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HOME HEALTH CARE NURSES' EXPERIENCES AND PERCEPTIONS OF PROVIDING CARE TO OLDER ADULTS DURING THE COVID-19 PANDEMIC: A QUALITATIVE DESCRIPTIVE STUDY

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BY

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ABSTRACT

Home health care nurses were essential front line healthcare providers during the COVID-19 pandemic in the United States. Research in this area has primarily focused on the experiences of nurses in the acute and long-term care settings. This study aims to: (1) gain an understanding of the subjective experiences and perceptions of home health care nurses providing care to OAs during the COVID-19 pandemic and (2) elucidate aspects affecting the care provided to OAs during the COVID-19 pandemic.

Twenty nurses were interviewed between July 2022 and September 2022. The interviews were semi-structured and were analyzed using reflexive thematic analysis. Four main themes were generated: (1) Increased fear for others and for oneself during the COVID-19 pandemic, (2) Substantial obstacles made it harder to provide care during the COVID-19 pandemic, (3) Multiple stressors caused a diminished sense of well-being during the COVID-19 pandemic, and (4) Finding ways to get through the day.

The greatest fear nurses experienced was of infecting others (patients and family members) and oneself. This was exacerbated by limited access to personal protective equipment and patients not always complying with masking recommendations. Masking related issues resulted in the personal ethical dilemma of whether to stop the visit (putting the patient at risk) or continue the visit (putting the nurse at risk). Multiple organizational challenges and barriers, including ever changing infection control practices and lack of clear support from leadership, increased the complexity of providing care to older adults, who were often sicker and reluctant to use hospital-based care due to fear of infection. Cumulatively this translated to increased stress on home health care nurses and a diminished sense of overall well-being. Despite these unprecedented challenges, nurses

developed a deeper connection with older adults and reported increased support from peers and providers that helped them to deal with the situation and continue in their roles.

These findings suggest that greater leadership support and clear infection control policies specific to home care are needed. This can assist home health care nurses to navigate the unique challenges of home-based care, provide quality care to older adults, and preserve overall personal well-being. Results from this study can inform future disaster planning for both nurses and the older adults and the development of education, training, nursing interventions and health policies to support nurses who provide care at home.

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Chapter One

Introduction

In December 2019, the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), commonly referred to as COVID-19, was first identified in Wuhan, China (Liu et al., 2020; Salari et al., 2020). On March 11, 2020, the World Health Organization (WHO) declared the COVID-19 outbreak a global pandemic. COVID-19 became the fifth documented pandemic since the 1918 influenza pandemic. The contagiousness and severity of the pandemic led the United States (U.S.) government to initiate a national shutdown to control the spread of the disease (Hering et al., 2022; Salari et al., 2020).

The shutdown tested the limits of the U.S. healthcare system and led to a crisis in the ill-prepared healthcare system. The pandemic forced healthcare organizations to make immediate, drastic changes in the model, structure, and processes of care delivery. Routine care was suspended, face-to-face visits pivoted to telehealth visits, elective surgeries were postponed, and resources were re-structured to minimize the spread of this unknown new disease. This change was necessary for healthcare organizations to reduce spread of disease and adapt to the sudden explosion of patients requiring emergency care.

This crisis and sudden change in healthcare delivery heavily impacted older adults (65 years and older) who were a highly vulnerable population, and utilize a greater proportion of healthcare resources. Increased rates of hospitalizations and deaths from COVID-19 disproportionately affected the older adult (OA) population. Hospitalization for OAs increased four to nine times and mortality increased 95–230 times among those aged 65 years and older (Agency for Healthcare Research and Quality, 2021). As of

January 2023, 13% of confirmed cases of COVID-19 were in the OA population. Furthermore, 75% of all COVID-19-related deaths occurred in OAs (Statista Research Department, 2023).

Registered nurses played a crucial and integral role in the response to the COVID-19 crisis. As with the OAs they cared for, a growing body of global research speaks to the devastating effects COVID-19 has had on these front line healthcare workers. Unlike workers in other fields, nurses were not able to work from home and were exposed to considerable risk to perform their job (Blau et al., 2021). Nurses were expected to provide care to patients diagnosed with COVID-19 across various healthcare settings with minimal preparation and inadequate protection. In the early phase of the COVID-19 pandemic, healthcare workers were at high risk of infection from an unknown disease, lacked experience in caring for patients with COVID-19, and were inadequately prepared for a disaster of this magnitude.

Preliminary evidence suggests that the devastating effects of the pandemic on patients, families, and co-workers has negatively impacted nurses' well-being. This is noted by increased prevalence of stress, anxiety, and depression among nurses caring for patients with or without COVID-19 (Hering et al., 2022; Luo et al, 2020; Salari et al., 2020). Multiple stressors have caused many nurses to adopt negative coping strategies, retire early, and leave the workforce, resulting in an unstable nursing workforce and a shortage of nurses to provide care across healthcare settings (Nie et al., 2020).

Significance of the Problem

As healthcare steadily moves towards a community-based model of care delivery, home health care nurses play an increasingly vital role in care delivery. Yet, despite the

increasing importance of nursing care at home, qualitative studies involving home health care nurses providing care to OAs during the COVID-19 pandemic in the U.S. are limited. To date, most research has focused on nursing care provided to OA populations in the acute care and long-term care settings due to the high mortality rate of OAs in these contexts (Centers for Disease Control [CDC], 2019). Conversely, there is limited research regarding how the COVID-19 pandemic has influenced home health care nurses and the provision of care to OAs at home (Elliott et al., 2023; Moi et al., 2022). The study is essential to give voice to these under recognized nurses and provide insight into their experiences and perceptions of caring for OAs in their home during the pandemic.

Purpose of the Study

The aims of this qualitative descriptive study were to: (1) gain an understanding of the subjective experiences and perceptions of home health care nurses providing care to OAs during the COVID-19 pandemic and (2) elucidate aspects affecting the care provided to OAs during the COVID-19 pandemic. This knowledge can inform interventions to improve nurses' overall well-being, ensure quality care is provided for a growing OA population, and improve preparations and the structure of work in organizations in the event of future disasters.

Subjective Perspective of the Researcher

Qualitative research depends on the researcher's subjective perspective, commonly referred to as reflexivity. Reflexivity is "a set of continuous, collaborative, and multifaceted practices through which researchers self-consciously critique, appraise, and evaluate how their subjectivity and context influence the research processes." (Olmos-Vega et al., 2022, p. 1). Reflexivity is a major component in the thematic analysis and

interpretation of the data in this qualitative study (Braun & Clarke, 2019, 2020). By using this method throughout the research process, beginning with development of the research questions and continuing through the analysis and interpretation of the data, the researcher consciously focused on embracing personal, interpersonal, methodological, and contextual reflexivity (Braun & Clarke, 2019, 2022; Olmos-Vega et al., 2022). Continuously reflecting on one's own perspectives and the impact they have on the interpretation of the data was critical for successful reflexive thematic analysis.

One's pre-understanding is a component in the subjective perspective, and it is important to be aware of, consider, and question one's professional pre-understanding in a way that neither enhances nor clouds one's view (Gillsjö et al., 2011). The researcher reflected on the interpersonal aspect of the semi-structured interview as participants may be known to the researcher as well as how the impact of one's role as the researcher may be perceived as a power differential. Being aware of one's professional pre-understandings of acquired biases and assumptions from the researcher's personal experience as an acute care and a home health care nurse pre-pandemic guided the interpretation of the data. These professional pre-understandings also occurred as a result of the researcher's professional role as an educator in gerontology and community health nursing. It is this awareness of one's pre-understandings during the interpretation of the text that helps the researcher to recognize, interpret and understand themes that are generated from the text (Gillsjö et al., 2011). Acknowledging the impact of pre-understandings on the research process and the conscious recognition of performing reflexivity allowed for a deeper, more nuanced interpretation of the data. By conducting these processes, one is able to more accurately represent the findings of the study.

Reflexively, the researcher leans toward inductive qualitative inquiry and the construction of new knowledge based on an individual's unique perspective and the context of the situation.

Chapter Summary and Structure of the Dissertation

In summary, this chapter provided a brief background and impetus for conducting this study about home health care nurses' experiences and perceptions of providing care to OAs during the COVID-19 pandemic. *Chapter two* comprises a review of the literature to date on nurses' experiences during the COVID-19 pandemic, followed by a comprehensive review of the limited research available on home health care nurses' experiences during the pandemic. The literature review will also address aspects of nursing care found to impact the care of OAs. *Chapter three* presents the research methods, design, and analytic approaches. The findings of the study are reported in *Chapter four*. *Chapter five* offers a discussion of the findings, along with summary and conclusions, followed by acknowledgement of limitations and implications for future practice specific to research and theory development, education, nursing practice, healthcare administration, and policy.

Chapter Two

Review of the Literature

This literature review provides an overview of home health care nursing and aspects of nursing care during the COVID-19 pandemic which impacted older adults (OAs) across settings, with a focus on care provided to OAs in the home setting during the COVID-19 pandemic.

The literature review was conducted by searching the databases Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and Google Scholar. No date ranges were included. Terms used in the search were 'COVID-19'/AND 'home care'/AND 'older adult', 'COVID-19'/AND 'home care'/AND 'elderly', 'COVID-19'/AND 'home care'/AND 'nurse'. The literature review was supplemented with gerontological textbooks to incorporate the latest evidence of gerontology and geriatrics and a manual search of relevant referenced articles. Throughout this chapter, the term "nurse" will refer to registered nurse (RN), and "home health care nursing" will be the term used throughout this study to indicate the specialty area of nursing practice whereby intermittent skilled nursing services are provided in the home by a RN.

Nurses in Home Health Care

Home health care is an area of nursing practice in which "skilled nursing care is provided in the home according to a plan of care" (Centers for Medicare and Medicaid Services, [CMS], 2022, p. 23) to promote optimal health and well-being for patients, families, and caregivers. Skilled nursing care is defined as "a level of care that includes services that can only be performed safely and correctly by a licensed nurse, either a registered nurse or a licensed practical nurse" (CMS, 2022, p. 24).

As of 2020, 61% of RNs were working in the hospital setting and 18% were working in ambulatory care services, which includes home health care (U.S. Bureau of Labor Statistics, 2021). There is an ongoing transition in healthcare steadily moving away from hospital-based care towards a community-based model of care delivery with increased demands on skills and competencies of home health care nurses (Aveling et al., 2017).

Various terms have been used to describe care delivered at home, including *home care*, *visiting nurses*, *home health nursing*, and *in-home nursing*. Home-based services can include personal care services, caregiving, and skilled nursing services, such as cardiopulmonary assessment, intravenous (IV) infusion, wound care, health promotion, and patient teaching regarding disease and medication management (Stanhope & Lancaster, 2022).

Nurses play a pivotal and integral role in providing care that enables OAs to remain in their homes. Home healthcare agencies and the nurses they employ provide care for more than 2.4 million OAs and persons with disabilities annually (CMS, 2022) and 82.6% of home health patients are older adults (Centers for Disease Control [CDC], 2016). It is estimated between two and four million homebound older adults in the U.S. with multiple chronic and complex diseases benefit from home-based services (CMS, 2016). During the COVID-19 pandemic (2020 to 2021) the prevalence of homebound adults aged 70 years or older increased dramatically, more than doubling from 5.0% in the years 2011-2019 to 13.0% in 2020. This increase was partially driven by the public health recommendations to stay home to minimize the risk of infection with COVID-19 (Ankuda et al., 2021).

Typically, home health care nurses use a holistic approach to help individuals achieve their highest level of functioning (Stanhope & Lancaster, 2022). The profession as a home health care nurse entails working together with other professionals in an interdisciplinary team model of care delivery. Other members of the team are from complimentary professional disciplines (e.g., physical therapy, occupational therapy, social work) who work collaboratively with nurses to achieve optimal health outcomes for OAs in their home environment (Stanhope & Lancaster, 2022). This collaborative model has demonstrated a positive impact on patients' adherence to medication regimens, patient satisfaction, and health-related quality of life. Compared to hospital or nursing home care, the home was a safer environment during the COVID-19 pandemic, with lower incidence of COVID-19 and decreased mortality (Gaspar et al., 2020).

Home health care nursing can be very rewarding but poses unique challenges that affect nurses and the patients and families being cared for. A common challenge that has been reported is the unpredictability of the home environment. According to Svetvilas (2022), every home visit is unique, as each older adult has different acute or chronic conditions, home environments, and support systems, which affect the delivery and reception of care. The variability of each OA's situation requires the home health care nurse to have greater flexibility to be prepared for the unexpected. Other challenges unique to home health care nurses include more autonomous working conditions that require the nurse to operate independently, providers and other nurses not being immediately available if needed, and the need to drive from house to house during extremes in weather conditions. Home health care nurses must have an intrepid spirit to successfully navigate the unpredictability of home visits. These unique challenges were

exacerbated by the COVID-19 pandemic, which created an even more unpredictable practice environment due to the ever-changing guidelines and unexpected obstacles faced during each workday (Svetvilas, 2022).

Historical Underpinnings of Providing Care to Older Adults (OAs) in Their Home

Prior to the 1900s, chronically ill OAs were most commonly cared for by family members. When families could no longer care for their dependent older family member, they were cared for by untrained nurses in almshouses or asylums. People cared for in almshouses and asylums received custodial, substandard, and often neglectful care. Use of physical and chemical restraints was common and immobility in these settings fostered older adults to become increasingly dependent and vulnerable to disease (Dahlke, 2011; Eliopoulos, 2022).

In 1935, the U.S. federal government began examining the rights and needs of OAs and the Social Security Act (SSA) was enacted. The SSA allowed for the transfer of older adults from almshouses to receiving paid care in nursing homes, which resulted in a better quality of overall healthcare. However, during this time nursing homes were unregulated and the care of the older adult continued to be suboptimal by modern standards. Due to continued substandard care and limited access to critical health services, home care services were added as a major benefit when the Medicare and Medicaid legislation was passed in 1965 (Eliopoulos, 2022; Dahlke, 2011). Home care services funded by the U.S. federal government provided opportunities for the OA to access services to support aging in place (i.e., at home) and maximize independence, which were important factors in maintaining a high quality of life for older adults. Thus,

nurses have been, and continue to be, strong advocates for the rights of older adults to receive needed services and support.

Older Adults (OAs) in Need of Home Health Care Nursing

The OA population is the fastest growing age group in the U.S., currently representing 16% of the U.S. population, and is estimated to grow to 20% by the year 2030 (Eliopoulos, 2022). An aging population does not necessarily equate to an increased number of OAs who will require nursing care. However, longer lifespan often brings increasing and complex healthcare needs due to normal age-related changes, multiple health problems, and frailty (Burbank, 2006; Fried et al., 2001; Shirai et al., 2022).

Normal age-related changes reduce the older adult's ability to maintain homeostasis and decrease functional reserve to handle biological stress and disease (Eliopoulos, 2022; Hogan-Quigley & Palm, 2022). These normal age-related changes place an OA at risk for developing chronic health conditions, which approximately 50% to 80% of older adults have (CDC, 2016). OAs with multiple health problems are at increased risk of becoming frail and more vulnerable to opportunistic infection, which is a major risk factor for COVID-19. Frailty, defined by Fried et al., (2001) is "a clinical syndrome in which three or more of the following criteria are present: unintentional weight loss (10 pounds in past year), self-reported exhaustion, weakness (grip strength), slow walking speed, and low physical activity" (p. 146). Normal age-related changes, chronic health conditions, and frailty increased the risk of contracting and dying from COVID-19 for older adults (Mete et al., 2022; Salini et al., 2022).

Despite having comparatively complex healthcare needs, 77% of adults aged 50 years and older want to remain in their home for the long term. The home has been found

to be linked with the older adult's identity, integrity, and way of living, and those who require nursing care for health problems prefer to receive care at home and remain at home as long as possible (Davis, 2021; Gillsjö et al., 2011). With the expected exponential increase in the population of OAs living longer and the inherent risk of aging and subsequent illness, the need for health care services at home will continue to be necessary.

In order for older adults to receive home care services from a Medicare and Medicaid certified agency, they must meet the requirement of being "confined to the home (i.e., homebound)." OAs are considered homebound if they meet the following two criteria: (1) require the use of special transportation or the assistance of another person in order to leave their place of residence due to illness, injury, or need for supportive devices such as crutches, canes, wheelchairs, and walkers and (2) have a condition such that make leaving the home medically contraindicated. If the OA meets only one of the criteria noted above, the patient must meet the following two additional criteria: (1) there must exist a normal inability to leave home and (2) leaving home requires a considerable and taxing effort (CMS, 2022).

Nursing Aspects Affecting Care of Older Adults (OAs)

Multiple nursing level aspects have been shown to impact the care that home health care nurses provide to older adults at home. This includes the workplace environment, nurses' attitudes towards the care recipient, and education on age-appropriate care. These are discussed below.

Nurses' Workplace Environment

Workplace environment and resource availability affect nurses' ability to deliver quality care to older adults. Identified barriers to providing quality care to OAs in the hospital and long-term care (LTC) setting include limited staffing, lack of time, and feeling ill-prepared to address the complex needs of the OA (Barba et al., 2011; Boltz et al., 2013; Shaheen et al., 2019; von der Warth et al., 2021). Previous studies of intensive care unit (ICU) nurses reported the stressful emotional and physical environment of the ICU, staff shortages, and limited resources all negatively impacted the nurses' ability to provide quality care to OAs (Heydari et al., 2019). Similarly, Lasater & Mchugh (2016) found hospital nursing staff shortages and work environment were associated with the negative outcome in older adults, including being readmitted to the hospital within 30 days following elective total hip and knee replacement.

According to Mitzner et al. (2009), transition and handoff errors during the transfer of the older adult to the home environment were identified as barriers in home health care nurses' ability to deliver quality care to older adults. This transition and hand-off errors were found to be a result of communication breakdown concerning medical diagnosis, medications, and treatment orders. Kieft et al. (2014) found increased complexity of care (due to multiple medical conditions) and increased workload negatively impact care of older adults in the home environment.

A nursing shortage exists nationwide and has been associated with the quality of care provided (Hanes, 2022; Kieft et al., 2014). However, in contrast to the shortage of nurses in the acute and LTC settings negatively impacting the care of OAs, the home health care environment has demonstrated a positive impact on care provided to older

adults despite a nursing shortage (Tyler et al., 2021). According to the Institute of Medicine (2011), home health care nursing has demonstrated a decrease in all-cause mortality among chronically ill older adults and improved long-term health outcomes for older adults.

Nurses' Attitudes

Prior research indicates that nurses can have complex coexisting positive and negative attitudes toward the care of older adults (Rush et al., 2017). Nurses with positive attitudes towards the care of OAs have greater knowledge of the aging process, prefer to work with older adults, and often have been cared for and have a good relationship with an older adult (Liu et al., 2013; Rush et al., 2017; Ugurlu et al., 2019). These positive attitudes have been associated with better quality nursing care (Fita et al., 2021; Mehri et al., 2020).

Butler (1969) coined the term ageism as the "discrimination against individuals or groups on the basis of their age" (p.243). Nurses' hold negative or "ageist" attitudes. Nurses' ageist attitudes have been found to be most commonly related to characteristics of the OA and increased care demands (Rush et al., 2017). For example, OAs with complex healthcare needs (i.e. cognitive impairment, immobility) can require nursing care that is more time intensive on the part of the nurse. Factors found to be associated with negative attitudes toward the care of OAs included limited resources and lack of staffing in the work environment, lack of knowledge and skills in gerontology, and less than 10 years' nursing experience (Heydari et al., 2019; Parke & Hunter, 2014; Rush et al., 2017; Topaz & Doron, 2013). These negative attitudes towards caring for OAs have been found to negatively impact the care provided (Dahlke, 2011; Nemiroff, 2022; Rush

et al., 2017). For instance, previous studies have shown that when older adults were exposed to ageism, they experienced increased functional decline, poorer quality of life, memory performance and impaired balance (Inouye, 2021; Levy et al., 2020).

Nurses' Education

Nurses' educational level and education specific to gerontology and geriatrics are the most investigated aspects pertaining to nursing care of OAs. However, studies have revealed inconsistent findings. Multiple studies suggest that lack of knowledge in gerontology and geriatrics is a major obstacle to providing quality geriatric care (Bahrami et al., 2019; Boltz et al., 2013; Burbank, 2006; Hanson, 2014; Lee et al., 2015; Ugurlu et al., 2019) whereas others have revealed no association (Fita et al., 2021; Liu et al., 2013). Lack of gerontology and geriatric education was directly associated with poor outcomes of care for older adults (Shaheen et al., 2019). Similarly, studies have found the impact of education on nurses' attitudes to be mixed, with higher education levels correlated with positive attitudes in some works (Fita et al., 2021) versus no association found in others (Liu et al., 2013). Iatrogenic complications, adverse outcomes from deconditioning and unrecognized delirium, were found to be three to five times more likely to occur and nursing interventions were more likely to be overlooked when gerontological nursing knowledge was absent (Heydari et al., 2019; Parke & Hunter, 2014).

This has precipitated educational initiatives to improve the care of older adults in the hospital setting by participation in geriatric focused initiatives such as *Nurses Improving Care for Healthsystem Elders* (NICHE). NICHE provides evidence-based education in support of high-quality older adult care and emphasizes education and practice development for nurses. Implementation of NICHE has been shown to improve

quality of care, increased patient safety, lower complications, and decreased length of stay for OAs (Squires et al., 2021), suggesting that enhanced education specific to care of older adults can lead to improved outcomes for this population.

Education may also impact new graduate nurses' decisions to pursue a career in gerontology, which in turn will impact the nursing workforce available to care for OAs. Limited gerontological and geriatric education, heavy emphasis on acute care, viewing the field of gerontology and geriatrics as "depressing" and less exciting, and not having previously worked with older adults are all factors that have been observed to affect graduate nurses' decision to not pursue a career in gerontology and geriatrics (Garbarino & Lewis, 2020; Garbrah et al., 2017). Conversely, positive clinical experiences with older adults, positive role models, positive attitudes toward older adults, and greater confidence in providing care to the OA during nursing clinical experiences increased the likelihood graduate nurses would enter the field of gerontology (Lee et al., 2018; Lun, 2010).

Nurses' Experiences During the COVID-19 Pandemic – Acute Care and Long-Term Care

Acute care and long-term care (LTC) nurses were front line healthcare workers during the COVID-19 pandemic. Nurses provided an essential service in-person and faced a high level of risk associated with performing their role (Blau et al., 2021). The pandemic created an unprecedented healthcare crisis. In particular, the acute care and long-term care settings were not prepared and less able to provide care to the OAs with chronic illness or those who were acutely ill with COVID-19. Across the board, nurses faced new and unprecedented challenges in caring for critically ill and contagious patients of all ages.

During the COVID-19 pandemic hospital nurses reported substantially increased workload, including increased patient volumes and high acuity patients. Continuously and rapidly changing regulations and restrictions, quarantining, social distancing, and wearing of personal protective equipment (PPE) increased effort to perform routine tasks (Tan et al., 2020). Absence of staff members due to infection with COVID-19, having to quarantine if identified as a close contact, and vaccine mandates resulted in increased strain to cover shifts and work with limited resources (Musto, 2021). Additionally, nurses had to quickly master specialized nursing skills such as advanced life support/ventilator support and knowledge of disaster rescue training, often with no prior training in these areas. This knowledge deficit in both specialized nursing skills and disaster rescue training caused nurses to be less confident and more anxious about performing their duties (National Academy of Science, 2021).

The increase in nurses' workload in both the acute care and LTC setting was compounded by the additional stressors of fear of infecting patients, oneself, and family members. Inadequate PPE availability and family visitation restrictions (often seen as a source of important patient information) limited the nurses' ability to recognize patient health status changes and deterioration (Firouzkouhi et al., 2022; Lekan et al., 2020; Liu et al., 2020; Tan et al., 2020). Both front line hospital nurses and long-term care nurses experienced increased psychological stress, anxiety, and depression due to the many challenges faced during the COVID-19 pandemic (Boamah et al., 2022; Hering et al., 2022; Salari et al., 2020).

Conversely, there is some evidence that nurses in acute care and LTC settings experienced positive impacts of being front line health care workers during the COVID-

19 pandemic. Recent qualitative studies have revealed that nurses felt an increased professional responsibility and identity, a sense of accomplishment, and an increased team spirit within the workplace. Nurses felt a sense of pride from patients' praise and affirmations from societal recognition of their service (Liu et al., 2020; Sarabia-Cobo et al., 2020; Tan et al., 2020).

Home Health Care Nurses' Experiences During the COVID-19 Pandemic

Few studies of home health care nurses' experiences exist to demonstrate how these nurses' experiences may be similar to or different from nurses in the acute care and long term care settings during the COVID-19 pandemic. Preliminary evidence points to similar challenges, such as fear of becoming infected or infecting other patients and family members. These fears were further exacerbated by staff and PPE shortages, and lack of infection control guidance (Emmesjö et al., 2022; Halcomb et al., 2020; Rowe et al., 2020; Tarvis et al., 2022; Tyler et al., 2021). These challenges may have increased complexity of providing care to OAs during the pandemic and created emotional, mental, and physical stress in home health care nurses. For example, there is some evidence from countries outside of the U.S. that home health care nurses experienced anxiety, depression, fear, and missing their peers (Moi et al., 2022; Rücker et al., 2021; Tarvis et al., 2022). Organizational support was insufficient and negatively impacted the nurses' emotional well-being. Physical exhaustion was experienced due to working longer hours due to staff shortages and wearing PPE (Billings et al., 2021; Ghezeljeh et al., 2022; Moi et al., 2022). However, evidence to date is limited, and further work is needed in this area.

In summary, the extensive impact of COVID-19 on nurses in the acute care and LTC settings and preliminary data in home health care settings suggests an urgent need to better understand nurses' experiences in home health care. This is supported by evidence that home health care nurses felt unrecognized with societal and media attention focused heavily towards hospital and long-term care nurses (Ghezeljeh et al., 2022).

Influence of the COVID-19 Pandemic on Older Adult's (OAs)

A recent systematic review and meta-analysis by Luo et al. (2020) revealed individuals with pre-existing and chronic conditions experienced more anxiety and depression during the COVID-19 pandemic. For older adults, this was related to a decrease in social contact across all communication avenues (e.g., texts, email, social media), a decrease in ability to leave the house, a decline in physical and cognitive function, and an increase in social isolation during the pandemic (Ankuda et al., 2021; Garcia, 2022). Some studies also point to age-based discrimination in distribution of healthcare and resources that negatively affected care of older adults (Cohn-Schwartz & Ayalon, 2021; Monahan et al., 2020). For example, in the acute care setting, ageism was seen with the medical triage of OAs to the lowest priority of care and access to life-saving measures. In the ill-prepared healthcare system, older adults were viewed as more vulnerable and less likely to survive, and age often became the criteria for access to intensive care treatment or a ventilator (Cohn-Schwartz & Ayalon, 2021; Truog et al., 2020). Chronological age (i.e., actual age in years) was the main criterion used when determining prioritization for ventilation despite directives stating that biological age (e.g., multiple morbidities, functional trajectory, degree of frailty) would be the main criterion utilized (Farrell et al., 2020; Le Couteur et al., 2020; Xie et al., 2020).

Increased Ethical Challenges During the COVID-19 Pandemic

Inequalities in the provision of care to older adults highlight the complexity of ethical decision-making during the COVID-19 pandemic and potential for ageism to influence healthcare delivery (Cohn-Schwartz & Ayalon, 2021; Monahan et al., 2020). Nurses reported facing specific ethical concerns while caring for patients with COVID-19, which created moral distress in nurses (Baxter et al., 2022; Cartolovni et al., 2021; Simonovich et al., 2022). For home health care nurses, ethical challenges included unequal exposure to an infectious environment, inability to respond in a timely manner to urgent patient needs, and lacking the knowledge and skills in adapting to a new environment (Jia et al., 2021; Li et al., 2021).

Chapter Summary

In summary, this chapter provided a review of the literature including the role of the home health care nurse, impact of the workplace environment, influence of attitudes and education on care delivery for OAs. The chapter also reviewed experiences of nurses providing care to older adults in acute and long-term care settings during the pandemic, along with preliminary evidence on home care nurses' experiences. While substantial work has been done in acute and long-term settings, data regarding the experiences of nurses caring for older adults at home remains limited. Evidence to date suggests that qualitatively understanding and exploring these experiences will be an essential first step towards gaining an understanding of the pandemic-related burden for home health care nurses. This information will be essential to preserving and promoting the health and well-being of front line healthcare providers. In the following chapter, the methods utilized to conduct the study will be presented.

Chapter Three

Methods

Introduction

Qualitative studies exploring home health care nurses' experiences providing care to the older adult (OA) during COVID-19 pandemic in the U.S. are limited (Bell et al., 2022; Elliott et al., 2023). As noted in Chapter two, research has focused on nurses' experiences in the acute care and long-term care setting, or has been conducted in countries outside of the United States, which might not reflect the U.S. home health nursing workforce experience. This gap highlights the need for the present study, which can inform future nursing practice, education, and theory development. The aims of this qualitative study are to: (1) gain an understanding of the subjective experiences and perceptions of home health care nurses providing care to OAs during the COVID-19 pandemic and (2) elucidate aspects affecting the care provided to OAs during the COVID-19 pandemic.

Research Design

An inductive qualitative descriptive (QD) approach was chosen to "describe the rich, truthful perspectives of those experiencing specific and focused situation" (Sullivan-Bolyai & Bova, 2021, p. 4). This is a naturalistic inquiry approach. Naturalistic inquiry does not involve *priori* variables or a commitment to any specific theoretical framework (Guba & Lincoln, 1982). Qualitative description is a flexible design in which decisions and changes can occur during the data collection and analysis phase of the study to allow a more person centric exploration of an experience. Qualitative research provides a straight comprehensive description of an event in everyday terms as viewed by those

having lived the experience (Bradshaw et al., 2017; Neergaard et al., 2009; Roberts, 2020; Sandelowski, 2000; 2010; Sullivan-Bolyai & Bova, 2021).

Unlike quantitative research, qualitative research recognizes the role of the researcher as the instrument in "recording, interpreting, and analyzing non-numeric data with an attempt to uncover the deeper meaning of human experiences and behaviors" (Renjith et al., 2021). This approach was selected based on the researcher's philosophical assumptions that multiple realities exist (ontology) and there is no one true way of seeing the world. Every individual offers a unique perspective and interpretation of their world. It is the researcher's belief that knowledge is developed from the meaning one constructs from personal experience (epistemology) and all knowledge is interrelated and has inherent value rather than objective truths (Guba & Lincoln, 1982; Peel, 2020).

This qualitative descriptive study utilized methods and procedures which fostered exploration and captured the unique perspective of home health care nurses providing care to OAs during the pandemic. The scientific and systematic methods and procedures employed to accomplish the study aims are outlined below.

Sampling Strategy

Participants were recruited from two Medicare and Medicaid certified home health care agencies in southern New England**.** These home health care agencies were selected because the majority of the patients receiving home health care services are OAs (65 years and older). They provided access to a range of diverse participants, including both urban and rural settings, and varying professional affiliation. The combined agencies employed 50 to 55 registered nurses.

The anticipated number of 20 participants was pre-determined based on estimates from prior research suggesting that data saturation (i.e., the point at which no new codes or themes are generated) can occur between 12 to 20 participants in qualitative descriptive research (Crouch & McKenzie, 2006; Guest et al, 2006; Sandelowski, 1995).

Eligibility Criteria

Nurses were eligible to participate in the study if they were: (1) licensed as a registered nurse, (2) understood and could carry out a dialogue in English, (3) had experience providing care to OAs during the COVID-19 pandemic in their home, (4) had access to a computer with a camera and microphone, and were (5) over the age of 18.

Recruitment Strategies

During study planning the researcher emailed the contact person of each agency's leadership team to confirm agency interest in participating as a referral source for the study. A teleconference meeting was scheduled to discuss the purpose and details of the study. Following this, the contact person agreed to distribute the recruitment flyer electronically to all potential participants (Appendix C). Interested participants were instructed to contact the researcher directly by phone or email.

The researcher performed the screening phone call for all interested participants (N=21). A telephone screening script (Appendix D) was used and if the potential participant met the eligibility requirements and agreed to participate in the study, a date and time was scheduled for the semi-structured interview at their convenience.

Purposive and Snowball Sampling

A purposive and maximum variation sampling technique was utilized to recruit participants deemed "information-rich" to provide rich, relevant, and diverse data

(DiCicco-Bloom & Crabtree, 2006; Sandelowski, 2000, p. 338). Purposive sampling is a strategy to choose participants who will provide a detailed description of the area of interest (Palinkas et al., 2015). Snowball sampling was also deemed an appropriate sampling strategy to identify and recruit participants for this qualitative study. The potential pool of participants is small, which makes this a useful strategy. After the interview with the first participant from both agencies, every participant thereafter was recruited utilizing snowball sampling. In this case, nurses who participated in the study subsequently recruited other nurses who they thought would potentially be interested in participating in the study. This sampling strategy affords the potential to discover uncommon variables and recruit participants who might have been hesitant to participate (Polit & Beck, 2018).

Twenty-one registered nurses were screened, twenty were eligible, and no one declined to participate. Twenty registered nurses participated in the study, and there were no withdrawals. Each participant received a $20 Amazon eGift card for participation in the study. One nurse did not meet the eligibility criteria as they did not provide direct care to OAs during the COVID-19 pandemic.

Data Collection

The data collection consisted of a demographic survey and individual semi-structured interviews and field notes.

Ethical Considerations

Interviews commenced following approval from the University of Rhode Island (URI) Institutional Review Board (IRB#00000599). The research process was guided by four ethical principles: beneficence, nonmaleficence, autonomy, and justice (Varkey,

2021). These principles were instilled throughout the research study as it posed no more than minimal risk, informed consent was obtained, confidentiality was maintained, and the participants were treated with respect and given unlimited interview time (Varkey, 2021).

Verbal consent was requested based on minimal risk and potential to hinder the recruitment process. All communication, beginning with initial contact, was conducted through the participant's personal email account. Prior to data collection, informed consent was obtained. Participants received the URI IRB approved informed consent (Appendix A) via email and were given the opportunity to review and ask any questions about the study. Participants received the web link for the URI Zoom videoconferencing interview and the web link to the Research Electronic Data Capture (REDCap) to complete the background data questionnaire (Appendix E).

Verbal consent was reiterated at the beginning of the recorded interview. Each participant verified receipt of the consent form via email, had read and understood the consent form, and had an opportunity to have their questions answered. Each participant agreed to be audio and video recorded. Participants were reminded participation was voluntary and that they could stop answering questions at any time without consequence.

Demographic Survey

Participants completed the demographic survey via REDCap. The link to the demographic survey was sent to the participant's personal email account. REDCap is a secure, web-based application hosted by the University of Rhode Island that allows for online HIPAA compliant data capture (Harris et al., 2009).

Interview Procedures

Interviews were conducted between July 29, 2022 and September 24, 2022. An interview is defined as "a conversation where two people talk about a theme of interest to both parties" (Kvale, 1983, p.178). Data collection through semi-structured interviews was chosen to be the best approach to capture the unique and individual experience of the home health care nurse providing care to OAs during the COVID-19 pandemic. The purpose of a qualitative interview is to contribute to a body of knowledge that is based on the participant's individual experience and the meaning they made of this experience (DiCicco-Bloom & Crabtree, 2006). The goal of the interview in this present study was to understand the "who, what, where, how, and why" of home health care nurses providing care to OAs during the COVID-19 pandemic (Neergaard et al., 2009, p. 2; Sandelowski, 2000). The structure of the interview chosen was a semi-structured interview, as compared to focus groups, which seek to obtain a broad range of information. The interview guide's trustworthiness was enhanced by conducting the four-phase Interview Protocol Refinement (IPR) method (Castillo-Montoya, 2016). This four-phase IPR method evaluated the interview questions to ensure that questions were: (1) aligned with the aims of the study, (2) proposed in everyday language, (3) reviewed by the expert qualitative researchers on the dissertation committee (JD, CG), and (4) pilot tested as described below.

Pilot Interview

Prior to the data collection in the study, a pilot semi-structured interview was conducted prior to the study with a colleague with expertise in qualitative research methods according to the approved research proposal. A pilot interview provides the

opportunity to learn from mistakes, strengthen interview skills, and identify potential biases (Castillo-Montoya, 2016; Roberts, 2020). The researcher was also able to assess and confirm the following post pilot interview: (1) the URI Zoom videoconferencing web link was easily accessible, (2) opportunity for the participant to have questions answered, (3) obtained verbal consent, (4) background data questionnaire completed via REDCap, (5) audio and audio and video file was obtained, (6) the interview questions were easily understood, and (7) acquisition of additional strategies to assist in obtaining rich descriptions.

Interviews with Registered Nurse Participants

One-to-one interviews were conducted using the semi-structured interview guide (Appendix F) that was pre-tested as described above. Interviews were audio and video recorded via URI Zoom videoconferencing, and lasted an average of 59 minutes (range 39 to 86 minutes). To ensure confidentiality and privacy, URI Zoom was "locked" so no one could enter and verbal confirmation was received from the participant no one else was in the room.

Role of the researcher. During the semi-structured interview, the researcher and participant worked toward forming a "conversational partnership" (Rubin & Rubin, 2012). In order to promote a conversational partnership throughout the interview, the researcher conveyed respect for the participant's experience and every attempt was made for the participant to feel their experiences were real, understood, and accepted. All interviews were conducted by JD. The researcher asked one question at a time to allow time for reflection, avoided interrupting participants to the greatest extent possible, used

gestures such as nodding and verbal expressions such as “Mm-hmm” to indicate understanding and attentiveness (Castillo-Montoya, 2016; Rubin & Rubin, 2012).

Interview structure. The semi-structured interview was structured around eight open-ended questions based on the aims of the study and developed from the literature review and feedback from the qualitative research experts on the dissertation committee (JM, CG). Open-ended questions were used to encourage a deeper dialogue and gain insight into the participant’s experiences and perceptions of providing care to OAs during the pandemic. This therapeutic communication strategy lends itself to obtaining a detailed self-report in which the participant determines which topic areas are most important to them (Polit & Beck, 2018). The order of the open-ended questions was not sequential, allowing the sequence of interviews to follow what was most important to each participant. The interview guide evolved with the addition of questions arising from member checking throughout the semi-structured interviews.

The interview began with the general question “Could you please describe your experiences providing care to older adults in their home during the different waves of the COVID-19 pandemic?” The eight laddered questions moved from general to progressively more specific, were written in everyday terms, and were asked in a conversational manner. Follow up prompts were used if the participant’s response to the main question was limited, unclear, lacked details, or if they had difficulty answering the question (Rubin & Rubin, 2012, p.7). These helped to increase understanding and deepen the reflection and dialogue (Creswell, 2007; Rubin & Rubin, 2012). The participant’s exact words were used so as not to mislead answers (DiCicco-Bloom & Crabtree, 2006; Kvale, 1983).

Field notes. Field notes and reflections were written by the researcher both during and post-interview. Initial interview reflection notes were shared with the qualitative research experts on the dissertation committee (JM, CG). Feedback focused on improving interview techniques and strategies to deepen the dialogue. Post-interview reflection notes for the remaining interviews were sent to the qualitative research experts for their review. The brief field note taken during the interview documented what the researcher perceived as most relevant and was used to inform the data analysis. The post-interview reflection provided the opportunity for the free flow of overall impressions and feelings about the interview and the participant, encouraged critical reflection, improvement and refinement of interview techniques, and insight to potential personal bias. Reflection provided essential context beyond the participant's response which informed data analysis and added rigor and provided rich context for analysis (Phillippi & Lauderdale, 2018).

Data Analysis

Transcription. The audio file only, with no personal identifiable data, was transcribed verbatim by Landmark Associates, Inc., a URI approved transcription service.

Thematic analysis. Inductive thematic analysis (TA) was utilized to analyze the data set. TA is a "method for identifying, analyzing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79, 2020; Clarke, 2017). TA can be categorized into three typologies: codebook thematic analysis (TA), coding reliability thematic analysis (TA), and reflexive thematic analysis (TA). Each category has a different analytical approach to the data. Reflexive thematic analysis (TA) was deemed to be the most appropriate as it is a flexible and iterative approach to data analysis and aligns

closely with the underlying philosophical assumptions of this study. Reflexive thematic analysis will be discussed in more detail below.

Codebook TA uses a codebook where themes are determined ahead of time or early in the analytical phase. In contrast, *Coding reliability TA* themes are understood as pre-existing topic summaries and typically reflect the interview questions. Coding is performed by independent researchers and agreement is through consensus (Braun & Clarke, 2022).

Reflexive TA is different from both codebook TA and coding reliability TA in approach to theme development. In codebook TA and coding reliability TA themes are developed early or pre-existed and guide coding. *Topic summaries* become themes with no evidence of a shared meaning. However, in reflexive TA themes are creative outcomes of coding by the researcher (Braun & Clarke, 2020; Clarke, 2021). In codebook TA and coding reliability TA themes can be conceptualized as "bucket" theme or topic summary theme. Conversely, in reflexive TA, themes are conceptualized as "books" that tell a story (Clarke, 2017).

The core principles of reflexive TA are the researcher's active role and subjectivity, recursive coding, and deep reflection and engagement in the data. Reflexive TA "is an iterative process where movement is back and forth between phases as needed" (Braun & Clarke, 2006, 2019, 2020, 2021, 2022). This flexible and iterative method was chosen based on close alignment with the underlying philosophical assumptions of this study.

The thematic analysis was conducted following the six-phase reflexive TA guide: (1) data familiarization and writing familiarization notes, (2) systematic data coding, (3)

generating initial themes from coded and collated data, (4) developing and reviewing themes, (5) refining, defining and naming themes, and (6) writing the report (Braun & Clarke, 2021; The University of Auckland, 2022).

Phase 1 Data Familiarization and Writing Familiarization Notes

Awareness of one's professional pre-understandings of acquired biases and assumptions is used to guide interpretation of the data and enhance recognition, interpretation and understanding of themes that are generated from the text (Gillsjö et al., 2011). Acknowledging one's pre-understanding as a researcher, home health care nurse, and an expert in gerontology was used to inform the analysis and represent the findings of the study.

The first step in the analysis of the data began with data familiarization and writing analytic notes. These notes were a result of "immersion in the data, reading, reflecting, questioning, imagining, wondering, writing, retreating, returning" (Braun & Clarke, 2021, p. 332). This phase began with writing field notes during the interview and ensuring accuracy of the interview transcript with the recorded interview. A reflection note was written after each interview noting familiar, new, or apparently significant comments made by the participant. Iterative reading of the interview transcript, field notes, and reflections, permitted depth and breadth with the data set.

Phase 2 Systematic Data Coding

Codes are "the building blocks for identifying patterns of meaning, underpinned by a central organizing concept" (Braun & Clarke, 2006). A data extract (i.e., unit of meaning) was coded if it captured something interesting or deemed significant in answering the research question.

All coding was performed using NVivo by JD. Codes were developed inductively. The limited scientific inquiry into this area of research made inductive coding an appropriate method of inquiry. Induction is the method of inquiry that allows the researcher to move "from the ground up" (Rubin & Rubin, 2012, p. 15) to an inferred generalization (Bergdahl & Bertero, 2015, p. 45). The codes and interpretations were created directly from the participant's responses, rather than pre-existing evidence.

Coding of each interview transcript was performed in an iterative manner. During the coding process, codes were modified, expanded, split, renamed, or merged as needed to best represent the data. Coding became more interpretative and moved from identifying the explicit to interpret underlying meaning in the text. Each code was thoroughly described so the associated data extracts were clear. Coding quality in reflexive TA stems not from consensus between coders but from depth of engagement with the data and reflexive interpretation (Braun & Clarke, 2021).

Discussion of the coding process was collaborative and reflexive between the researcher and members of the dissertation committee. Biweekly qualitative analytical meetings with the qualitative research experts of the dissertation committee (JM, CG) and a PhD student researcher via URI Zoom were conducted from September 2022 to January 2023. Coding and theme development was discussed in a collaborative manner to encourage reflection of the data and gain deeper insights as to the meaning of the data.

Phase 3 Generating Initial Themes from Coded and Collated Data

Themes are "stories" actively created from the data, data analysis, and the researcher's subjectivity (Braun and Clarke, 2021, p. 208). Themes reflect a pattern of shared meaning at a more abstract level than codes, while still staying close to the data. In

generating and reviewing the initial themes, themes were checked against the coded data and the entire data set to ensure they told a coherent "story" of the data and related explicitly to the research question. After iterative coding of the transcribed interviews in NVivo, thematic mapping began by clustering codes in a related manner using XMind. XMind is a mind mapping and brainstorming software which allows for a visual analytical map amenable to making immediate edits based on feedback (Mammen & Mammen, 2018). The initial themes were iteratively reviewed, consolidated, and renamed to deepen the meaning. Initial themes were actively created in an interpretative manner based on whether it captured information related to the research question, a shared meaning, and not a topic summary or category (Braun & Clarke, 2021).

Phase 4 and Phase 5 Developing, Reviewing, Refining, Defining, and Naming Themes

The fourth and fifth phases were conducted simultaneously. Ongoing iterative analysis, moving back and forth between phases, continued as themes were merged, further developed, reviewed, refined, defined and re-named. Themes, thematic statements, and definitions were created to add clarity to the shared patterns of meaning. Discussions about developing and naming themes between the researcher and members of the dissertation committee (JM, CG) served to enhance reliability of interpretations (Campbell et al., 2013).

Phase 6 Writing the Report

The 6th and final phase of reflexive TA involved selecting the most meaningful data extracts, final analysis of the selected extracts, and formulating answers to the research question (Braun & Clarke, 2021; Vaismoradi et al., 2013). This analysis allowed for the identification of underlying ideas and assumptions about the data (The University

of Auckland, 2022). The dissertation committee participated in all phases of the reflexive TA process, edited drafts of the analysis, and supervised the writing of the final report.

Techniques to Ensure Trustworthiness

Throughout the research study, reflexivity was used to uncover and address underlying assumptions, potential biases, prejudices, education, experience as a human being and a nurse of the research topic. This enabled the researcher to move beyond personal assumptions and biases to develop a shared understanding with the participant (Elo et al., 2014*;* Gillsjö et al., 2011). Guba & Lincoln (1982) also established four criteria to confirm appropriate steps have been taken to ensure trustworthiness of a naturalistic inquiry. Trustworthiness refers to the ability of the reader to have confidence in the results of the study and data from the participants is "meaningful, trackable, verifiable, and grounded in real-life situations." p. 250. These four criteria are: credibility, dependability, transferability, and confirmability (Amankwaa, 2016; Bradshaw et al., 2017; Lincoln & Guba, 1985; Morse, 2015; O'Brien et al., 2014).

Credibility

Credibility is achieved if the researcher's analysis, formulation, and interpretation of the data is believable (Guba & Lincoln, 1982). Credibility was enhanced by being engaged throughout the interview, maintaining mutual respect, and demonstrating empathy and compassion. Credibility of the analysis and interpretation of the data using the reflexive TA method was enhanced with biweekly thematic analysis meetings from September 2022 to January 2023 with the qualitative research experts of the dissertation committee (JM, CG) and another PhD student researcher. These collaborative meetings encouraged open dialogue to recognize and discuss biases and assumptions on the part of

the researcher that could impact the study, gain new insight into the explicit and underlying meaning of the data, and discuss the analysis of the data in NVivo and XMind.

Member checking, continuously checking with participants to ensure data and interpretations accurately reflected their experience, was conducted during data collection to assist in recognizing normative patterns (Guba & Lincoln, 1982; Morse, 2015). Participants' responses, if deemed significant or repetitive, were discussed in following interviews to determine if a pattern exists. The qualitative research experts on the dissertation committee (JM, CG) critiqued reflection notes of each interview by the researcher to ensure rigor and improve interview techniques in the data collection process. In presenting thematic findings, data tables were used to demonstrate prevalence and representativeness of themes using coded extracts from interviews (Appendix G).

Dependability

Qualitative research is considered dependable if the findings are stable over time and could be repeated (Amankwaa, 2016; Guba & Lincoln, 1982). Dependability was addressed by having members of the committee evaluate the consistency in representation of the collected data set from transcribed interviews. Recommended changes by the committee were implemented to ensure depth and breadth of information and assist to ensure consistency of data collection within and across interviews.

Transferability

Transferability refers to the extent to which findings can be transferred to other settings or groups (Polit & Beck, 2018). Transferability of the findings of this study was achieved as the researcher included clear descriptions of the sample, data collection and

analytic processes. Verbatim quotes from participants are provided with participant identifiers to demonstrate representativeness of findings and potential applicability to other populations with characteristics similar to the study participants. Rich, detailed descriptions allow for the reader to experience the event second-hand and determine the relevance and transferability to other contexts, situations, or groups (Polit & Beck, 2017).

Confirmability

Confirmability refers to the findings not being influenced by the researcher's bias (Amankwaa, 2016). Confirmability was addressed by maintaining an audit trail and documenting data collection and analytic phases, meetings, and dialogue with members of the dissertation committee members (JM, CG). Quoted findings are presented in a way that can be traced back to the raw data via participant identifiers to illuminate explicit and underlying latent meanings and to demonstrate the representativeness of findings.

Chapter Summary

In summary, this qualitative descriptive study was conducted to explore nurses' experiences and perceptions of providing care to older adults during the COVID-19 pandemic. This chapter described methodological approaches, data collection procedures, and analytical techniques along with underlying theoretical assumptions that impacted planning, implementation, data collection, and analysis of the data. Chapter four will present the findings of the study.

Chapter Four

Results

The results of this qualitative study provide a detailed understanding of home health care nurses' experiences providing care to older adults (OAs) during the COVID-19 pandemic. The reflexive thematic analysis generated four prominent themes and nine sub-themes, as shown in Table 1. A supporting coding diagram showing the relationships between individual codes and related themes is present in Appendix H. Each theme and sub-theme is described below with supporting illustrative quotes. Additional supporting data is presented for each theme in Appendix G. Throughout this chapter, the term "nurse" refers to registered nurse (RN).

Table 1

Themes and Sub-Themes

Themes		Sub-themes	
1.	Increased fear for others and for oneself during the COVID-19 pandemic	A. B.	Fear of the unknown disease Perception of fear in the OA
2.	Substantial obstacles made it harder to provide care during the COVID-19 pandemic	A. B.	Increased organizational challenges and barriers Increased complexity of home visits
3.	Multiple stressors caused a diminished sense of well-being during the COVID-19 pandemic	A. B.	Diminished sense of overall well-being Perception of diminished sense of well-being in the OA
4.	Finding ways to get through the day during the COVID-19 pandemic	A. B. C.	Developing flexible and creative strategies to provide care Developing deeper connections with OAs Increased peer and provider support

Description of Participants

Twenty home health care RNs from two separate home healthcare agencies participated in the study. Demographics are presented in Table 2. Participants were mainly white, female nurses, which is consistent with current data on the nursing workforce (Flaubert, 2021). Participants were diverse regarding age, years in nursing, and years in home health care. All of the participants had received gerontological and geriatric education.

Table 2

*Characteristics of Study Participants (N=19) **

	(n=19)
Gender	
Female	18
Male	1
Race	
White	18
Asian	1
Ethnicity	
Non-Hispanic or Latino	18
Not known/Not reported	1
Highest level of education	
BS	10
AD	2
Diploma	1
Graduate school	5
No reply	1
Employment Status Hours Per Week	
Full time (32-40 hours)	15
Part time (20-31 hours)	4
Gerontological Education	19
Nursing School	12
Continuing Education	4
In-service Education	1
	Mean (Range)
Age (years)	44.5 (29-68)
Years in Nursing	14.3 (2-42)
Years in Home Health Care	7.89 (1-36)

*One participant did not complete the background data questionnaire

Increased Fear for Others and for Oneself During the COVID-19 Pandemic

One of the most common experiences nurses described during the COVID-19 pandemic was of feeling afraid, which is defined as an uncomfortable heightened emotion from a perceived threat (Merriam-Webster, 2023). Nurses' primary fear was of giving COVID-19 to older adults. Fear for themselves becoming infected with COVID-19 was less of a concern. This fear of transmitting COVID-19 was based on recognition that the highest mortality from infection was occurring in OAs. Over time, fear decreased when exposure did not result in acquiring COVID-19 and vaccines and treatments became available. Nurses' fear was expressed in two ways: fear of the unknown disease and perception of fear in the OA. One RN described the unpleasant situation with the words: "It was like a black-and-white horror movie where everyone was afraid." (RN20)

Fear of the Unknown Disease

The unknown nature of COVID-19 caused the participants to feel afraid. Particularly early in the initial phases of the COVID-19 pandemic, unknown modes of transmission, not knowing what infection control practices were effective in preventing transmission, and uncertainty regarding the consequences of becoming infected with this new disease contributed to feelings of fear. This was different from before the pandemic when home health care nurses did not have the fear of potentially bringing a highly contagious and deadly disease into an older adult's home.

Fear of Transmitting COVID-19 to Their Family. The nurses' fear of the unknown spilled over into their personal lives, with many nurses reporting feeling afraid of transmitting COVID-19 to their family. Nurses spoke at length describing the new time-intensive "decontamination" process they performed when arriving home from work

each day. Prior to the pandemic, a nurse's routine upon arriving home from work did not include the risk of exposing their family to a highly contagious and potentially deadly virus.

Infection prevention measures included common as well as unique approaches to decontamination. Common routines included: calling ahead to inform their family they were on their way home, instructions to family not to talk or touch them (pets included) until after they had showered (generally as hot as they could tolerate), and placing the uniform immediately in the washer with bleach. Shoes never came into the home and were seen as a source of potential infection. Some nurses used a separate entrance/exit, separate living quarters, and would wear a mask when spending time with family members to reduce risk of exposure and transmission. Some unique routines included wiping down their groceries and placing their head over a boiling pot of water as one nurse heard steam killed the virus. These complex decontamination procedures had to be completed before the nurse could be with their family. As one RN expressed: “It was—we were crazy.” (RN9)

Nurses’ fear was heightened when they received notification that a patient who was negative for COVID-19 at the time of the visit had since tested positive for COVID-19. This occurred because at the time of the visit sometimes all the required PPE was not donned. Notification of COVID positive status increased the nurses’ fear of potentially having transmitted COVID-19 to oneself and to others through these inadvertent exposures. Nurses described constantly re-thinking through the infection control practices performed with patients they visited after a potential exposure during a visit.

Perception of Fear in the OA. The nurses also perceived OAs as being very afraid of getting COVID-19 from nurses or the hospital. Nurses indicated that they had to address this fear on a daily basis with older adults who were home all day due to the shutdown and spent most of the day watching news about COVID-19 on the television. Nurses explained infection control procedures to older adults during the pre-visit phone call as well as demonstrated infection control practices in the home to reassure them that everything possible was being done to avoid transmission of the disease to the older adult. The nurse believed that the OAs' fear was created and heightened by the constant media barrage and graphic images on television of older adults dying in the hospital alone. Nurses indicated that refusing home care visits, only allowing the same nurse to visit, or waiting for their "regular" nurse to return were some of the ways that OAs maintained control over potential exposure. Conversely, older adults also would refuse having the nurse visit if they themselves were exposed to COVID-19.

Substantial Obstacles Made it Harder to Provide Care During the COVID-19 Pandemic

The nurses reported that the COVID-19 pandemic created organizational challenges and barriers and increased the complexity of care when conducting a home visit. Based on available resources, nurses reported having to make adjustments in their decision-making, workload, and workday. One RN explained the situation with these words: "My days are harder and longer." (RN10)

Increased Organizational Challenges and Barriers

During the early phases of the pandemic, increased organizational challenges and barriers were described as making it harder for nurses to provide care to OAs. In

particular, the nurses faced substantial obstacles regarding *availability* and *access* to essential resources which affected their ability to provide safe, competent care to the older adult and also protect themselves. Nurses expressed feelings of frustration with the lack of essential resources such as personal protective equipment (PPE), sufficient nursing staff to deliver care, timely access to providers, and leadership support.

Lack of PPE. During the initial phase of the COVID-19 pandemic, a major obstacle for most nurses was not having the necessary PPE supplies, and consequently having to reuse PPE. In specific, the nurses encountered a lack of N95 masks, surgical masks, hand sanitizer, and gloves. The lack of PPE was challenging and a major barrier in providing safe care. Pre-pandemic, nurses had unlimited access to PPE supplies and pre-approval for use of these resources was not required. However, due to nation-wide hoarding and lack of suppliers, PPE supplies were either unavailable or strictly rationed. Administrative policies were instituted to control the availability and distribution of PPE supplies. One RN described it this way:

> ***RN1***: *I think people started to panic and someone or a few people took all of the masks, and we had to wait for them for weeks. We were re-wearing our regular masks.*

Most nurses found these new PPE policies to be an obstacle in providing care to OAs. The nurses indicated that policies were developed whereby they could only obtain PPE supplies on specific days and times. Supplies were kept under lock and key and commonly required a pre-order request a week in advance. In order to obtain essential PPE, the nurses described having to schedule their workday around the days/times that PPE was available and having to allocate increased travel time to go to the office and

retrieve PPE, as well as increased time to find the individual with the key to unlock the PPE supply closet. The logistics required to obtain essential PPE caused the nurses to feel mistrusted by and frustrated with leadership. One nurse expressed this feeling of mistrust in this way:

> ***RN13***: *Honestly, . . . it felt like, they're trusting me with people's lives, but I can't be trusted with gloves? Like, come on, really? But, I mean, whatever.*

This lack of PPE supplies resulted in nurses having to frequently reuse PPE, wear masks for longer periods of time than recommended, borrow from peers from other agencies, or purchased PPE on their own. Nurses reported placing a surgical mask over the N95 mask and disposing of the surgical mask in order to protect and re-use the N95 for longer. One RN described keeping the N95 mask in an igloo cooler because they were so afraid the rubber band on the N95 would break and they did not have a replacement mask. The shortage of PPE resulted in feelings of not being adequately protected and increased fear and anxiety about putting the OA and themselves at risk for infection with COVID-19.

Lack of Nurses. During the initial phases of the COVID-19 pandemic, there was a decrease in the number of nurses available to make home visits, which was an added organizational challenge to providing care. Nurses reported that the shortage of nurses in home health care prior to the pandemic dramatically escalated during COVID-19 as a result of nurses being out on medical leave, quitting due to stress, changing jobs, becoming infected with COVID-19, quarantining for exposure to COVID-19, needing to be home with children learning remotely, or decreased access to child and day care centers due to closure.

Participants described their workday as being negatively impacted by the nursing shortage. For example, nurses were required to make more home visits, which made their workday longer and led to feeling exhausted from working overtime. Similarly, the limited number of nurses able to visit COVID-19 positive patients, who could only be seen by nurses who were fit-tested, often required nurses to work outside their known geographical area. The nursing shortage was also evident in the daily open/unassigned list. The patients on this list were scheduled to be seen, but were not assigned a visit as a nurse was not available that day. One nurse described the added stress and responsibility of not having enough nurses to see older adult patients with these words:

> ***RN14***: *It was more rushed. They were asking us to see more people because a bunch of nurses were out with COVID or their kids had COVID. So now, instead of seeing four clients, they're begging me to see seven and stay late to see eight. So now you're running in and out of these houses.*

Lack of Access to Providers. Participants described decreased access to direct communication with providers during the pandemic. Limited access was a barrier to carrying out daily work as it was harder to receive timely feedback. If nurses were unable to obtain feedback from a provider in the home during the visit, this created increased stress due to nurses needing to continue to make scheduled visits. Nurses felt the optimal time to provide instructions and assess understanding of the changes was during the face-to-face visit. This delay required the nurses to telephone the patient and give the instructions over the telephone, which the nurses felt was not optimal to ensure understanding. Nurses generally communicated patient concerns to a receptionist, nurse case manager, or nurse in the provider's office. This information was relayed to the

provider and the call back was typically from the office staff. This communication process was commonplace pre-pandemic however, the shutdown severely limited access to providers. Providers were no longer seeing patients face-to-face and office staff were working remotely. Nurses expressed frustration in having to leave messages on automated office machines and not receiving a timely response. Nurses reported calling day after day due to receiving no response, which resulted in a delay in treatment. Nurses described feeling stressed, anxious, and worried about the older adult's condition until they received a call back from the providers. Thus, the delay in responses from providers resulted in increased personal stress for nurses, in addition to impacting patient care. The frustration and feelings of being powerless resulting from not being able to connect with providers was expressed by one RN in this way:

> ***RN12***: *That was a huge barrier. We felt very isolated and alone because we just couldn't get in touch with anyone.*

The closure of provider's offices during COVID-19 resulted in a decrease in face-to-face visits between the older adult and the provider. Thus, during COVID-19 telehealth visits were often conducted as either telephone calls or videoconferencing (Zoom or FaceTime). Nurses described both positive and negative feelings regarding these telehealth visits, but felt telehealth was generally convenient and appropriate for non-urgent visits. As one RN expressed:

> ***RN13***: *I only see five to six patients a day, and there were days where I was doing eight or nine telehealth visits because I had more leeway with the telehealth.*

However, the nurses also encountered challenges in conducting telehealth visits with the patient and the provider. Technological capabilities, assisting the OA in setting

up the equipment, rearranging their workday, and having to use a personal cell phone to conduct visits made the visits more complicated. Nurses also found telehealth visits to be difficult because older adults did not own a smartphone and nurses were dependent on the OA's family to assist with the set-up and access. One RN expressed this situation:

> ***RN10***: *[It's] ridiculous. They [the older adults] are having trouble breathing. You [the provider] need to see them. You need to listen to their lungs . . . [or] they [the older adult] have an eye infection and they would put their eye up to the camera . . . it was ridiculous . . . these people are 80 and 90 years old. They can't use [the] technology. I found most of the time, [telemedicine] was a waste of time.*

When facing the challenges with setting up the access device and scheduling it was viewed as an obstacle in provision of care. When these barriers were resolved, nurses felt that telehealth visits were effective. As a result of these technological challenges, it became common practice to ask patients at the start of care if they were interested in having telehealth visits *and* had the technological capabilities to do so.

Decreased Access to a Computer During the Home Visit. New infection control guidelines did not permit the use of the work computer in the home. Nurses indicated this was an obstacle because they had to change their way of working with regards to preparing for the visit, and had to rely only on memory for review of the medical record as well as any data obtained during the visit. This was problematic due to the multiple chronic medical conditions, medications, and treatment orders. Lack of access to the electronic medical record resulted in a feeling of vulnerability, concern for accuracy, and a lack of confidence that a thorough assessment had been conducted and documented. Nurses were also concerned that missing something could potentially

negatively impact the OA directly. For example, not remembering the older adult had a history of Diabetes Mellitus and the blood glucose level was not accessed could negatively impact the older adult. Nurses would frequently telephone the patient from the car to confirm and gather more data. One nurse described the impact of not having a computer in the home like this:

> ***RN4***: *We depend so heavily upon that [computer] . . . I felt a certain level of incompetence because I didn't have the patient's whole history and background.*

Leadership Support. Participant's held mixed views, both positive and negative, of the support received from leadership during the COVID-19 pandemic. These experiences ranged from feeling very supported to not feeling sufficiently supported. Some nurses described feeling supported when overwhelmed, fatigued, and having to make complex decisions regarding patient care. One nurse commented: "Our managers made sure support was there if we needed it." (RN13) Other nurses did not feel sufficiently supported, particularly when organizational decisions were made without input from the nurses in the field or when patient concerns raised by the nurse were not addressed. Similarly, some described a sense that leadership did not understand the need of the nurses on the front line of care. This is seen in the following quotes:

> ***RN11***: *The hardest part was witnessing the isolation [of the OA]. I have voiced that. I'll be very honest . . . with higher leadership fell on deaf ears. It was, "Just do it. Just do it." And we did it.*
>
> ***RN10***: *I got the feeling the people at the top didn't understand. [leadership would tell us] "Make sure you're drinking plenty of fluids because you get dehydrated behind those masks." [But] We have no place to go to the bathroom!*

The lack of PPE also influenced nurses' opinions of leadership. Most commonly, nurses expressed frustration towards leadership regarding rationing of PPE supplies. As noted by one RN:

> ***RN11***: *You could go to the office to get your one little bottle of Purell and your one bottle of soap, like little minions. We would ask for our bottle of Purell and why can't we get our supplies back into the office where we're not begging for what we need.*

Increased Complexity of Home Visits

Nurses characterized home visits as being more complicated during the COVID-19 pandemic. New and more frequent obstacles were incurred on a daily basis that made it harder to provide consistent, quality care to OAs. New and ever-changing infection control guidelines, change in the process of conducting visits, and the "decontamination" routine post visit made visits more complicated and cumbersome. This in turn led to feelings of exhaustion and being overwhelmed from working harder and longer.

Burdensome and Ever-changing Infection Control Guidelines. Nurses felt overwhelmed and unsure of the current infection control guidelines, which often changed on a daily basis. Donning and doffing PPE outside the home, exhaustion from working more hours, and problems communicating with OAs due to wearing extensive PPE added to the difficulties of conducting a home visit. Chronic uncertainty and having to constantly adjust to manage these issues affected their ability to provide safe, competent care to the older adults and protect themselves. As one nurse stated: "We were flying by the seat of our pants." (RN 20)

Donning and Doffing of PPE. COVID-19 changed infection control practices in home health care. Nurses were no longer able to donn (put on) and doff (take off) PPE inside the home due to potential cross-contamination and increased risk of COVID-19 exposure to OAs. Thus, donning and doffing procedures occurred outside the home. A majority of nurses described quite vividly feelings of anxiety, frustration, and insecurity regarding correct PPE procedures, as these changed on a daily basis. Extreme weather conditions (wind, rain, sleet, snow, heat waves) also affected perceptions of PPE for both the OA and the nurse. For example, one RN described that at times they were forced to continue to wear wet or re-use PPE, which led to concerns about decreased efficacy of the equipment. Privacy issues were raised by OAs that neighbors could see the nurse putting on PPE outside their home. The older adult did not want their neighbors to know they had COVID-19. Nurses recounted many creative and flexible places used to donn and doff PPE. This included putting on PPE inside their car, inside the garage, outside a slider deck door, or on the back porch in order to protect the patient's privacy. Doffing was often performed in the patient's garage and equipment disposed of in the patient's garbage receptacle or in the nurses' trash bag.

Exhaustion from Wearing PPE. Nurses described feelings of exhaustion from wearing a gown, gloves, bonnet, N95 or surgical mask, face shield, goggles, and shoe coverings. The wearing of all these layers of PPE felt heavy, bulky, and cumbersome when performing a skill, procedure, or conducting the physical examination. Most commonly, nurses expressed frustration with glasses or goggles fogging up, which limited vision, and having to constantly re-adjust the PPE which increased risk of exposure. One RN expressed their frustration in this way:

RN20: *All of a sudden you go in and your goggle steams up. So now you've got particles, you know, under your shield because you're going from your cold car to their warm house. And everything's clouding up. You're holding a laptop, which now you can't see, so what do you? Do you wipe your shield and break infection control? Or do you wing it and not chart anything?*

Harder to Communicate with Older Adults through PPE. Participants indicated that many OAs had pre-existing hearing and visual impairments and relied on lip-reading to assist with communication. Infection control guidelines requirements, such as wearing an N95 or surgical mask, face shield, and social distancing, inhibited lip-reading by the older adult. This added an additional layer of complexity in conducting the home visit. Nurses expressed feeling sad and frustrated when trying to communicate through a mask with OAs who had visual and hearing impairments. Nurses attempted to enhance communication by having a family member repeat the questions or instructions directly in the patient's ear, using more non-verbal gestures, writing more information on paper (which made the visits longer), using more words to add clarity, and repetition. Nurses also noted that when they had to relay critical or "life and death" information they would pull their mask down (while maintaining social distancing) so the OA could read their lips and see facial expressions to ensure they fully understood the instructions. One RN described this experience this way:

RN19: *They [OA] couldn't see my lips, and they couldn't hear me. It was very challenging having to then write everything down.*

RN11: *And many times, I would get, like, six to eight feet away from them, and this was a no-no, but I would pull the mask down if I had to do some education*

and explain something that was life or death. I wasn't going to leave without them knowing this.

Difficulties in Scheduling and Conducting Home Visits. COVID-19 also affected how nurses scheduled and conducted the home visits, including daily scheduling, daily pre-screening of the OA and themselves for COVID-19, and being more flexible regarding duration of visits. The COVID-19 status of the older adult often affected when a visit could be conducted, rather than geographical location. Pre-pandemic, the nurses' sole criteria for the sequence of visits was based on acuity and geographical proximity. During the pandemic, in order to minimize the risk of transmission between patients, OA who tested positive for COVID-19 were seen at the *end* of the workday. The limited number of nurses available to see patients who were positive for COVID-19 and having to travel to unfamiliar geographical locations added another layer of complexity to the nurses' workday. Nurses reported feeling more overwhelmed and exhausted at the end of their workday if they had to see more COVID-19 positive OAs or drive outside their typical geographical area to conduct additional visits. When rescheduling visits, the participants perceived older adults as being upset and angry with them if they had to come at a time which was not convenient for the older adult. This further increased stress for nurses. One RN described this experience with these words:

RN9: *She [OA] went up one side of me and down the other because I came to her house too early. I was almost in tears.*

New time-consuming policies were constantly implemented to verify symptoms, potential exposures, and COVID-19 status of the OA, anyone residing in the home, and

the nurse. Nurses were required to complete this required documentation in the medical record prior to each visit. As one nurse explained:

> ***RN15***: *We had to screen every patient prior to going out to see them . . . a COVID questionnaire form. We would ask whether or not they had symptoms, if they were around anybody that had symptoms. Based off of, that would tell us what we would wear into the home for PPE.*

Change in Duration of Visits. Nurses experienced greater variability in visit duration, with both shorter and longer visits occurring during the pandemic. For example, participants conducted shorter visits to "get in and get out" (RN7) so as to minimize exposure. Often, the primary focus of the face-to-face component of the visit was to do the physical assessment, and most of the history and health assessment questions were asked in the car via the telephone prior to entering the home.

Longer visits occurred due to older adults requiring increased education on breathing exercises, increased assessment and teaching regarding new medications, nutritional and mobility status, as well as health promotion strategies to prevent complications and exacerbations of chronic conditions. The visit also included a more in-depth assessment and interventions regarding the nurses' sense of needing to provide emotional support to an isolated OA. One nurse stated: "It would take longer to take care of them, find resources for them, and to keep people company. They [OA] missed the personal contact. Everything seemed like it took longer." (RN11) A second issue prolonging visits was that older adults were often sicker than usual. Those who had been admitted to hospital returned home faster and had not recovered to the extent that their health was stabilized. These OAs were sent home earlier after treatment because longer

hospital stays increased risk of exposure to COVID, and older adults were refusing to go to the skilled nursing facility due to risk of additional exposure or potential for a lockdown to occur and not being able to see their family. In other instances, OAs stayed home *despite* having severe illness due to the fear of acquiring COVID if admitted to the hospital. Cumulatively, this resulted in a higher level of acuity in patients at home, translating to increased care complexity and need for longer home visits.

Multiple Stressors Caused a Diminished Sense of Well-Being

Fear for others and oneself, demands of providing increasingly complex patient care, and multiple operational challenges and barriers negatively impacted nurses' sense of overall well-being. The constant unrelenting stress throughout the COVID-19 pandemic took a toll on nurses' emotional, mental, physical, and social well-being. This is seen in the following extracts:

> ***RN12***: *All they [nurses] think about is all the stuff they haven't gotten done. They can never walk away . . . they never get a chance to just be clear.*
>
> ***RN16***: *I was chronically stressed all the time.*

Diminished Sense of Overall Well-Being

Nurses described the profound cumulative effect the COVID-19 pandemic had on their well-being as stemming from the daily struggle to keep up with the unrelenting changes, challenges, and obstacles. In one RNs words:

> **RN12**: *Oh, my God. I don't think I can—I don't know how I'm going to make it through the day.*

Diminished Sense of Emotional and Mental Well-Being. The pandemic negatively affected nurses' emotional and mental well-being, with depression and anxiety

being most commonly reported. Nurses described often feeling depressed and sad as a result of their clinical care for OAs at home. In particular, it was emotionally stressful for the RNs to witness the isolation many OAs experienced. The experience was expressed by one RN in this way:

> ***RN11***: *I didn't want to be the be-all, end-all. I wanted it to be the way it was, and it wasn't, there wasn't a light at the end of the tunnel. I was clinically depressed.*

Many nurses reported heightened anxiety during the pandemic. A common trigger for this was viewing the daily open/unassigned list. One RN described: “It’s like you scroll and you scroll and there’s like 35 people! It’s like you’re playing shuffle.” (RN6) This analogy of “Shuffle” referred to the need to constantly rearrange nurses’ schedules to ensure the most acute patients were seen each day. Visits were re-scheduled based on a verbal assessment on the telephone by the nurse. Nurses reported feeling overwhelmed and afraid that trust in the nurse would be lost if they were unable to make the visit. Nurses often had sensations of moral distress: ethically they felt all patients should be seen if scheduled but knew it was not possible due to the lack of available nurses. To address the shortage of available nurses to see patients and prevent delay in patient care, nurse case managers would sometimes see all their own patients. However, this created more stress and exhaustion for nurses due to increased workload.

Higher level clinical decision making, limited access to providers, and higher acuity level of the OA also contributed to increased stress and anxiety. As explained previously, the acuity level of older adults in the home was higher as OAs were discharged sooner from the hospital, with older adults refusing to go to skilled nursing facilities or refusing to even go to the hospital. The nurses felt pressured to be more

independent and felt unsupported in making decisions, which was due to being the only one seeing older adults face-to-face and closure of provider's offices.

All nurses described anxiety provoking encounters where the OA, or someone present during the visit, refused to wear a mask. During the pre-screening telephone call, nurses reminded patients to wear a mask during the visit. However, they were not able to enforce mask wearing if the patient and family did not voluntarily cooperate. One RN said: "I feel as a nurse going into someone else's home, it's their space. I can't make someone wear a mask. I do the best that I can to be safe." (RN3)

Nurses were exposed to situations where patients did not believe COVID-19 was real or felt it was "their home" to do what they wanted—which included the right to not wear a mask during a home visit. For example, some OAs and their families would argue that COVID-19 was "not real", a "conspiracy," or a "hoax". When these discussions occurred, nurses tried to avoid controversial conversations but would try and provide education to encourage masking. However, these beliefs that COVID was a "hoax" were not congruent with the nurses' reality and created emotional and mental stress. One RN expressed this difficult situation with these words:

> ***RN3***: *I'm not here to argue [to OAs or others during the visit]. It's not worth my time. It was disheartening . . . I usually can deal with it [but] I was just done.*

In these situations, nurses used their clinical judgment and weighed the risk of infection to determine whether to complete the visit or leave. Nurses also described allowing patients to lower their mask when patients were having a hard time breathing or their oxygen saturation levels were low, relying on social distancing to reduce transmission risk (e.g. sitting further away from the patient). These ethical dilemmas

created emotional stress for the nurses who had to balance caring for the patient with a need to protect other patients, their families, and themselves from a transmissible disease. Most nurses indicated that they completed the visit and informed leadership regarding the non-compliance with the masking recommendation.

Jealousy. Feelings of jealousy occurred when viewing other people who were able to work from home during the COVID-19 pandemic. They recounted seeing and hearing others discuss having more free time and doing activities with their family. This left nurses feeling more isolated, as they were working longer hours and often self-quarantining to reduce risk of exposure to others. Nurses described how they would have liked to have had the option to work from home, but could not because they were front line workers. Others described a wish for "hazard pay" for working harder and longer and risking their lives. These experiences can be seen in the following excerpts:

> ***RN13***: *There was some jealousy as I would drive by seeing people playing . . . outside enjoying the day with their family. People complaining about being on lockdown, and I am out every day, working harder than I was before.*
>
> ***RN14***: *It felt like we were being put at risk, but weren't necessarily being given anything extra for being put at risk. I felt like we could have been compensated a little bit more for actually going to the homes that we're putting right at risk for getting COVID.*

Cumulatively, these experiences diminished the nurses' emotional and mental well-being. Some nurses began taking antidepressants, anti-anxiety medication, sleep medication, and seeing a mental health provider or support group to cope with the additional job-related strain. Others reported that the emotional and mental health impact

resulted in nurses changing their jobs, decreasing their hours, or leaving the nursing profession altogether.

Diminished Sense of Physical Well-Being. COVID-19 also had a negative impact on nurses' physical health. Participants reported feelings of exhaustion, fatigue, and weight gain. Surprisingly, the most vehemently and commonly voiced effect on their physical health was the inability to go to the bathroom. Nurses described with vivid details recurring issues of not being able to find a bathroom and meet their basic human needs during the COVID-19 pandemic. The shutdown forced restaurants and gas stations to close the public restrooms nurses typically visited throughout their workday. Similarly, nurses were not allowed to use the bathroom in the patient's home. Thus, nurses' workdays were lengthened because they had to travel further, sometimes into unknown areas, just to find a bathroom. Nurses described stopping by a friend's house, rearranging their schedule, more trips back to their home, eliminating in the woods, returning to the office, limiting fluids, or postponing going to the bathroom until the end of their workday. Some nurses reported using the bathroom of known patients, which one RN stated was a "no-no" . . . what do they [leadership] expect us to do?" (RN 11) At the same time, leadership was emphasizing a need to drink plenty of water to stay hydrated, which resulted in nurses feeling frustrated with leadership for not knowing the realities of their working conditions.

Nurses also described feelings of physical exhaustion and fatigue from following infection control practices (donning and doffing PPE, heaviness and the amount of required PPE) when providing care to OAs. Feelings of exhaustion and fatigue continued throughout the pandemic as the shortage of nurses resulted in increased

visits from the open/unassigned list, traveling outside usual catchment area to see COVID-19 positive patients, and overtime.

Many participants described having gained weight during the pandemic. Gaining weight during the pandemic was due to fatigue, decreased activity, shutdown of gyms, coping strategy to manage stress and isolation, and cooking more at home. One RN expressed: "I gained quite a bit of weight. I just wasn't feeling well at all. Very fatigued throughout the day. Not eating well." (RN15) However, the COVID-19 pandemic also had a positive impact on nurses' physical health. Some nurses began attending virtual exercise classes, walking more, and purchasing home exercise equipment.

Diminished Sense of Social Well-Being. Nurses described feeling isolated during the pandemic. Due to the shutdown, the unknown nature of COVID-19, and mandates regarding social distancing, nurses were spending minimal time with family, friends, or peers. Gatherings with family and friends were virtually non-existent for fear of transmitting COVID-19 to family, friends, and others. Conversely, nurses felt an ethical responsibility not to visit with family and friends to minimize risk of transmission of COVID-19 to immunocompromised OA patients. Participants felt older adults were doing their part to minimize exposure and they should do the same. The pandemic made nurses feel even more isolated and alone. With the shutdown, the office closed which increased nurses feeling isolated and alone. However, one RN described a positive impact of the pandemic in this way:

> ***RN17***: *The good that came from the pandemic is it made people really take a step back and forced people to slow down and just be like, you know, it's okay to just*

be home and not do anything or just to do things around the house or just to be alone for a little while.

Perception of Diminished Sense of Well-Being in the OA

Nurses also described the effect COVID-19 had on the older adult's emotional and mental, physical, and social well-being. Being a witness to these negative effects had a profound effect on nurses own emotional and mental well-being. The shutdown forced the OA into isolation and the RNs described the emotional and mental health changes in the older adults, which included loneliness, depression, and changes in cognitive function. For example, in the assisted living facilities, all social events (church, dining, and activities) ceased due to the shutdown and families were not allowed to visit for fear of transmission of COVID-19 and facility policies restricting visitors. In these situations, the RN might be the only person that the older adults interacted with week after week. One RN expressed: "Some older adults had family members dropping off groceries on their doorstep and then left." (RN13) Another nurse described it as: "being in solitary confinement." (RN20)

Other adverse impacts included greater immobility, fostered by the shutdown of gyms and all social events, which resulted in decreased stamina, strength, and weakness in OAs. This led to an increase in exacerbations of Congestive Heart Failure (CHF), Deep Vein Thrombosis (DVT), delayed wound healing, and weight loss. The RNs did their best to help the older adults but perceived these situations as emotionally stressful, which diminished their individual sense of wellbeing.

Finding Ways to get Through the Day

Nurses described ways in which they were able to successfully provide and gain strength to care for older adults throughout the COVID-19 pandemic. Participants, in spite of enduring many challenges and obstacles to care, felt a moral and ethical obligation to continue to care for OAs. Nurses persevered by being flexible and creative, developing a deeper connection with older adults, and increased peer and provider support. As one nurse said: “We kept everyone safe and alive.” (RN2)

Developing Flexible and Creative Strategies to Provide Care

Nurses described being more flexible and creative in their approaches to get through their workday. This included things such as lowering their mask at times so that the OA could understand what was being said, writing the assessments on paper, telephoning before and after the visit, and suggesting interventions to providers to keep OAs from going to the hospital. One RN described needing to be creative when calling the provider:

> ***RN20***: *They [OA] have more edema, they’re a little bit short of breath. Can we try increasing their Lasix or can we try an antibiotic . . . manage this at home Instead of sending them right away to the hospital?*

Developing a Deeper Connection with OAs

Nurses described an increased sense of duty and loyalty to their patients. This was expressed in a variety of terms, such as, “this is what we signed up for”, “you don’t jump ship”, “I have to put the armor on, like a soldier, and I have to help take care of these people because nobody is going to do it."

Out of this sense of duty to provide care to the OA during the pandemic, nurses described experiencing a deeper connection with the older adults. Because of perceived negative effects of isolation on the OAs, nurses stayed longer in the homes of the older adult during the COVID-19 pandemic. This was because family and friends did not visit and many OAs lived alone. Thus, the only person they would see for weeks on end would be the home health care nurse. As a result of this change in social patterns, more personal conversations ensued. Older adults talked with nurses more about their personal lives, including sharing new recipes and television shows. Nurses felt their presence was the link to the outside world for the older adult, giving them a sense of still belonging and a sense that someone cared about them. Older adults looked forward to their visits as it was often the only connection to the outside world. This deeper connection was reciprocated in that many times, the only connection the nurse had was visiting the older adult. Nurses described it this way:

RN20: *There's this connection. It's love from people that don't have to love you.*

RN9: *They [OA] needed warmth and companionship, to tell me about their kids. You can connect with them and help them through their day.*

One nurse described being the "toilet paper fairy" as she would bring toilet paper to her older adult patients to show she cared and was there for them. Nurses expressed providing good care within the context of available resources. RNs described this situation in these words:

RN14: *I feel like I did my best with what I was working with. I know it wasn't the care that maybe they deserved. But it was the care we could give it the time.*

RN10: *I feel I was able to, in spite of the barriers, give good care. It was so critical because it was the only care they got.*

Increased Peer and Provider Support

Increased Peer Support. Increased peer support helped nurses get through their workday. Pre-pandemic, home health care nurses would see their peers at the beginning of their day in the office or during meetings, and their face-to-face interactions with other nurses was limited. However, the pandemic heightened feelings of being alone and isolated. The shutdown and home health agency policies for in-person meetings changed how peer support was provided. During COVID, nurses most commonly received support from peers through text messages, phone calls, or virtual meetings. This enabled them to receive the support they needed without increasing risk for infection. Often, they would call one another to discuss how they were handling certain situations, what infection control practices they were following that day, or just to vent. One nurse described peer support with a team spirit, while others described the frustration in still not having face-to-face meetings with peers, as seen in the following quotes:

RN14: *It was a sense of camaraderie. These four are out. They're not working. We'll just keep pushing.*

RN11: *We still don't see them. It's terrible. There's, already in homecare, a disconnect, an isolation that you felt. All our meetings are on Zoom. So you don't get to have those bubbler conversations.*

Increased Provider Support. Nurses also described providers as being more amenable to suggestions regarding patient care during the COVID-19 pandemic. Nurses reported feeling more trusted, respected, and valued by the providers than pre-pandemic,

as they were the only ones conducting face-to-face visits during the shutdown. Providers were more reliant on the nurses' assessment as the OAs were not able to be seen in the provider's office. One RN described this as: "I was the eyes and ears. I could call and report the blood pressure is this, two plus pitting edema. They [providers] made the decision based on you." (RN20)

Chapter Summary

In summary, nurses recounted their experiences and perceptions of providing care to OAs during the COVID-19 pandemic. They experienced increased fear and numerous obstacles to care which resulted in a personal insult to their own sense of well-being. In spite of these difficulties, home health care nurses were able to persevere. This fortitude resulted in nurses being able to, with support of peers, providers, and leadership to provide the best care possible and develop a deeper connection with older adults.

Chapter 5

Discussion, Implications, and Conclusions

This qualitative study examined the experiences of 20 home health care nurses and their perceptions of providing care to older adults (OAs) during the COVID-19 pandemic. Four major themes and nine sub-themes were generated as presented in chapter four. In this chapter the similarities, differences, and uniqueness between the findings in the current versus previous studies will be detailed and discussed. The findings from this study will also be discussed in relationship to contributions to new knowledge and implications for future research and theory development, practice, education, health care administration, and policy. Throughout this chapter the term "nurse" will refer to registered nurse (RN).

Fear of the Unknown

For all nurses in this study, fear undergirded experiences of providing care to older adults during the COVID-19 pandemic. Fear of the unknown permeated nurses' daily life at work and at home, and particularly fear of transmitting COVID-19 to other patients or their family. This has been reported in prior studies in the U.S. and Sweden, which also showed that home health care nurses mainly feared transmitting COVID-19 to their patients and family (Elliott et al., 2023; Tarvis et al., 2022). In contrast, Rücker et al. (2021) conducted a study of home health nurses' aides in Sweden, and found that the primary fear was of contracting COVID-19 themselves, which was based on experiences of seeing patients severely ill and their co-workers acquiring COVID-19.

Fear of acquiring and transmitting COVID-19 was heightened for nurses when patients or individuals in the home refused to wear a mask. This led to the ethical

dilemma of whether to complete the visit (placing the nurse at risk) or leave the home at any point during the visit (placing the patient at risk). Nurses encountered situations where patients refused to wear a mask because the patient felt COVID-19 was not real, or rationalized it as “their home” (i.e. they could do what they wished). This occurrence added to nurses feeling unsafe, being at greater risk for contracting COVID-19, and feeling concerned about giving to others. Lehmann & Lehmann (2021) revealed similar findings, in which the patient's refusal to mask was based on political views. Similarly, Svetvilas (2022) found patients refused to mask in their own home, while Elliott et al. (2023) extended on the issue of not masking for political reasons and described home care nurses having to make a conscious decision not to engage in political conversations in order to continue providing care to their patients.

A unique finding, not reported in prior studies, is the intensive infection control and decontamination procedures nurses performed upon arriving home before interacting with their family. The unknown new disease created fear in nurses, who were afraid they would transmit the virus and cause harm to their family. Because of this uncertainty, nurses performed their own extra infection control measures to exert some control and to decrease their fear of potentially exposing their family to COVID-19.

Nurses in the current study also had to deal with the older adult’s fear of contracting COVID-19 and dying. This resulted in OAs refusing to allow visits, only allowing the same nurse to visit to decrease potential exposure, or refusing to go to the hospital when in-hospital based care was needed. This was frightening and frustrating for nurses who perceived the OAs as being in need of care, and powerless to remedy the situation. Inloes et al. (2023) and Sama et al. (2021) reported similar findings of OAs

refusing home care visits for fear of acquiring COVID-19, which lead to exacerbations of existing medical conditions. By refusing visits, monitoring and interventions to prevent exacerbations of the older adult's chronic medical conditions could not be achieved.

In light of these findings, and to prepare for potential future pandemics, clear and standardized infection control policies are needed. These policies would decrease fear in the nurse and older adult, decrease ethical ambivalence for the nurse, and ensure care is continued for the homebound OA. Another possible recommendation to ensure care continues in the home, is to offer telehealth visits if it is appropriate to do so and in-home care is deemed safe.

Organizational Challenges and Barriers During the COVID-19 Pandemic

The home health care nurses in the study faced many organizational challenges and barriers during the pandemic that influenced their daily work. Lack of resources was one of the most widely reported issues. This included lack of personal protective equipment (PPE), and insufficient nursing staff and leadership support, all of which negatively impacted nurses' ability to provide care. Similar challenges have been highlighted in research from several countries during the pandemic in the context of home health care. Home care nurses in Norway experienced a lack of PPE supplies (Moi et al., 2022), nurses in Australia reported a lack of PPE and leadership support (Halcomb et al., 2020), and in Sweden nurses reported a lack of PPE and a shortage of nurses (Emmesjö et al., 2022; Tarvis et al., 2022). These findings from other countries are consistent with the findings from this U.S. study, and illustrate the widespread nature of global challenges and barriers related to lack of resources for home healthcare organizations during the pandemic.

Shortage of PPE was one of the most concerning organizational challenges nurses faced. Nurses described feeling vulnerable, unprotected, and frustrated when having to reuse PPE, wear masks longer than the recommended time, or continue to wear contaminated PPE (e.g., wet from weather). The lack of essential PPE supplies during the pandemic has also been highlighted worldwide and across settings, including the home (Bell et al; 2022; Emmesjö et al., 2022; Halcomb et al., 2020; Rowe et al., 2020; Tarvis et al., 2022). However, in this study it was observed that nurses felt mistrusted by leadership as a result of the policies surrounding rationing of the PPE supplies, which has not been reported elsewhere. These feelings of mistrust have the potential to erode the nurses' commitment and relationship with leadership, and increased awareness is needed of these potential impacts. Including nurses in policy decisions pertaining to PPE to foster a collaborative spirit in the workplace, especially in difficult situations such as a pandemic with ever continuously changing policies, will be needed to foster a sense of trust and collaboration.

For participants in this study, experiences with leadership support *lessened* or *added to* perceived organizational challenges and barriers. Nurses had mixed feelings regarding the leadership support they received during the pandemic. Many reported insufficient leadership support, stating that leadership did not understand the challenges of home visits. This translated to a sense of disconnect between leadership and the nurses making the home visits. This feeling of being insufficiently supported by leadership has also been highlighted in previous studies that have shown nurses felt "abandoned" by their managers and had to deal with the demanding work alone while managers

"escaped" risk of infection by remaining in their offices (Elliott et al., 2023; Rücker et al., 2021; Halcomb et al., 2020).

In contrast to these negative experiences, other nurses described strongly supportive leadership. This type of leadership support was evident when leaders made home visits to help lessen the workload, acknowledged the value of the nurses' hard work, and thanked them for making extra visits or working overtime. The positive impact of leadership acknowledging the value of the nurses' work and making home visits was also reported in Norway and Sweden (Moi et al., 2022; Rücker et al., 2021). According to Elliott et al. (2023), a recommendation made by home health care providers was for "home care leaders to step out of their offices and put themselves in the home" (p. 25).

Cumulatively, these divergent perspectives regarding leadership highlight the critical importance of leadership acknowledging and supporting the work of home health care nurses conducting visits. The physical presence of leaders and offering words of praise and support to nurses may help build team spirit and a sense of unity.

Another major challenge reported in this study was a lack of nurses to perform home visits, resulting in increased workload. Consistent with previous studies, the lack of available nurses in this study was a result of the nurses being COVID-19 positive or in quarantine due to exposure (Emmesjö et al., 2022; Tarvis et al., 2022). In another study of home care nurses conducted in Iran, the lack of nurses was attributed to nurses retiring because they did not want to care for patients with COVID-19 (Ghezeljeh et al., 2022). In the current study all nurses, except one, encountered limited access to providers. This led to nurses feeling alone in decision-making since they rarely were speaking to providers and had to communicate patient concerns via office staff. This created a delay

in treatment that affected the provision of care to older adults. Also, nurses worried about their patients until they received a call back and then would have to address the recommendations with the previously visited patient. Similar challenges relating to lack of providers during the COVID-19 pandemic resulting in nurses feeling alone in decision making has been described in other studies (Ghezeljeh et al., 2022; Pujolar et al., 2022). In light of the lack of available nurses and limited access to providers during the COVID-19 pandemic, home health care leaders may address these challenges by developing pre-disaster policies and procedures for resource allocation.

All nurses in the current study conducted telehealth visits with older adults, with variable perceptions of usefulness for the home setting. Telehealth was implemented as an avenue to conduct visits and prevent hospitalizations during the COVID-19 pandemic (Osakwe, 2020). Federal and state regulations were enacted to enable use and allow reimbursement (Hoffman et al., 2020; Kichloo et al., 2022). These new regulations provided a virtual modality for older adults to receive care from nurses and providers. Negative perceptions of telehealth for nurses were linked to challenges in conducting telehealth visits with older adults, specifically difficulties with set-up and use of technology. Many older adults had landlines and did not own a smartphone, which limited their ability to conduct video visits. In these situations, the nurses were often dependent on the OAs' families to provide the smartphone set-up and access. Similar findings were reported by Ruiz-Fernandez et al. (2022) regarding older adults in Spain, who were not familiar with the use of technology or how to access the internet. When this barrier was solved, nurses felt that telehealth visits were effective in increasing access to

care for OAs, minimized exposure to COVID-19 in the hospital by triaging patients, and convenient for the older adult, which is consistent with findings by Kichloo et al. (2022). Despite mixed views, home health care nurses perceived telehealth as beneficial for the older adult needing non-urgent follow-up appointments. The long-term potential benefits of telehealth visits for older adults would be increased convenience, decreased wait time, and reduced transportation issues. Leaders in home health care could increase older adult's access to care by developing new policies and initiatives to assist with the set-up and access to telehealth visits.

Increased Care Complexity

Home health nurses in this study reported that providing care to older adults was more complex during the COVID-19 pandemic. Complexity was due to ever-changing infection control practices, trouble communicating with older adults who had vision and hearing impairments, and higher acuity of older adults in the home. Nurses indicated that infection control practices often seemed haphazard and confusing and were constantly changing. These inconsistencies left nurses feeling unsure if they were adequately protecting their patients and themselves. This issue of uncertainty in relation to ever-changing infection control protocols has been highlighted in previous studies (Li et al., 2021; Rücker et al., 2021; Tarvis et al., 2022). Pandemic infection control protocols required complex procedures for donning and doffing PPE, both inside and outside the home, followed by extensive decontamination upon arriving home from work and before interacting with family members. The issue of managing PPE to avoid transmission of COVID-19 has been highlighted in other studies in the home care environment (Rowe et al., 2020; Rücker et al., 2021). These infection control procedures further varied

depending on the nurses' assessment of the OA's home environment, privacy concerns, and weather conditions, which aligns with findings from Elliott et al. (2023) and Svetvilas (2022). For example, nurses in this study determined where to perform infection control practices based on the home environment (e.g., garage, car, or porch), concerns from patients who did not want their neighbors to see the nurse in full PPE, and extremes in weather, all of which made conducting visits more complex.

Participants also reported that they faced increased difficulty in communicating with OAs due to vision and hearing impairments exacerbated by wearing PPE (masks and face shields) and social distancing restrictions. In these situations, older adults were not able to lip-read or read facial cues to assist with communication due to mask wearing. Consequently, nurses adopted flexible and creative strategies to communicate effectively with OAs. Petry et al. (2022) found difficulties in communication and use of creative solutions in the hospital environment, but no studies were found in the context of the home setting. Similar to strategies used in the hospital setting, home health care nurses in this study adopted more non-verbal communication techniques, such as using paper and pen or simulated hand gestures, and talking from the doorway with their mask lowered so the OA could lip-read and view their entire face for cues. These strategies made the home visit more complicated and longer as more time was required for instructions and having to use multiple methods to assist with communication.

Participants in this study also described older adults coming home from the hospital sooner and sicker and refusing to go to the hospital when needed. This increased nurses' workload and the need for more complex decision making as resources were limited and the patients were more vulnerable and at risk. These findings correspond with

Famakinwa (2022), Svetvilas (2022), and Elliott's et al. (2023) work, which revealed home health care nurses were caring for older adults with higher acuity during the COVID-19 pandemic. Nurses in this study revealed that often older adults were discharged home to reduce their exposure to COVID-19 and refused to go to the skilled nursing facility for fear of lockdown and family being unable to visit (i.e., fear of being isolated). Thus, instead of receiving 24-hour post-hospital nursing care, older adults were receiving intermittent nursing care at home with the possible consequence of a negative health outcome. This increased acuity level required nurses to perform more detailed and frequent assessments, increased care coordination, and make more complex decisions in the home setting with limited resources.

This issue of higher level acuity and increased complexity in providing care to OAs in their home has been reported globally (Busnel et al., 2021; Elliott et al., 2023; Johnson et al., 2018). Discharge to home requires nurses to have available and accessible resources to meet hospital-level of care demands. The post-acute transitional care program is a newer model of care delivery which aims to keep OAs out of the hospital if their care can be safely managed at home (McElroy et al., 2022). As mentioned previously in this dissertation, OAs wanted to recover in their home. Assessing the resources required to successfully implement and the outcomes of this new model of care delivery will be needed to determine its future usefulness.

Diminished Sense of Well-Being

A majority of nurses (18/20) experienced multiple stressors every workday during the COVID-19 pandemic that resulted in a diminished sense of overall well-being. Primary stressors stemmed from fear, lack of resources and increased complexity of care.

This finding is in alignment with previous studies of home health care nurses in other countries who experienced anxiety (Holroyd et al., 2021; Ruiz-Fernandez et al., 2022), worry (Emmesjö et al., 2022), depression (Ghezeljeh et al., 2022) and physical fatigue (Billings et al., 2021), as a result of providing patient care during the COVID-19 pandemic. However, this study extends beyond these findings and provides a deeper understanding of how COVID-19 impacted home health care nurses' emotional and mental, physical and social well-being. These are described below.

In this study, witnessing the isolation and its profound negative effects on the older adult was the most significant factor negatively impacting nurses' sense of emotional and mental well-being. Nurses described witnessing how OAs experienced anxiety and depression, decline in cognitive function, decreased mobility, and exacerbations of chronic conditions. These findings are similar to other studies which reported increased anxiety, depression, decreased mobility and cognitive decline in OAs at home during the pandemic which occurred as a result of isolation (D'Arrigo, 2022; Felipe et al., 2023; Lekan at al., 2020; Luo et al., 2020). Nurses in this study expressed feelings of sadness, anxiety, worry, and depression when witnessing older adults' isolation, and feeling powerless and helpless, which has also been reported by Emmesjö et al. (2022). Including nurses in advanced planning of available community resources in the event of future crises to ensure older adults have access to needed services may benefit the OA and also reduce vicarious stress for nurses (Bell et al., 2022).

Most home health care nurses in the current study described facing frequent and unique ethical dilemmas during the pandemic that negatively affected their emotional and mental health. Previous studies have found ethical dilemmas create distress in clinical

nurses across settings, and from diverse environments ranging from neonatal care to older adults (Haahr et al., 2020). Moral distress, a result of a nursing shortage, has been found in community health nurses during the COVID-19 pandemic (Baxter et al., 2022). This is consistent with the findings in this study in which nurses incurred distress from the increased number of patients on the open/unassigned list due to a lack of available nurses.

The present study not only revealed the impact the lack of nurses had on nurses' emotional and mental well-being but also highlighted the impact on the organizational structure and scheduling of patients. Clear communication and expectations of the nurses in how this list will be managed would alleviate nurses' feelings of helplessness and anxiety in viewing the open/unassigned list. Home health care leaders, with the assistance of the entire nursing team, could address nurses' feelings of helplessness by developing a strategic plan to manage the overflow of scheduled visits.

Nurses also felt anxious when patients or persons in the home did not follow the masking recommendation during the visit. This created an ethical dilemma in which nurses needed to make a decision to complete the visit or leave. In most cases, nurses were able to navigate the conversation with the patient to enable compliance with the masking recommendation and complete the visit. Elliott et al. (2023) revealed home care nurses also faced ethical issues regarding masking of patients and family members but the findings in the present study speak directly to the ethical decision making of nurses to continue with the visit or leave. This finding highlights the importance of a supportive leadership to discuss difficult and uncomfortable situations and to develop policies regarding requirements for patients receiving home health care services.

A second major cause of increased stress and anxiety was when OAs refused to go

to the hospital for a deteriorating health condition. This occurred because OAs were afraid of acquiring COVID-19, which is consistent with previous findings (Czeisler et al., 2020). A new factor found in this study which affected older adults' refusal to go to in-hospital care was fear of "lockdown," whereby they could not get home or have any visitors. All nurses who encountered this ethical dilemma stated they had to do more "coaxing and convincing" for the older adult to finally agree to go to the hospital. In some cases, the older adult still refused, and nurses would worry until they made the next visit or sometimes called the patient early in the morning to assess their health status and safety.

In this study, a few nurses expressed feelings of jealousy due to not having the option to work remotely or take time off, which has not been previously reported in the nursing literature. Their feelings of self-reported jealousy were triggered by seeing other people being safely able to work from home and spending more time with their family. This finding is somewhat similar to a recent study conducted in the discipline of communications by Villamil & D'Enbeau (2021), which revealed essential workers' feelings of jealousy about having to work while others had time off from work. This raises awareness of the need for greater acknowledgement of these feelings and sensitivity regarding role expectations and responsibilities on home care nurses.

A surprising finding not reported in previous studies was the inability to locate a bathroom during their workday to meet their basic needs. The global shutdown caused public restrooms to be closed and forced nurses to be flexible and creative in managing their need for a bathroom. For example, nurses would limit their fluid intake, arrange their schedule so they could stop by a friend's house, or go to the bathroom in the woods.

This issue was compounded by leadership suggestion to increase fluid intake to stay hydrated. This affected nurses' sense of well-being and revealed a disconnect between leaders in the office and the nurses in the field. Previous studies have shown employees have a higher risk of mental distress that occurs when leadership is perceived as unsupportive (Flovik et al., 2020). Home health care leaders can prioritize and promote physical health of nurses by providing and encouraging accessible and affordable resources. This feeling of a disconnect existing between leadership and the nurses in the field speaks to the need to have weekly conferencing to discuss the challenges and barriers encountered that week and potential solutions for moving forward should that challenge/barrier be encountered again. Involving all members of the home healthcare team in developing strategies and solutions for everyday challenges would increase respect, understanding, and appreciation for the role of each member of the team.

Nurses' also described a diminished sense of well-being in their social life. Decreased social interaction with peers, family, and friends resulted in nurses feeling lonely and isolated. These findings can be viewed in light of research by Moi et al. (2022) in which nurses missed the comfort and the opportunity to discuss difficult situations in person with their colleagues. However, in the current study some nurses' also embraced solitude and reported finding new hobbies that they enjoyed. Despite this, nurses continued to report negative effects on their social well-being after the conclusion of the pandemic, including decreased social contact with family and friends and reduced attendance at social events. It has been suggested that this type of ongoing self-isolating behavior may imply lingering fear and stress from COVID-19 for front line home health care nurses (Saladino et al., 2022). Addressing issues of isolation of nurses is needed and

it will be important for organizations to facilitate and encourage peer support and build team spirit in the workplace (Tarvis et al., 2022).

Nurses in the current study from both agencies acknowledged the availability of support services (e.g., chaplain, individual counseling, meeting with leaders). However, only one nurse reported actually making use of these services. It is unclear from the present study why nurses did not access available help to manage emotional and mental distress. Possible causes could include stigma surrounding health care providers having mental health conditions which has been reported in previous studies (Sharif-Razi et al., 2022). Another potential cause for nurses in this study not accessing available support services may be due to feeling exhausted from the increased workload and lack of nurses. Additionally, during the COVID-19 pandemic, health care providers were viewed as "heroes" by society. Being seen as a hero might be a potential barrier to acknowledge the humanizing aspect of having mental health conditions and seeking support (Halberg, 2021). In light of these findings, education on mental health conditions would be an avenue to decrease the stigma associated with mental illness in front line health care workers, and could help to increase access to supportive services in future stressful situations.

Nurses in this study described also feeling increased stress and anxiety when confronted with ethical dilemmas (e.g., rationing care to OA, withdrawing care due to non-compliance with masking in the home, or OAs refusing transition to higher level care). When this occurred, nurses were forced to make a decision which could put themselves or the older adult at risk. This caused distress, as nurses experienced a deep sense of conflict between what they believed was the right thing to do yet not being able

to perform this action. These experiences can be understood as moral distress. Moral distress occurs when one "knew what was good for the patient but unable to provide it because of constraints beyond their control" (Jameton, 1993). Reports of moral distress in previous epidemics also lead to fear and increased anxiety, and were often precipitated by concern for others welfare (Simonovich et al., 2022). This finding corresponds with other studies where nurses experienced moral distress related to higher acuity of patients and lack of knowledge regarding treatment for COVID-19 (Ghezeljeh et al., 2022; Rücker et al., 2021). In the present study, during the pandemic home health care nurses experienced moral distress when faced with ethical dilemmas regarding the uncertainty in how best to provide safe care. This suggests greater leadership support and clear guidelines are needed for nursing practice in the home, which can alleviate moral distress by providing greater structure in unstable situations.

Cumulatively, the findings from the current study suggest that leadership can play a vital and integral role in advocating, preserving, and promoting home care nurses' overall well-being. Strategies that could enable home health care leaders to support nurses' well-being include: 1) support nurses' autonomy and participation in decision-making, 2) encourage a supportive collaborative environment with peers, providers, and leaders, 3) and develop clear guidelines specific to home care and a mechanism for addressing complex care issues (Corley, 2002).

Finding Ways to Get Through the Day

Despite the many challenges encountered, nurses in this study were able to successfully get through their workday and provide care by developing a deeper connection with OAs, and implementing flexible and creative strategies to overcome

challenges, and accessing peer and provider support. The reward of having developed a deeper connection with older adults helped to offset the stressful situations home care nurses experienced during the pandemic. The boundaries of the nurse/patient relationship became less rigid as nurses described becoming friends and both parties feeling the sense of a deeper connection. This sense of connectedness has been reported in other countries in which home care nurses "kept going" by developing personal bonds with their patients (Holyrod et al., 2021). In spite of fear and limited resources, the nurse/patient relationship between the older adult and the nurse flourished, which provided emotional support that enabled nurses to get through their workday.

Similarly, increased peer support also helped nurses to get through their workday. All participants reported having a support system of nurses that helped to alleviate the stress encountered on a daily basis. Nurses reported that while they no longer had opportunities for in-person support, they were able to give each other mutual support, guidance, and a sense of working as a team via texts, emails, and telephone calls. Many nurses only spoke to their peers regarding stressful issues encountered during their workday because they did not want to frighten their family and friends with the realities of their workday. This finding aligns with similar experiences in previous studies in which peers provided mutual emotional support and a sense of camaraderie (Billings et al., 2021) and a stronger sense of team spirit (Rücker et al., 2021; Tarvis et al., 2022). The present study findings shed light on how valuable peer support was in reducing nurses' stress in providing care to OAs during the pandemic.

In contrast to these positive experiences, some nurses described the feeling of loss of "nursing" community during the pandemic. This occurred as a result of meetings being

held virtually and having limited access to seeing people in the office. Previous studies have revealed similar concerns about the loss of the "collegial" community with peers during the pandemic (Moi et al., 2022). Based on this finding, leadership may wish to pursue rebuilding a sense of community, strengthening trust, and providing opportunities for nurses to gather together again (Sherman & Cohn, 2022). Providing opportunities in the workplace for peer support and team building might encourage nurses to return to the workplace to resume those "bubbler" conversations that previously helped nurses feel a part of a nursing community.

Due to ever changing guidelines and unexpected obstacles, nurses developed creative and flexible strategies to get through the workday and provide quality care. This meant that at times, nurses had to "think outside the box" to resolve issues related to new infection control guidelines, the patient's level of acuity, and vision and hearing impairments of the OA. Nurses used unique strategies to provide care while still maintaining safety for OAs and for themselves. Examples of this included conducting visits on outside porches, using painter's gloves when there was a lack of PPE, and lowering their mask for OAs with hearing and vision impairments. In a previous study by Elliott et al. (2023), the one strategy mentioned was nurses purchasing their own supplies. This study extends the previous findings by giving more examples of home health care nurses' unique ability to develop effective interventions based on limited resources.

Lastly, nurses in this study felt more valued by providers during the pandemic. Many nurses described the provider's responses being more supportive to inquiries regarding assessment findings or patient concerns. These interactions with providers were viewed as more respectful, more receptive, with greater reliance and trust in the nurse's

assessments for treatment decision making. Providers would frequently thank nurses for being their “eyes and ears". These positive responses made the nurses feel appreciated and respected for the care they provided. This has not been reported in prior literature, and suggests that it may be beneficial to the nurse-provider relationship to promote expressions of appreciation regarding the contributions each discipline offers to support care of the OA in the home. This aligns with other literature showing that positive feedback has a strong impact on workplace satisfaction (Porath, 2016). Enhancing supportive dialogue might be particularly important during crisis periods when individuals require greater support.

Strengths and Limitations

This is the first qualitative study in the U.S. that focused on the experiences of home health care nurses providing care to older adults during the COVID-19 pandemic. Nurses in this study were mostly white, female, and lived in southern New England, were diverse in age, years in nursing, years in home health care, and education. The relatively homogenous sample of study participants may be viewed as a limitation (Jager et al., 2017). To gain a deeper understanding, future studies should encompass a more diverse sample and employ nurses from different geographical locations. Another strength of the study involved the writing of self-reflection field notes after each interview. These field notes enhanced the credibility of the findings as it demonstrated reflexivity during data analysis (Phillippi & Lauderdale, 2018).

In this study, all interviews were conducted via videoconferencing with nurses at home. A potential limitation with interviewing through a video link could be subtle nuances may not have been detected. However, in this study, videoconferencing was

appropriate for several reasons. Videoconferencing allowed greater flexibility and convenience for nurses' schedules, and provided a safe alternative for interviews while still maintaining infection control precautions. Furthermore, the home environment has been found to support a deeper dialogue. Prior research in mental health shows that conducting the interview from the secure, comfortable, convenience of one's own home has been demonstrated to have equal efficacy of in-person visits (Palmer et al., 2022; Waite et al., 2022). Thus, while findings from the present study might not be generalizable to all home care nurses in the U.S., transferability is possible to other similar contexts (Graneheim & Lundman, 2004; Guba & Lincoln, 1982; Polit & Beck, 2018).

Trustworthiness was considered throughout all phases of the study. Trustworthiness in a qualitative study refers to the ability of the reader to have confidence in the truthfulness of the results as a reflection of real-life situations. The trustworthiness of a study is determined by evaluating the study for *credibility*, *dependability*, *confirmability*, and *transferability* (Guba & Lincoln, 1982). Credibility is confidence in the truth of the findings. Dependability refers to the findings being consistent over time. Confirmability refers to the findings not influenced by the researcher's bias and transferability refers to the ability of the findings to be applicable to other contexts (Amankwaa, 2016; Graneheim & Lundman, 2004; Guba & Lincoln, 1982; Lincoln & Guba, 1985).

Credibility was enhanced by the participants being diverse in age, years in nursing, years in home health care, and education. Coding and the generation of themes and sub-themes occurred in the context of prolonged, deep engagement, iterative review

of the data, and biweekly meetings with members of the dissertation committee (JM, CG) and a PhD student. During the biweekly meetings, discussions were facilitated by using analytic coding maps created in XMind, which is a visual analytical mapping software (Mammen. J. & Mammen, C., 2018). This facilitated recursive dialogue about the analysis, coding, and the generation of themes and sub-themes. Negotiated consensus among the qualitative experts on the dissertation committee (JM, CG) occurred during the meetings, which support the overall credibility of study findings (Wahlström et al., 1997).

Dependability refers to the stability of data over time and the reliability of the development in the researcher's analysis (Graneheim & Lundman, 2004). Dependability was achieved in this study by the detailed description of the research design, method of data collection and all steps of the analysis. In addition, transparency and confirmability of the analysis was ensured through use of an audit trail including analytic maps for each stage of coding and use of analytic memos and field notes, which supported reflexivity (Amankwaa, 2016). Reflexivity, which includes being aware of the researcher's underlying assumptions and biases, was accomplished by documenting detailed self-reflection notes after each interview. These self-reflection notes were shared with members of the dissertation committee (JM, CG) and feedback was obtained. The researcher maintained a record of all research steps from inception to reporting of findings.

Implications

The findings from this study have implications for research, theory development, education, practice, health care administration, and policy. These implications will be discussed below.

Research and Theory Development

Experiences of moral distress have been noted among nurses in previous epidemics (e.g., Ebola, West Africa). Moral distress occurred during epidemics when there existed a conflict between one's professional obligation and the ability to perform one's duty (Jameton, 1993; Cartolovni et al., 2021). Symptoms of moral distress from previous epidemics included fear, anxiety, and frustration precipitated by changes in protocols, concern for others welfare, and knowledge of how deadly the infectious agent was (Simonovich et al., 2022). Nurses in this study reported experiences similar to those of moral distress, which has been defined as "knowing what is good for the patient but unable to provide it because of constraints beyond your control" (Jameton, 1993). Future research would be to explore experiences of moral distress to better understand underlying causes and potential alleviating aspects. Nurses in this study expressed the same symptoms of moral distress pertaining to ethical decision making during the COVID-19 pandemic. This was seen in situations where patients refused to mask in the home, viewing the open/unassigned list, and patients refusing to go to in-hospital based care when needed. In these situations, nurses had to weigh the risks to others and themselves of providing care versus abandoning care. They also experienced feelings of powerlessness resulting from organizational constraints and conflicts with patient's right to self-determination vs. infection control policies. Nurses' moral distress can be

understood through the theoretical lens of Corley's (2002) Nurse Moral Distress (MDS) theory, which suggests that moral conflict is a risk factor for moral distress. Further research regarding moral distress in the context of home health care would assist in defining and clarifying experiences, and could help to identify unique sources of moral distress specific to home care. Identifying experiences and aspects that create moral distress can help to develop interventions to reduce distress and encourage dialogue surrounding the challenges of ethical decision making specific to the home environment. Deeper understanding of nurses' experiences of moral distress might be achieved by using a deductive approach by applying Corley's Moral Distress Scale—Revised (MDS-R) (Corley et al., 2005) to the concepts revealed in the interviews. This approach for future research has the potential to assess deductively the extent of moral distress and changes over time.

Education

In this study, nurses experienced a substantially diminished sense of overall well-being, but did not access support services to address or mitigate this. Increased education may be needed for nurses regarding mental health conditions and the impact of providing care to older adults during the COVID-19 pandemic (Halberg, 2021). This can reduce the barriers to accessing support services and the stigma associated with health care providers and mental health conditions (Maben & Bridges, 2020). Prior research indicates that education addressing the myths and stereotypes surrounding mental health, the signs and symptoms of mental health conditions and the support services available will help improve the health and well-being of this essential workforce (Maben & Bridges, 2020; Riedel et al., 2021). Mental health awareness should be provided regarding early

interventions and treatment. Early interventions are important as mental health conditions can cause a decrease in quality of life (Halberg, 2021; Riedel et al., 2021).

Lack of available home health care nurses found in this study speaks to the need to recruit more nurses to home health care. This can be achieved by increased education in the nursing curriculum and in healthcare exploring the role of home health care nurses and this specialty area of nursing practice. Increasing education in the nursing curriculum of gerontology, geriatrics, and home health care has the potential to increase the nursing workforce available to provide care to older adults in the community (Boutin et al., 2019; Garbrah et al., 2017).

Nursing Practice

As noted previously, one of the most significant findings in this study was the negative impact of the pandemic on nurses' emotional and mental well-being. This further underscores the importance of increasing access to mental health and peer support. For example, leaders or mental health counselors, if available and accessible during nurses' workday, could provide intermittent check-ins with nurses regarding their health and well-being either face-to-face or remotely. Encouraging a support group at the agency may provide the opportunity to encourage peer support. In a study conducted by Lamb et al. (2018), during the Ebola epidemic, nurses found it beneficial to sit down together at the end of their day and share a cup of tea. During this time of sharing, nurses received support and learned that being upset when having to face difficult and challenging situations was a perfectly "normal" reaction. Journaling may be another strategy to alleviate stress, and has been found to be effective for managing psychological threat and distress in nurses and society during the COVID-19 pandemic (ANA, 2023;

Wurtz, 2022). Development of a seamless referral protocol to support nurses who would benefit from more individual counseling may decrease barriers in accessing and participating in mental health services.

COVID-19 also negatively impacted nurses' physical and social well-being. The need to foster a more supportive workplace environment, in which the priority for nurses is in maintaining self-care strategies, maintaining a work-life balance, and in taking time off from work to restore and rejuvenate is supported.

In this study nurses spoke quite vividly about being unable to locate a bathroom, and felt unsupported by leaders in meeting their basic physical needs. Home health care nurses face unique challenges during their workday (i.e., unpredictable home environment, meeting basic needs, available resources in the home to meet complex care needs). Providing the opportunity for nurses to discuss challenging issues such as this and brainstorming ways to address problems would increase as sense of collaboration and community.

Nurses commonly described feeling a loss of the "nursing" community. Peer support could be increased through resumption of regular face-to-face meetings and facilitating a team approach. Nursing leadership should also seek ways to decrease the sense of disconnect and inadequate support between the nurse and leaders. Actions such as including nurses from all home care departments in the development of new policies may foster a team spirit and sense of inclusivity.

The issue of the older adult's difficulty setting-up and accessing telehealth visits during the pandemic reported by nurses in this study should be further explored, along with nurses' attitudes and assumptions about the older adult's capability for telehealth.

From the present study, which was focused on nurses' experiences of providing care, it is unclear to what extent these views represent personal or observed experiences versus possible ageist assumptions which have the potential to negatively impact care (Heydari et al., 2019; Rush et al., 2017). Further exploration would be beneficial to guide the development of interventions to improve care and access to telemedicine for this age group.

Healthcare Administration and Policy

With the current shortage of nurses in home care (AACN, 2023; Tyler et al., 2021), active recruitment of home health care nurses will be needed to alleviate stress and burdensome workloads reported in this study. Implementing interventions (i.e. periods of rest and recovery) into nurses' workdays to promote health and well-being might be necessary. Greater well-being will translate to increased productivity, a culture of safety, and retention of staff (Lu et al., 2022; Woodward & Willgerodt, 2022). Nurses in this study described feeling a disconnect from leadership which highlights the need for home health care nurses to be included in policy decisions that influence how care is delivered in the home. Home care nurses can provide a valuable insight into emergency public health planning (i.e. developing policies) to improve protection and care for older adults during disasters (Fisher, 2022; Franzosa et al., 2022).

Development and enforcement of agency policies requiring mask wearing of patients and family members as a condition for receiving home health care services would assist in alleviating the ethical dilemma of nurses continuing to conduct the visit or leave the home. This policy would also decrease nurses' fear of transmitting infectious

diseases to other patients and their family. This type of mandated masking policy has recently been implemented in some agencies in the United States (Svetvilas, 2022).

Conclusions

During the COVID-19 pandemic, home health care nurses faced many organizational challenges and barriers that increased the complexity of care provided to older adults. Lack of nurses, lack of essential resources, and higher acuity level of the older adult were daily challenges for the home health care nurse during the pandemic. Navigating these unchartered waters on a daily basis resulted in nurses experiencing a diminished sense of personal overall well-being. In spite of the multiple challenges, nurses were able to persevere by developing deeper connections with older adults and increased peer and provider support. These findings suggest that greater support from leadership and opportunities for nurses to be part of the decision making process will help ensure the health and well-being of this essential nursing workforce.

Appendix A: University of Rhode Island Institutional Review Board (IRB) Approval

THE
UNIVERSITY
OF RHODE ISLAND
DIVISION OF RESEARCH
AND ECONOMIC
DEVELOPMENT

THINK BIG WE DO℠

OFFICE OF RESEARCH INTEGRITY
70 Lower College Road, Suite 2, Kingston, RI 02881 USA
p: 401.874.4328 f: 401.874.4814 web.uri.edu/researchecondev/office-of-research-integrity

FWA:	00003132
IRB:	00000599
DATE:	June 20, 2022
TO:	Jennifer Mammen, PhD, APRN-CNP
FROM:	University of Rhode Island IRB
STUDY TITLE:	Home Health Care Nurses' Experiences and Perceptions of Providing Care to Older Adults during the COVID-19 Pandemic: A Qualitative Descriptive Study
IRB REFERENCE #:	1921360-1
LOCAL REFERENCE #:	IRB2122-241
SUBMISSION TYPE:	New Project
ACTION:	DETERMINATION OF EXEMPT STATUS
EFFECTIVE DATE:	June 19, 2022
REVIEW CATEGORY:	Exempt 2(iii) Limited

Thank you for your submission of materials for this research study. The University of Rhode Island IRB has determined this project falls into the **EXEMPT REVIEW** category according to federal regulations 45 CFR 46. Per URI IRBpolicy, the project has been reviewed by either the IRB Chair or the IRB Administrator. **Approval is valid for the duration of the project.**

No changes to procedures involving human subjects may be made without prior IRB review and approval. You must promptly notify the Office of Research Integrity of any problems that occur during the course of your work using Appendix S - Event Reporting.

If you have any general questions, please contact us by email at researchintegrity@etal.uri.edu. For study related questions, please contact us via **project mail through IRBNet**. Please include your study title and reference number in all correspondence with this office.

Matthew Delmonico, Ph.D., MPH
IRB Chair

Appendix B: Consent Form

THE UNIVERSITY OF RHODE ISLAND

IRB
Exempt Consent

Jennifer Mammen, PI
Joan R. Dugas, Student Researcher
College of Nursing

Home Health Care Nurses' Experiences and Perceptions of Providing Care to Older Adults during the COVID-19 Pandemic: A Qualitative Descriptive Study

You are being asked to take part in a research study. The purpose of the research study is to gain an understanding of the subjective experience of home health care nurses providing care to older adults (OAs), 65 years and older, during the COVID-19 pandemic, describe the experiences and perceptions of home health care nurses providing care to OAs during the COVID-19 pandemic, and elucidate factors affecting the care provided to OAs during the COVID-19 pandemic. Please read the following before agreeing to be in the study. If you consent to be in this study, you are agreeing you are over the age of 18. The interview will take you approximately 60 to 90 minutes to complete the interview. Questions will be asked about your experience and perceptions of providing care to older adults during the COVID-19 pandemic. There are no known benefits and minimal risk. However, we will be asking personal questions that you may feel are sensitive. You are free to answer or skip any questions.
You will be compensated $20 per interview. The $20 will be in the form of an Amazon eGift card which will be sent to your email address upon completion of the intervew.

The interview will be audio and video recorded via URI Zoom videoconferencing at your convenience. Interview transcripts, and subsequent notes, will be de-identified and reported using an ID known only to the researcher Joan Dugas. The storage of transcripts, and other research material in paper form, will be in a locked cabinet in the researcher's locked office at the University of Rhode Island. Data will be stored separately from identifying documents. Zoom recording creates two files, audio only and audio and video file. Only the audio file, with no personal identifiable data, will be given to the transcriptionist for transcription. Audio and video files will be deleted upon completion of the study. De-identified research data will be destroyed after 10 years. The responses may be used in the student researcher's dissertation and published manuscripts.

The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time without affecting your relationship with the investigators of this study or the University of Rhode Island (URI). Your decision will not result in any loss of benefits to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely from the interview at any point during the process; additionally, you have the right to request that the researchers not use any of your responses.

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have questions about the study, at any time feel free to contact Jennifer Mammen (401)-874-5313 or myself (401)-487-8197 from the College of Nursing at the University of Rhode Island.

By consenting you agree you are over 18 years of age.

Appendix C: Recruitment Flyer

THE
UNIVERSITY
OF RHODE ISLAND
COLLEGE OF
NURSING

THINK BIG WE DO

ATTENTION ALL RNs
RESEARCH STUDY
Home Health Care Nurses' Experience Caring for Older Adults during the COVID-19 Pandemic

I am a RN with home care and gerontological experience, and a student in the PhD program in nursing at the University of Rhode Island. My area of research interest is your experience providing care to older adults (65 years and older) during the COVID-19 pandemic. At your convenience, I would like to have a 60 to 90-minute interview with you to talk about your experiences providing care to older adults during the COVID-19 pandemic in their home. For participation in this study you will receive a $20 Amazon eGift card.

For more information regarding this study please contact:

Joan Dugas at (401)-487-8197 or via email at jrdugas@uri.edu or Jennifer Mammen at (401)-874-5313 or via email at jmammen@uri.edu

This research study has been approved by The University of Rhode Island Institutional Review Board.

The University of Rhode Island is an equal opportunity employer committed to community, equity, and diversity and to the principles of affirmative action.

Appendix D: Telephone Screening Script

Home Health Care Nurses' Experiences and Perceptions of Providing Care to Older Adults During the COVID-19 Pandemic: A Qualitative Descriptive Study

Hi my name is Joan Dugas and I am a PhD student in the URI College of Nursing at the University of Rhode Island. I would like to thank you for your consideration in participating in my research study, Home Health Care Nurses' Experiences and Perceptions of Providing Care to Older Adults during the COVID-19 Pandemic. You were identified as someone who might be interested in participating in this study. This study is for completion of my doctoral dissertation.

Do you have a few minutes to discuss this study?
If yes, continue below.
If no, but the potential participant is interested in participating, determine a better time to call back to discuss the study.
If no, thank them for their time.

I am inviting you to participate in this study because:
You are an RN, have provided care to older adults during the COVID-19 pandemic in their home, understand and carry out a dialogue in English, and have access to a computer with a camera and microphone.

The purpose of this research study is to explore home care nurses' experiences providing care to older adults during the COVID-19 pandemic. The aims of this study are to gain an understanding and describe the subjective experience of home health care nurses providing care to OAs during the COVID-19 pandemic and identify aspects that have affected the care nurses have provided to OAs during the COVID-19 pandemic.

As part of this study, you will participate in:
One audio and video recorded interview via URI Zoom. The interview will be approximately 60 to 90 minutes. The interview will be scheduled at your convenience and ability to meet.

Risk of being in this study include:
There is minimal risk involved to participate in this study.

Compensation for being in the study:
You will be compensated $20 for participating in this study.

Do you have any questions or concerns?

Does this sound like something you would be willing to participate in?

- ☐ Yes: Continue with eligibility criteria below.
- ☐ No. Thank them for their time.

I need to confirm you are eligible to participate in the study.

Confirm that potential participants meet the eligibility requirements	**YES**	**NO**
1. Are you a registered nurse?		
2. Have you provided care to older adults during the COVID-19 pandemic in their home?		
3. Are you able to carry out a dialogue in English?		
4. Do you have access to a computer with a microphone and camera?		

Eligible and Interested?

- ☐ **Yes:** Schedule the interview, have them sign and return the consent form, and complete demographic data form.
  Appointment Date and Time:

- ☐ **No:** Thank them for their time and let them now they are not eligible.

Person Conducting screening:

Name: _____ Date_____

Appendix E: Background Data Questionnaire

DOB: _____Age: _____

What is your gender identity? _____ Race/Ethnicity:

_____

Educational Level (Diploma, AD, BS, or Graduate Degree) _____

Years in nursing _____

Years of nursing in home health care_____

How many hours per week do you work? _____

When and where did you receive education in gerontology? Be specific to pre-licensure, post-licensure, graduate school, or at your place of employment? Describe the education.

Appendix F: Interview Guide

1. Could you please describe your experience providing care to older adults in their home during the different waves of the COVID-19 pandemic?

Could you please describe a normal day for you during the pandemic? How did this change during the different waves?

What challenges were present? Who, what, and when? How did this change during the different waves? How did it influence your work?

2. Could you please describe a positive experience when providing care to an older adult in their home during the pandemic? What did you do and how did this make you feel?

3. Could you please describe a negative experience when providing care for an older adult in their home during the pandemic? What did you do and how did this make you feel?

4. Can you please describe factors that influenced your ability to provide care to older adults during the COVID-19 pandemic?

How did it make you feel? Why do you think you felt this way?
What has been your experience? Can you describe how attitudes, level of education, the workplace and available resources affected the care you provided to older adults?

5. What is your perception of how older adults were cared for during the COVID-19 pandemic?

6. What is your perception of how older adults reacted to the care provided during the COVID-19 pandemic?

7. Have you experienced any specific physical or mental health changes since the COVID-19 pandemic?

8. Is there anything you expected me to ask that I didn't ask or anything you want to ask, add or talk about?

Appendix G: Themes and Sub-themes with Illustrated Quotes

Theme 1: Increased fear for others and for oneself during the COVID-19 pandemic

"It was like a black-and-white horror movie where everyone was afraid."

A. Sub-theme: Fear of the unknown disease

RN5 "I was terrified. I was terrified, because it was the very beginning of the pandemic. It was right when we were still of that unknown, still trying to figure out what we were doing."

RN 14 "You don't want to bring stuff home to your little one because you don't know. Then she (mother) got too nervous because of my exposure to all these people."

RN4 "I think the common thread was terror. Everybody was just terrified of the unknown. Everybody knew someone who had it and everybody was responding different to it. You know, some people were doing very well. Other people were doing very poorly, just the fear of the unknown."

RN9 "We were petrified. We were petrified of getting someone sick. We were petrified of getting sick, spreading something. I'm doing a good thing. Helping where help is needed … but then there's another part of it am I sacrificing my family?"

RN6 "I remember feeling so freaked out. I cried before I put all my stuff on. I don't even know if I'm putting this on right."

RN2 "You'd be in your mind going "When did I see them last? How was I feeling when I saw them? Did I see anyone else that had him? To make sure you weren't the one that was the cause of this thing."

B. Sub-theme: Perception of fear in the older adult

RN10 "They (older adults) really were afraid of what you might bring them. A lot declined our services."

RN13 "I started having patients asking me to discharge them from services because they were afraid to have anyone in their home."

RN9 "I had a big challenge getting some of my patients at the beginning that needed to go to the hospital for non-COVID reasons to go to the hospital. I could not get them to go because they were terrified of going. They were afraid of going from the hospital to the nursing home and dying and never being able to see anybody."

RN 8 "People were terrified to go to the hospital."

RN3 "Patients would even refuse service with us because they were afraid to let anybody into their home."

RN2 "They (older adults) were afraid. They didn't want to go outside. They were afraid to see anyone."

RN1 "People (older adults) would be anxious about us coming in to their home because we're around COVID-positive people all the time."

Theme 2: Substantial obstacles made it harder to provide care during the COVID-19 pandemic

"My days were harder and longer."

A. Sub-theme: Increased organizational challenges and barriers

RN3: "She actually had to go and get them … painter's gloves or something at her house … she used them because … They don't have any more gloves down here for me."

RN8 "We'll get a callback either that later afternoon or the next day. . . it wasn't uncommon for me to have to call day after day after day just to get orders or verify something or ask them for wound care changes, having to call over and over again."

RN12 "We felt very isolated and alone because we just couldn't get in touch with any—we couldn't speak with anyone and in homecare, that's already the bane of our existence is getting in touch with somebody while you're in the home and you've got something going on."

RN14 "And the feeling that my people needed doctors and they needed follow-ups. We actually called doctors' offices that weren't even picking up the phone—It was kind of a disgrace, in a way.

RN6 "I know that we've had such a terrible shortage (nurses) for the last year that they actually just hired travelers (nurses).

RN11 "If you cannot get me what I need and what the other nurses need to care for patients, I'm not going to do it. If I can't be protected and I can't protect others from coming down with this because we're either rationing . . . I can't do it." I'm merely asking for leadership to take a stance and say, "My frontline nurses and the help need the supplies or they can't take care of patients."

RN10 "This person needs to be seen again. They (leadership) would be like, "We don't have anybody." I morally feel like, if we really don't have anyone to go back in there tomorrow to make sure their O2 stats are high enough or whatever it is? All right, I'll go back."

RN17 "It's always the same thing with all the meetings, do more, work harder, work faster."

RN7 "When they have to put on their scrubs and roll up their sleeves and get out on the field, they (leadership) will."

RN13 "I could go to any of the managers and they always help me."

RN2 "A lot of times, the problem with the older people is they can't do the Zoom stuff."

RN6 "Dealing with telehealth has been a pain. It (telehealth visit) would be a terrible wrench thrown in my day."

B: Sub-theme: Increased complexity of home visits

RN17 “That was a nightmare (donning and doffing PPE). In the wintertime, it was awful, because you’re standing out there freezing.”

RN19 “Sometimes I had to see some more patients outside of my area because of who was COVID-trained and fit-tested.”

RN8 “The longer they were in there (hospital) the longer they were exposed. They (acute care providers) wanted them to be treated and sent home. Yes, we absolutely saw a lot more acute patients in home care.”

RN19 “I had so many patients who relied somewhat on lip-reading because of being hard-of-hearing and now you’ve got an N95 on and a face shield. That made it difficult so I had to do a lot of writing.”

RN5 “Things were just constantly changing. Policies were changing. Information was changing. We would have staff meetings and things would just constantly be like, “All right, we’re doing’ it this way this week, Oh, nope. Next day, we’re going to do it this way.” There was just a constant fluctuation of knowledge being thrown at us, and it was overwhelming.”

RN8 “It took longer having to gown up, do the phone call beforehand, go in there, jot down the notes, come back to the car, document, take off the PPE. It was just a very long process that I wasn't used to. My biggest challenge was trying to memorize this whole assessment. We learned to do a lot from the car after we left. Doing that physical assessment and physical care in the home and then sitting in the driveway for about an hour afterwards on the phone with them.”

Theme 3: Multiple stressors caused a diminished a sense of well-being during the COVID-19 pandemic

"I was chronically stressed all the time."

A. Sub-theme: Diminished sense of well-being

RN10 "This person needs to be seen again. They (leadership) would be like, "We don't have anybody." I morally feel like, if we really don't have anyone to go back in there tomorrow to make sure their O2 stats are high enough or whatever it is? All right, I'll go back."

RN19 "And a little bit of jealousy of all of the people that had time to play with their kids and work on their yards."

RN3 "That's the first time I ever walked out on a patient because I just felt uncomfortable with the conversation and their demeanor. It happened more than you think. Not a lot but there was a lot of people that were just, "This is all a hoax."

RN2 "It stresses me out if I can't see all the people that I need to see. These are my patients. This is my caseload."

RN10 "I wasn't getting help anywhere else, so I had to find my own help."

RN20 "It's like I never wanted to let the team down, and I felt like by not being strong enough, I let the team down. I am feeling the pressure, there are always consequences, you know? Am I making a good choice? I'm doing the best I can, and again, nobody else is out here."

RN1 "There are people that didn't even think it was real."

RN6 "We're supposed to have our patients wear their masks. Does everybody in the house wear their mask? No. Can you leave if people are refusing to wear masks? You can, but I have found that's a battle I'm really just not willing to fight with my patients at this point."

RN14 "I definitely noticed my level of anxiety certainly was much higher at the beginning, for sure and just that isolation piece."

RN16 "I developed some PTSD from being around COVID and knowing how deadly it is and I've gained like 60 pounds."

RN4 "I had friends in town that I asked if I could stop there to use the bathroom."

RN7 "Weight gain. I definitely gained a lot of weight."

RN17 "I was more active because I found more things to do by myself. As far as mentally, I felt like I was in a good space."

RN12 "It's already an isolating job. Then, in COVID, you got further isolated."

B. Sub-theme: Perception of diminished sense of well-being in the older adult

RN10 "What I saw was mostly cognitive changes and the isolation, they (older adults) became more forgetful."

RN13 "They don't socialize, they're just so isolated because they're still—even though they've had the vaccines—they're (older adults) still very fearful."

RN8 "There was a lot of congestive heart failure. There were a lot of blood clots because people weren't allowed to walk. All they could do was just kind of walk along in their square apartment."

RN 14 "They were isolated. We were their only friends most of the time. Even their friends in the building didn't want to come over."

RN3 "They were alone during' the pandemic, lived alone, had no family around, were significantly affected. They were so isolated in their last couple months, couple years."

Theme 4: Finding ways to get through the day during the COVID-19 pandemic "We kept everyone safe and alive."

A. Sub-theme: Developing flexible and creative strategies to provide care

RN14 "I couldn't follow every rule that was set up by someone who wasn't in there, don't use the patient's bathrooms. That's just not realistic. I would use my judgment."

RN10 "Get in the doorway and talk to me from there because I can't hear you if you're wearing your mask." (older adult). So you take your mask off and get in the doorway."

RN11 "Sometimes I would write them all down (medications) or I would take a snapshot of them on my phone."

RN8 "The only issue I had with patients that didn't really want to wear the mask were those that really struggled to breathe. And so I would try to keep my six-foot distance and say, "You know, when I come up close to you, I need you to make sure you put that on for me." (mask) and they would. I tried to get their vitals and listen to their lungs quickly and then back up, again, six feet away so they could take their mask off.

RN20 "We became the problem solvers, like the hub to the wheel."

RN16 "I used to always try to do is get the nurse care managers because they're easier to get than the doctors."

RN17 "I would do a lot of follow-up calls. I'd go home at the end of the day, and I'd say (to the older adult) "I'm going to call you later on and so I so I can ask you some more questions."

B. Sub-theme: Developing deeper connections with older adults

RN3 "We became that front line, that's who they (older adult) wanted to see; that's who they really trusted."

RN14 "We were their primary contact. I feel like we were kind of their friends at the time when everything was really shut in."

RN13 "I was going into COVID-positive homes not seeing any family or friends. I can't interact with people so the only human interaction I would have would be with my patients."

RN4 "I got a lot closer to many patients. There's a lot more personal time. There was a lot of conversation that I may have not normally had with patients because I had the time to. They needed that talk. They needed that conversation. There were a lot of patients that lived alone."

RN9 "That was their only socialization. My visits were longer. They needed that. They needed a person, a real body, not somebody on the telephone. They needed that warmth, and they needed that companionship. You can go and you can make it as quick as you want to, or you can connect with them and help them through their day."

C. Sub-theme: Increased peer and provider support

RN14 "We kind of relied on each other. I'd call whoever else was out there and be like, "Hey, what are you doing' with, or did you see so and so yesterday? Like, what are we going to do with this?" We took it upon ourselves to figure things out."

RN15 "I did have support from other nurses that were out there."

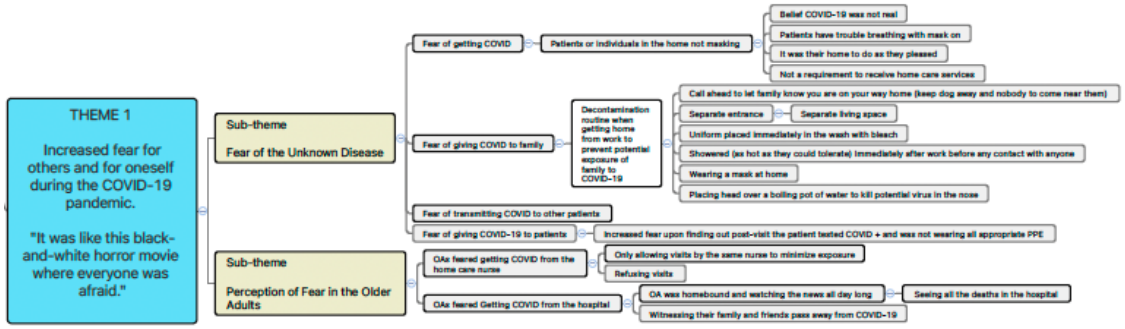
RN16 "I feel like my coworkers and I, we sort of made sure we reached out to each other because things were so tough."

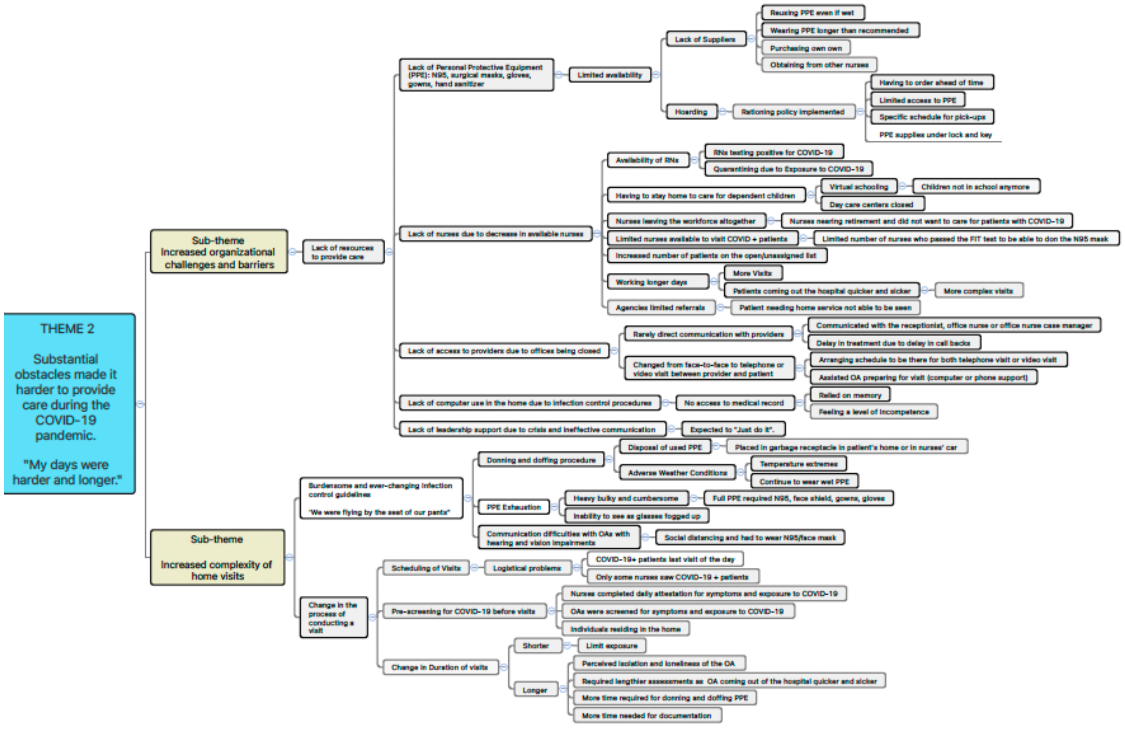
RN1 "Talking to other coworkers helps that are going through the same thing."

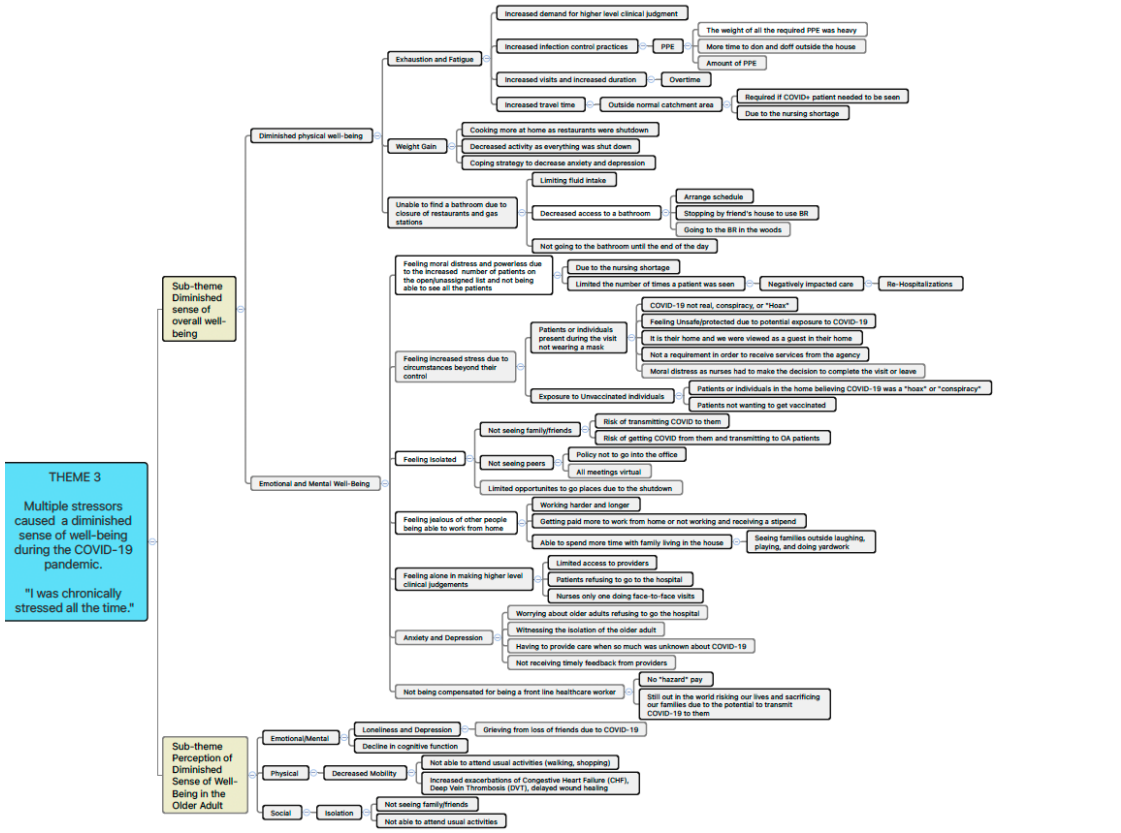
RN9 "I don't hesitate to email or pick up a phone or text message a fellow nurse. "Hey, tell me about this patient," or "This is what I found, and I'm a little concerned." We

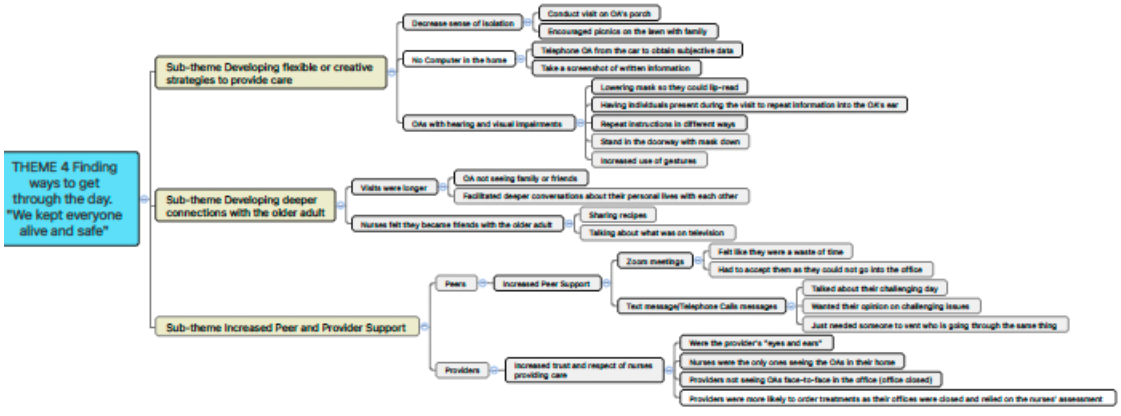
opened up other avenues but I do miss seeing my coworkers."
RN4 "I feel like since COVID they've become (providers) a lot more sensitive to our assessment, and they've felt more comfortable going ahead and ordering testing."
RN17 "I feel like physicians are more apt to do treatment over the phone than they were prior to the pandemic." I feel like the physicians were more appreciative of what you were doing. I felt like I got a lot more appreciation from the physicians."
RN20 "Thank you for going there. you're the only one out there. You're the only one seeing them. Tell me what you see." (provider) They weren't even seeing people at all." I think we got more respect. I got a lot more cred."
RN6 "Some doctors were amazingly responsive and are willing to what feels like trust the nurses."

Appendix H: Coding Tree for Themes






THEME 3
Multiple stressors caused a diminished sense of well-being during the COVID-19 pandemic.
"I was chronically stressed all the time."
Sub-theme Diminished sense of overall well-being
Diminished physical well-being
Exhaustion and Fatigue
Increased demand for higher level clinical judgment
Increased infection control practices
PPE
The weight of all the required PPE was heavy
More time to don and doff outside the house
Amount of PPE
Increased visits and increased duration
Overtime
Increased travel time
Outside normal catchment area
Required if COVID+ patient needed to be seen
Due to the nursing shortage
Weight Gain
Cooking more at home as restaurants were shutdown
Decreased activity as everything was shut down
Coping strategy to decrease anxiety and depression
Unable to find a bathroom due to closure of restaurants and gas stations
Limiting fluid intake
Decreased access to a bathroom
Arrange schedule
Stopping by friend's house to use BR
Going to the BR in the woods
Not going to the bathroom until the end of the day
Emotional and Mental Well-Being
Feeling moral distress and powerless due to the increased number of patients on the open/unassigned list and not being able to see all the patients
Due to the nursing shortage
Limited the number of times a patient was seen
Negatively impacted care
Re-Hospitalizations
Feeling increased stress due to circumstances beyond their control
Patients or individuals present during the visit not wearing a mask
COVID-19 not real, conspiracy, or "Hoax"
Feeling Unsafe/protected due to potential exposure to COVID-19
It is their home and we were viewed as a guest in their home
Not a requirement in order to receive services from the agency
Moral distress as nurses had to make the decision to complete the visit or leave
Exposure to Unvaccinated individuals
Patients or individuals in the home believing COVID-19 was a "hoax" or "conspiracy"
Patients not wanting to get vaccinated
Feeling Isolated
Not seeing family/friends
Risk of transmitting COVID to them
Risk of getting COVID from them and transmitting to OA patients
Not seeing peers
Policy not to go into the office
All meetings virtual
Limited opportunites to go places due to the shutdown
Feeling jealous of other people being able to work from home
Working harder and longer
Getting paid more to work from home or not working and receiving a stipend
Able to spend more time with family living in the house
Seeing families outside laughing, playing, and doing yardwork
Feeling alone in making higher level clinical judgements
Limited access to providers
Patients refusing to go to the hospital
Nurses only one doing face-to-face visits
Anxiety and Depression
Worrying about older adults refusing to go the hospital
Witnessing the isolation of the older adult
Having to provide care when so much was unknown about COVID-19
Not receiving timely feedback from providers
Not being compensated for being a front line healthcare worker
No "hazard" pay
Still out in the world risking our lives and sacrificing our families due to the potential to transmit COVID-19 to them
Sub-theme Perception of Diminished Sense of Well-Being in the Older Adult
Emotional/Mental
Loneliness and Depression
Grieving from loss of friends due to COVID-19
Decline in cognitive function
Physical
Decreased Mobility
Not able to attend usual activities (walking, shopping)
Increased exacerbations of Congestive Heart Failure (CHF), Deep Vein Thrombosis (DVT), delayed wound healing
Social
Isolation
Not seeing family/friends
Not able to attend usual activities


THEME 4 Finding ways to get through the day. "We kept everyone alive and safe"
Sub-theme Developing flexible or creative strategies to provide care
Decrease sense of isolation
Conduct visit on OA's porch
Encouraged picnics on the lawn with family
No Computer in the home
Telephone OA from the car to obtain subjective data
Take a screenshot of written information
OAs with hearing and visual impairments
Lowering mask so they could lip-read
Having individuals present during the visit to repeat information into the OA's ear
Repeat instructions in different ways
Stand in the doorway with mask down
Increased use of gestures
Sub-theme Developing deeper connections with the older adult
Visits were longer
OA not seeing family or friends
Facilitated deeper conversations about their personal lives with each other
Nurses felt they became friends with the older adult
Sharing recipes
Talking about what was on television
Sub-theme Increased Peer and Provider Support
Peers
Increased Peer Support
Zoom meetings
Felt like they were a waste of time
Had to accept them as they could not go into the office
Text message/Telephone Calls messages
Talked about their challenging day
Wanted their opinion on challenging issues
Just needed someone to vent who is going through the same thing
Providers
Increased trust and respect of nurses providing care
Were the provider's "eyes and ears"
Nurses were the only ones seeing the OAs in their home
Providers not seeing OAs face-to-face in the office (office closed)
Providers were more likely to order treatments as their offices were closed and relied on the nurses' assessment

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