caring for residents who have tested positively for COVID-19 increased the chance of staff experiencing anxiety and PTSD. Throughout this period, uncertainty in relation to the overall impact and duration of the pandemic prevailed for staff. In addition to increased levels of care required during such a period of uncertainty, staff had to cope with members of their own team contracting COVID-19, often without knowing how the infection had spread. This, in peak times of crisis, also led to staff shortages adding to caregiver burden. Staff numbers were also impacted by staff who were themselves considered vulnerable and unable to work in isolated areas. There were obvious concerns with using external agency staff to supplement staffing or having staff work in multiple locations.

The narrative in the media portrayed a very negative view of residential long-term care, with much blame being attributed to staff. There were of course problematic elements, as with any industry during the pandemic, such as a lack of PPE, but successes were overlooked and the focus fell on the negatives. This was even the case when negative factors were beyond the control of residential long-term care staff due to shortages of resources or lack of external support. Staff in both countries compared experiences during instances of high COVID-19 cases as being in a war zone or a wildfire—constantly fighting to get ahead in times of extreme exhaustion and uncertainty. In the Swiss case study, where floors were isolated on a case-by-case basis, shifts on non-isolated floors were observed to be running relatively "business as usual" beyond the required masks and additional infection control procedures. Meanwhile, neighboring floors were in crisis, with the majority of residents having tested positive for COVID-19. In non-isolated areas, aside from signage, disinfectant hand gel and masks ever present, it was easy to forget just how arduous the situation was for staff working in isolated areas. However, despite this, teams in isolated areas became stronger than ever, and staff adapted to go above and beyond for the residents in their care.

The ongoing situation caused residential long-term care to revert back to more of a medical care model in many cases, even in Switzerland and in US residential long-term care communities where a culture shift had previously seen a move away from this approach to care. This resulted from time constraints, staff shortages, and the need for extensive protective measures in a time when resident safety was the main priority. Overburdened staff in isolated areas focused on keeping residents testing positive for COVID-19

alive and comfortable during a time when they were told to expect few survivors. At the same time, staff became more than just carers during times of isolation and were still expected to provide key elements of a person-centered care approach. They became the main source of interaction and both intermediaries and (in some cases) replacements for relatives. Care staff provided the additional care and emotional support usually given by family and friends when visiting a resident. In extreme cases, this included additional palliative support, making sure no resident was left alone or without contact at the end of life. This was the case in both the US, where a medical model of care still largely prevailed prior to the COVID-19 pandemic, and in Switzerland, where the research site was known for providing a person-centered approach to care. While the US continued extreme restrictions on long-term care throughout the pandemic, the situation in Switzerland enabled long-term care communities to respond to specific situations and open for more visitation, rather than continuing with a total shutdown. This more nuanced approach was equally challenging for staff but was positive in terms of the lower level of isolation and loneliness experienced by the residents they care for. In the Swiss case, protective measures were more effectively balanced with an effort to provide adequate quality of life.

In both the US and Switzerland, the COVID-19 pandemic continues to impact residential long-term care homes, whether they currently have positive cases or are dealing with the aftermath. With the duration of the pandemic and the severe shortage of workers in long-term care currently, it is impossible to say when residential long-term care staff will get significant relief. It is clear from the interviews and observations undertaken during the height of the pandemic that this level of expectation on staff is unsustainable in the long term. It is important that lessons are learned from this pandemic, and that strategies are designed for the future based on staff experiences.

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Notes

1. FFP stands for "Filtering Face Piece," with the number corresponding to the level of protection the piece provides: 1 being the lowest level of protection and 3 being the highest.
2. Adapted from Freidus et al. (2022).