2024

We did our Best!: The Experience of Frontline Workers in Long-Term Care during COVID-19 Outbreaks

Jillian M. Gratton  
*School of Nursing, Queen's University, Kingston, Canada*

Lenora Duhn  
*School of Nursing, Queen's University, Kingston, Canada*

Rosemary Wilson  
*School of Nursing, Queen's University, Kingston, Canada*

Pilar Camargo-Plazas  
*School of Nursing, Queen's University, Kingston, Canada*

Follow this and additional works at: [https://pxjournal.org/journal](https://pxjournal.org/journal)  
Part of the Other Medicine and Health Sciences Commons

**Recommended Citation**  

This Research is brought to you for free and open access by Patient Experience Journal. It has been accepted for inclusion in Patient Experience Journal by an authorized editor of Patient Experience Journal.
We did our Best!: The Experience of Frontline Workers in Long-Term Care during COVID-19 Outbreaks

Cover Page Footnote
Thank you to the frontline workers who were open and honest in the research study. There is vulnerability that comes along with sharing an experience such as this. Your courage and dedication do not go unnoticed.

This research is available in Patient Experience Journal: https://pxjournal.org/journal/vol11/iss2/8
RESEARCH

We did our Best!: The Experience of Frontline Workers in Long-Term Care during COVID-19 Outbreaks

Jillian M. Gratton *, Lenora Duhn, Rosemary Wilson, Pilar Camargo-Plazas

School of Nursing, Queen’s University, Kingston, Canada

ABSTRACT

In Canada, the COVID-19 pandemic had devastating effects for those living in long-term care (LTC) homes, yet little is known about the experiences of the frontline workers who endured in those settings with COVID-19 outbreaks. Specialized knowledge will improve our understanding of the effects of the pandemic on frontline workers (FW), enabling the development of stronger practices. The purpose of this research was to gain a deeper understanding of the experiences of FW caring for residents in LTC homes during a COVID-19 outbreak, using narrative inquiry. The methods used for data collection include interviews, field notes, and photovoice. Participants were asked to capture photographs representing their experience working during the COVID-19 outbreak at their LTC home. Participants’ stories were collected through reflection on their photographs in interviews. The setting for this research was LTC homes in Ontario, Canada. Data analysis followed Frank’s hermeneutic method of analysis of stories. Psychosocial effects, support, loss of normalcy, increased workload, and altruism and dedication resonated throughout the three participants’ stories. The burnout, stress, and mental exhaustion, as detailed by the participants, emphasizes the importance of protecting the mental health of the FW during outbreaks. Equipping FW with relevant knowledge helped them to feel prepared and confident in protecting the residents, themselves, and their families. Support from management personnel influences the experience of FW during infectious outbreaks.

Keywords: COVID-19, Frontline worker, Long-term care, Patient experience, Patient-centered care, Quality of life, Quality of care, Workforce engagement, Healthcare leadership, Narrative inquiry, Infectious outbreak, Pandemic

As of February 2023, there were 754 million COVID-19 cases worldwide and 6.83 million associated deaths. In Canada, during the same period, 4.56 million cases were reported, and 50,629 deaths were confirmed. According to the Ontario Ministry of Health and Long-Term Care, over 78,000 residents live in 627 long-term care (LTC) homes across the province. During the COVID-19 pandemic, outbreaks were declared in over 450 LTC homes. In Ontario, as of May 26, 2022, 4,545 deaths occurred in LTC homes; within Ontario, 13,156 cases of COVID-19 infections in health care providers (HCP) and 11 HCP deaths were associated with outbreaks in LTC homes. The COVID-19 crisis in LTC stemmed from factors, including: pandemic preparedness favoring acute care; the novel nature of COVID-19; long asymptomatic incubation period; inadequate infection control knowledge; inability to separate residents due to the physical layout in LTC homes; and personal protective equipment (PPE) shortages. During the pandemic, some individuals who assisted in patient-facing areas in LTC homes and provided direct care to residents did not have health related training. For this reason, the authors used the term Frontline Worker (FW) to describe participants rather than HCP. Referenced literature used HCP to describe individuals

Received 16 October 2023; accepted 23 January 2024.
Available online 8 August 2024

* Corresponding author.
E-mail addresses: sjg6@queensu.ca (J. M. Gratton), duhl@queensu.ca (L. Duhn), rosemary.wilson@queensu.ca (R. Wilson), mdpc@queensu.ca (P. Camargo-Plazas).

https://doi.org/10.35680/2372-0247.1893
2372-0247/© The Author(s), 2024. Published in association with The Beryl Institute. This work is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 4.0 License.
in roles with health related training including registered nurses, registered practical nurses, personal care assistants or personal support workers, nurse practitioners, and doctors.

The nature of newly identified diseases leading to outbreaks, such as COVID-19, sparked fear in HCPs.6,7 HCPs indicated they feared not only for themselves, but the safety of their family.8–11 The unpredictable trajectory of the COVID-19 pandemic led to anxiety, fear, and panic among FWs.10 Maintaining a positive attitude during an outbreak was a challenge, especially with restrictions on regular coping strategies, such as socializing and exercise.12

During the COVID-19 pandemic healthcare facilities were left understaffed.13–15 Staffing challenges, precipitated by fear and staff illness, led to increased workload for those who continued to work.15 Working in high-risk settings, such as LTC homes with COVID-19 outbreaks left HCPs at risk of increased symptoms related to stress and trauma compared to HCPs in low-risk settings.16,17 Depression was a concern of HCPs working during SARS17,18 and has been described by HCPs in China during the COVID-19 pandemic.19

Given the novelty of COVID-19, there was a deficit in evidence about the experiences of FWs and the COVID-19 pandemic. At the time of the study there was no published related research with use of photovoice illustrating experiences of frontline workers and outbreaks. At the time of the study, members of the research team (L. D. & P. C-P.) conducted an arts-based research related to provider experiences in a group home.20

1. Research approach and methodology

The aim of this study, as developed by the first author (J.G.), was to gain a deeper understanding of the lived experiences of FWs caring for residents in LTC homes during COVID-19 outbreaks. The first author (J.G.) has worked the past 10 years as a Registered Nurse in the Intensive Care Unit and felt for the FWs in LTC homes, as they experienced the traumatic situation they (J.G.) had feared in their nursing practice. The mix of emotions the first author felt during the pandemic piqued their interest to explore the experience of other FWs. Through a narrative approach, ‘voice was given to’ and meaning generated from FWs’ experiences in LTC homes during a COVID-19 outbreak. The effects of the pandemic on FWs were considered, to generate foundational evidence for informing longer-term resilience, stronger practices, and disaster preparedness.

1.1. Design

Using a narrative approach to inform an understanding of the experiences of FWs who worked in LTC during a COVID-19 outbreak, their stories were obtained. Narrative inquiry is about collecting stories from individuals to illuminate and understand their lived experiences during specific events or actions.21,22 The narratability of a story affirms that the events and lives of those within it are worth telling, implying value.23

1.2. Setting and participants

This study occurred at LTC homes in Ontario, Canada, from May 2021 to April 2022. Three participants were recruited using a purposeful sampling strategy. The Letter of Information and Consent Form was e-mailed to FWs to review. Following this, a one-on-one introductory meeting was conducted with each of the FWs. During this meeting, the study was introduced, individuals were screened for inclusion and exclusion, and the potential participant’s questions were addressed. All participants in this study participated voluntarily. Participants provided written or recorded verbal informed consent prior to participating in the study. Ethics approval for the study was granted by Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board (File#6032638). Online interviews were then scheduled for each participant.

1.3. Data collection

Methods included photovoice, interviews, and field notes. Photovoice is a method of data collection wherein participants determine the images they photograph, ‘directing’ the narrative, and are empowered advocates for their community.24 The participants were asked to use their personal smart phone camera to take the photographs and were provided with a photograph release to allow their photographs to be used in the study. If participants required a camera, an iPad would be provided, as well as a return envelope with pre-paid postage. The first author—who managed recruitment and study enrollment, as well as conducted the interviews and analysis—provided participants two weeks to take photographs representative of their experiences working during the COVID-19 outbreak at their LTC home; however, this was altered as participants wanted to submit
photographs previously taken during a COVID-19 outbreak. The participants were instructed they could take photographs in any setting. In the initial meeting, ethics of photographing people and events was discussed with the participants (photos should not identify the participant or other people, should not contain features that may identify the LTC home, refrain from including logos in their photos).  

One to two interviews, which were conversational were completed with each participant. The interviews were 30–50 minutes and managed virtually one-to-one via Zoom©. During the interviews the submitted photographs were displayed one-by-one. The participants were asked an open-ended question with each photograph to elicit the story of the picture (e.g., How does this picture reflect your experience during the COVID-19 outbreak in the LTC home where you work? What is going on in this photo? Why did you feel it was important to capture this moment?). The unstructured nature of this interview meant subsequent questions were guided by the participant's response to a broad question (e.g., You mentioned staff from other floors did not want to help on your floor due to the exposure to COVID-19. You said you “...had girls come up there crying saying I don’t want to be here”. Can you give me an example of one of these conversations? When you were coming and going, you said the media and the police were outside. Did you have trouble coming and going from the home?). Each interview was transcribed verbatim using Otter.ai©, and independently proofread for accuracy by the first and last authors. All participants were sent the transcript from their first interview to review prior to the second interview. The strategies to address trustworthiness of the study were credibility, transferability, dependability, and confirmability.  

Credibility was demonstrated in this study with triangulation (photovoice, interviews and researcher journal); peer debriefing with my thesis supervisor; member checking (validation of data, findings, interpretations, and conclusions with participants). Transferability was demonstrated through thick descriptions of the setting, sample, context, and findings. Dependability was demonstrated in this study through an audit trail for adequacy of analysis and decision-making processes, recorded in researcher’s journal. Confirmability was demonstrated through an audit trail, triangulation, and reflexive journaling.

1.4. Data analysis

The collected data was analyzed using Clandinin and Connelly’s three-dimensional narrative analysis, as well as Frank’s exemplar outlined in Letting Stories Breathe: A Socio-Narratology, and included reading each transcript while listening to the audio and video recordings, and arranging the narratives side-by-side, such that the photographs and relevant quotes of each participant’s narrative were visible. Frank suggested our imaginations create images as we read a story. In this study, the participants’ photographs guided our imagination in visualizing their stories; as their stories were arranged and rearranged, analytic interests resonated through the stories. For each participant, a narrative was composed. Plotlines were determined by the clusters of quotes that resonated the same theme. Per Frank’s suggestion, each story was considered from the perspective of a marginal character, and this helped to harness the multiple perspectives within the story for interpretation. Additionally, expected details were looked for to determine if they were omitted as Frank suggests what was missing in the story may have been withheld or may not have happened for a reason that is notable.

2. Results

Five analytic interests were identified in the participants’ stories: psychosocial effects, loss of normalcy, increased workload, support, and altruism and dedication.

The characteristics of the participants are described in Table 1.

2.1. Psychosocial effects

The psychosocial effects discussed by the participants included feelings of shock, stress, frustration, fear, trauma, and darkness. Jennie described the first day of the outbreak: “...that was just kind of a day of shock trying to deal with uncertainties, not knowing what was going to happen next... So, what was it like? It was surreal.” Cathy explained the three months of the outbreak as scary, terrible, and traumatic: “This was

<table>
<thead>
<tr>
<th>Table 1. Participant descriptions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant</td>
</tr>
<tr>
<td>Role in LTC home</td>
</tr>
<tr>
<td>Years of practice in LTC</td>
</tr>
<tr>
<td>Number of photos included</td>
</tr>
</tbody>
</table>

©Pseudonyms are used; LTC = Long-term care; RPN = Registered Practical Nurse

Participants reported they did not review the transcripts sent to them.
all unknown to us as well, so we were all scared. We were all running around trying to figure out how we’re going to keep residents safe, how we’re going to keep the staff safe.”

The participants were quarantined from their families within their homes. Cathy recalled, “I usually just go in my porch and just take it [work attire] off there and throw it in the washing machine and straight to the shower and then to your room; we had to stay away from our families.” Jennie detailed her experience of isolating from her family: “My husband would literally meet me at the front door, not close, and I always came in like a full mask and everything. He’d say, ‘I love you, up you go, and I’ll deliver dinner in like half an hour’ if I got home in time for dinner.” Bernie talked about support and concern from friends and family. She assured them she was diligently wearing PPE to protect herself. She recalled:

_They were begging me not to go to work but I said, ‘Well, I have to’ like I can’t just say ‘I can’t because I’m scared’ you know, I said ‘somebody has to do it and I’m doing the proper PPE and you know, looking after myself._

The participants said their LTC homes were “different” and “happy” before the COVID-19 pandemic. For example, Bernie discussed the decline in staff, residents, and families with the start of the pandemic restrictions in the LTC home. The mental health of the residents was affected by living in an environment filled with fear and sadness; Cathy noted: “It was so hard on these residents . . . they watched their roommates die, they watched the staff crying, they didn’t see their families . . .” Jennie was teary as she talked about a “truly awful day” at the LTC home:

_We lost four residents and staff were just cracking and as a group of managers, I said ‘We’re going to go and prepare each of them. We’re not going to ask the staff to do that, if they want to, they can be involved’, because sometimes it’s very, it’s part of the grieving process to prepare the body, but the staff at that point were just so beaten, we all were, but I just said to the team, our management team I said, ‘Come on, we can do this we have to do this for them._

Staff were required to put the deceased residents in shrouds and take them outside to the hearse. Cathy spoke of her and the other LTC home staff’s heartbreak in doing this repeatedly. Cathy found the quick transition to reopening did not allow for time to mourn the loss of the residents who died during the outbreak. Jennie felt the loss of the residents to whom she had become close and the loss of engaging with the residents’ families. Jenny recalled having in depth discussions with residents about the death of their roommates, tablemates, and friends. Mental exhaustion resulting from the COVID-19 outbreaks was evident from Cathy’s and Jennie’s narratives. Bernie experienced increased stress during the COVID-19 outbreak; she was diagnosed with clinical depression, which she attributed to stress and burnout. Bernie took a leave from work after having an anxiety attack. Bernie shared a photo from this time (Fig. 1) stating, “. . . the doctor said, you know, ‘Don’t hide at home.’ He says, ‘Get out and enjoy life and do things that make you happy’.” Bernie later resigned from the LTC home where she worked during a COVID-19 outbreak. Cathy stated, “We had staff that had to leave after the initial outbreak and when things were kind of getting back to some form of like normal running of the building, we had staff that had to take time off, stress leave. There was no time to decompress.”

2.2. Loss of normalcy

The loss of the normal pre-pandemic surroundings and procedures in the LTC homes was reflected on by all the participants. Bernie and Jennie revealed working at the LTC homes before the pandemic was easier, happier, and less stressful. Jennie thought about what she missed as a FW before the COVID-19 pandemic:

_Daily interaction with people was something that I absolutely love, and it’s something I treasure, I still love and treasure it but before there was just a freedom in_
movement you didn’t have to be careful . . . and now of course we’re just incredibly cognizant of all of our movement.

The isolation of the residents to their rooms meant the dining room was now being used for PPE storage (Fig. 2). Jennie indicated there were no residents in the dining room; the room became the staff break room, enabling them to always be available. Jennie and Bernie noted, at times, staff lost break time because it was too busy to step away. Meals were delivered to the residents in their rooms during the COVID-19 outbreak. Jennie also offered a photograph (Fig. 3) of hot food arranged in the hallway to limit the distance the staff had to travel to deliver the residents’ meal trays. Before the pandemic, hot food could not be in the hallway because of the safety risk to the residents. Jennie commented on this photograph:

To me it signifies that everything we knew, every process we had that had been fine-tuned and reworked over the years, every process we had was just like, sucked out of an airplane right away and we were suddenly having to figure out, well, how are we going to do this? How are we going to do that?

Jennie talked about their normal parting of ways with the families of the residents before the pandemic and the closure it brought. Before the pandemic, they could hug the family members, say goodbye, and attend the funeral of the resident. During the pandemic, the restrictions on people entering the LTC home and the restrictions on funerals meant this could not occur. Before the pandemic, there was an area in the LTC home where Jennie works that was seasonally decorated, but with the pandemic that ceased. Jennie told a story of a staff member who decorated the area during the outbreak stating, “we’ll feel better if we decorate it.” The photograph of sock monkeys wearing masks (Fig. 4) in that decorated area as Jennie pointed out, “was a moment of levity that we all needed.”
2.3. Increased workload

All the participants discussed the impact the increased workload had on their experience. They were physically exhausted from the extra precautions, the residents needing to isolate to their rooms, the increased communication with families, and the residents who required more care due to their infection.

Cathy and Bernie spoke of how they were required to prioritize aspects of care because it was so busy. Cathy discussed their priorities, "Make sure they’re bathed, they’re clean, they’re fed, their medications, hydrated, you know skin breakdown that’s, that’s all we could focus on because we were just trying to keep these people alive.” Bernie gave an example of bathing residents with little water to be as quick as possible, there was no time for the tub to fill, which she acknowledged was not fair to the residents. Bernie stated her medication distribution took longer than usual because she had to tend to each resident in their room and take their temperature, rather than completing this in the dining room as done pre-pandemic. The requirement to don and doff PPE upon entering and exiting each resident room compounded the workload. Staff were “literally running” according to Jennie.

The absence of staff (due to sickness or other reasons) also meant more work for the staff who were present. Working beyond their scheduled shifts was common among all participants. During the outbreak at the LTC home where Bernie worked, there were incidents where staff refused to assist when reassigned to the floor with the outbreak, leaving them short-staffed. Bernie reported she picked up extra shifts to assist in safely staffing the floor, while Jennie detailed she often worked 16-hour days (eight hours assisting on the floor and eight hours completing her managerial role).

2.4. Support

All the participants reflected on photographs of demonstrations of community support, including PPE donations, cards, art, and food donations, as well as support from their families. They also discussed the effect the support of coworkers and managers in the LTC homes had on their experience. Bernie and Cathy discussed community members who donated PPE and disinfecting supplies. Bernie shared a photo thanking a local company for their donation of gloves (Fig. 5). Cathy reflected on donations of food (Fig. 6), “They certainly made sure we didn’t starve, and we were well looked after, and they were thinking of us” and felt these donations meant “people had some idea what we were going through and know we, we provide excellent care . . .”—despite the media tearing them apart.

Jenny spoke of how messages of affirmation and positivity, in the form of sidewalk chalk art as well as signs posted on the LTC home grounds was a reminder
family members and the community relied on her to care for their loved ones, which she viewed as a continuous circle of support—she relied on them (Fig. 7). Recognizing this, when Jennie saw a staff member was overwhelmed, she would assume their tasks and suggest they step outside to appreciate these signs of support. The LTC home where Jennie worked provided meals for the staff, which she described: “We decided from day one that we were going to feed the staff 24 hours a day... no staff member had to worry while they were at work about food...”

Jennie, in a management position, acted as a role model, adhering to the same protocols she enforced. Unfortunately, Bernie felt unsupported by the management staff where she worked. During the outbreak, Bernie pleaded for assistance and additional staffing on her floor, to help with the increased workload and to provide adequate care for the residents. She felt the management at the LTC home did not make an effort to ensure the staff were alright. Cathy and Jennie believed it was each member of the LTC home team who brought one another through a dark time. Bernie shared a photo of a card sent to her floor as a sign of support from another floor in the LTC home (Fig. 8). Bernie stated the photograph gave her mixed emotions. She shared:

...they sent us that card for support, ...they were thinking about us. ...it was nice they sent us up some donuts and that card signed by all the staff that were downstairs. ...I kind of got a little upset, and so did some of the other staff that were on my floor because of the other staff recording themselves downstairs or outside saying that we got this [COVID-19], and they weren’t on my floor, and they didn’t have any idea what was going on up there.

In regard to family, as previously shared, when Bernie’s family discovered there was a COVID-19 outbreak at her LTC home, they begged her not to go to work. Once Bernie helped them understand her position, her family accepted her choice to continue to work and demonstrated caring and helping by contacting her often. Jennie gave recognition to her spouse and the families of the staff; they were required to manage the extra chores and independently care for children when staff were required to isolate.

2.5. Altruism and dedication

The FWs who participated in this study all showed altruism and dedication. Jennie and Cathy spoke of staff who left because they were terrified of being infected with COVID-19 and infecting their families, and Bernie revealed there were staff who refused to assist on the floor where she worked during the COVID-19 outbreak. In Bernie’s example, she explained to those who were hesitant to work there, that the residents relied on the staff. She imparted her sense of obligation and ethical and professional responsibility as she continued to provide care despite the high personal risk. Cathy described the PPE as very uncomfortable; upon further reflection on her photo (Fig. 9), the depth of professional responsibility struck her anew, saying: “this is so powerful to me because we did what we had to do”. All the participants disclosed how working during the outbreak caused mental exhaustion and stress for themselves and the staff. After the outbreak, there was no time to sit...
and process what had happened, Cathy said: “All of a sudden life goes on. We gotta, you gotta pick up your socks and reopen”; this is testament to her dedication, and that of the staff, to keeping the residents and the quality and safety of their lives as priority.

Jennie demonstrated altruism in her concern for all the staff and residents at the LTC home, and repeatedly discussed the fear she had for everyone else. She shared the photograph of a piece of artwork created by and donated to the LTC home from the granddaughter of a resident (Fig. 10). She concluded her second interview discussing this photograph, stating: “We did our best, we truly did, we did everything we could. And I think that I love, I still love that [photo]. I told you it’s framed in the home.”

3. Discussion

The aim of this study was to gain a deeper understanding of the experiences of FWs caring for residents in LTC homes during COVID-19 outbreaks. The psychosocial effects, loss of normalcy, increased workload, support, and altruism and dedication, were the primary experiences identified by the providers. These findings are consistent with other studies conducted during the COVID-19 pandemic, SARS epidemic in Canada, and the Ebola outbreaks in Africa.

The participants spoke of mental exhaustion resulting from the COVID-19 outbreaks. Similarly, in a survey conducted by White et al., nursing home staff remarked on mental and physical exhaustion leading to burnout. They described the staff at the LTC homes were mentally cracking and beaten. Some participants had to take stress leave because of their experience during the outbreak, and some staff resigned. The feelings of fear stemmed from many aspects associated with working during an outbreak. The participants described an element of fear in the LTC home when they were first told there were residents who tested COVID-19 positive. It has been found HCPs’ fears subsided as they learned more about the proper use of PPE and how to protect themselves, helping them feel more confident in providing care during an outbreak. Participants isolated from their families within their homes, or, as other staff did, isolated in separate homes and trailers. Living separately from family, out of fear of infecting them, also was an action taken by HCPs during the SARS and Ebola outbreaks.

The loss of normalcy regarding their surroundings and routines that occurred during the pandemic was prominent in the participants’ stories. They all mentioned how life was easier and happier in the LTC homes prior to the outbreaks. The participants missed the daily interactions with the residents and freedom of movement. Similarly, the LTC staff in Hung et al.’s COVID-19 study discussed effects such as distress, confusion and loneliness from social isolation imparted on residents in LTC homes in Canada. Furthermore, in this study, communication and therapeutic relationships were found to be challenging given the increased requirement of PPE during the outbreaks. Related, the HCPs working during an Ebola outbreak felt the PPE ‘dehumanized’ them. In our study, the residents were contained to their rooms during the COVID-19 outbreaks, this affected them psychologically, leading to depression and misbehaviour.
The residents’ family members were not allowed to enter the LTC homes to visit the residents unless they were actively dying. The participants described how separation from their families affected the mental health of the residents. The use of technology to connect residents with their family and friends was an aspect discussed by Estabrooks et al., who considered it essential to comfort.

An increase in workload was inevitable during the COVID-19 outbreaks. All participants discussed the impact the increased workload had on their experience. They were physically exhausted from extra precautions, residents requiring to stay in their rooms and requiring more care due to their infection. The increase in workload due to changes in job responsibilities and requirements, and staff-shortages is echoed in a COVID-19 qualitative studies with FWs in LTC facilities in the United States, The participants spoke about donations of PPE and cleaning products to the LTC homes. They also shared photographs of signs posted on the grounds at their LTC homes, as well as images of sidewalk chalk art and art created by relatives of residents for the staff at the LTC homes. Further, food was donated as a gesture of support by individuals in their communities. They felt the food donations and signs of support meant community members recognized the excellent care they were providing and appreciated they were trying their best, even if there was some unfavourable media coverage. Respondents to White et al.’s survey felt negative media coverage to be demoralizing. A positive attitude and a sense of “pulling together” has been reported to have a significant impact on reducing stress. A social media platform created for frontline staff to support each other during an Ebola outbreak in Sierra Leone was found to help HCPs cope. Praying together before work and religion has also aided HCPs in coping with the death of patients. Additionally, other frontline HCPs spoke about how the support and encouragement from their families helped them with the stress of their work.

Ethical and professional obligation and responsibility were paramount to the participants in our study, which has also been found in other studies; providers continued to provide care despite the high risk to themselves. In a study by Koh et al., conducted during the SARS outbreak, they concluded HCPs accepted the risk of infection that came with attending work. In our study, the participants shared their stories of altruism and dedication during the outbreaks, and revealed others were hesitant and or opted not to work. Similarly, in previous studies about epidemics, coworkers refused to provide care to infected patients. The unwillingness of others to continue to work in their professional roles during a high-risk condition demonstrated the dedication of the three participants in this study, particularly given they chose to do extra shifts resulting in increased COVID-19 exposure. Like the findings in the study, Duhn et al. found HCPs extended shifts to ensure residents were cared for. The isolation requirements for those working in LTC homes also deterred people from continuing to work. All the participants described the difficult experience of isolating, yet continued to do it to protect their families, the community, and the residents from COVID-19.

4. Conclusion and implications

This study gave FWs in LTC homes an avenue to share their experiences and provide firsthand insight into the events that took place during the COVID-19 outbreaks. This unpacking of their experiences shone a light on their courageous efforts in providing the best care possible in never-before-seen circumstances. The psychosocial effects and mental exhaustion noted by the participants emphasized the importance of protecting the mental health of FWs. Providing easily accessible mental health support for staff is essential. Going forward, it is offered educators must teach students coping mechanisms and the importance of building a support system as all participants discussed the supportive role their friends and families played during the outbreaks. Protecting the mental health of FWs will translate to an improved experience for long-term care residents. Participants reported the effect the loss of normalcy within the LTC homes had on their interactions and care for the residents. Jennie told a story of the comfort decorating the lobby brought to her, demonstrating the importance of trying to maintain routine and procedures where possible. Maintaining normalcy where possible is helpful for residents as it is for FWs. The increased workload that results during the outbreaks is difficult to mitigate. Maintaining a fully staffed workplace prior to outbreaks, providing incentive, and reallocation of staff within the LTC home may help to improve workload and allow for care beyond the necessities. Some of the LTC homes that had declared COVID-19 outbreaks in Ontario were not prepared—evidence of the need for insights and new information for better preparedness and enhanced policy development in the event of a disaster. There is opportunity for a longitudinal study, with follow-up interviews or a future study with other participants about their experiences
after the pandemic. Future studies may reveal the long-standing effects of working through a traumatic outbreak once HCPs have had time to reflect.

Acknowledgement

Thank you to the frontline workers who were open and honest in the research study. There is vulnerability that comes along with sharing an experience such as this. Your courage and dedication do not go unnoticed.

Conflict of interest

The Authors declare that there is no conflict of interest.

References


