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RESEARCH

COVID, Communication and Care Homes: A Staffs' Perspective of Supporting the Emotional Needs of Families

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An important part of care home life is the support given to older residents by their families/friends through regular visiting. Social visits to residents by their families ceased in response to the COVID-19 pandemic and residents were confined to their rooms. This paper reports on how care home staff improvised to address this situation during the first wave of the pandemic. It focuses on steps taken to maintain communication between residents and families to support emotional well-being. We undertook in-depth café-style interviews with twenty-one staff to explore creative practices that they introduced. It was part of a wider Scottish study examining the effect of lockdown on families whose relative was living/dying in a care home (May–October, 2020). Findings reveal the enormous effort by care staff to maintain family connections and the rapid acclimatisation involved working with a number of different on-line platforms, the pulling together of staff from across the care home, and, the attention to emotional well-being of residents living and dying in the care home. Findings highlight the professionalism and commitment of the leadership and staff involved. Whilst some of the staff accounts need no further comment, we draw on some themes from the care home research literature to make sense of the findings in terms of what we might learn going forward. This in-depth qualitative study emphasises the importance of recognising, fostering and nurturing relational compassionate care within long-term care. There is however little evidence whether health and social care policies recognise the importance of this on-going relationship.

Keywords: visiting; care home practice; residents and families; COVID-19 pandemic; technology; communication improvisation

Introduction

The COVID-19 pandemic announcement in March 2020 (WHO, 2020) has had a major impact on the global ageing population (Salcher-Konrad *et al.*, 2020; Gordon *et al.*, 2020; Burton *et al.*, 2020). The impact on residents of long-term care has been particularly severe due to increased risk factors including multi-morbidities, frailty and inability to self-report symptoms (ECDC Public Health Emergency team *et al.*, 2020; Gordon *et al.*, 2020; Office for National Statistics, 2020). In addition, there were challenges related to staff borne virus transmission and the physical infrastructure of the environment, making isolation and containment of the virus challenging.

In common with other countries, Scotland took action to protect residents and staff in long-term care settings by restricting visiting. There has been some limited opening to facilitate socially-distanced, outdoor visits following the height of the first wave. However, as a result of second and third waves (September 2020 and January 2021), many restrictions are still in place. This has impacted on some 32,691 older people living in care homes in Scotland (ISD, 2018), as well as their significant others from whom they have been physically separated. Long-term care facilities are variously named; in this paper, we use the term care homes to talk about generic facilities in Scotland, but highlight them as nursing care homes where nurses are employed on-site.

There is limited research evidence on the impact of barriers to visiting for family members, particularly in relation to staff-to-family-member relationship, as to date the research focus has been on the benefits of visiting (Miller, 2019; Müller *et al.*, 2017), and impacts of moving into a care home (Graneheim, 2014; Puurveen *et al.*, 2018; Pritty,

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2020). The importance of communication and relationships between family and staff is well established, particularly around shared decision making (Petriwskyj, 2014). A review of studies by Haesler (2006) highlighted evidence on the strategies, practices and organisational characteristics that promote constructive staff–family relationships in the care of older adults in healthcare settings.

No period has been more significant for examining and reviewing these issues, from the perspective of care staff themselves. The courage and commitment of staff, some of whom moved into the care home at the beginning of lockdown to protect residents (Learner, 2020), has rightly highlighted staffs' dedication. Staff were themselves not immune to the virus and were faced with continuing to support the emotional needs of residents and their families despite an already slim workforce.

This paper reports on an in-depth study conducted with care home staff to explore how staff explained their reliance on communication, digital technologies and improvisation within lock down practice. It focussed on innovations in practice by staff and was part of a larger investigation of the psycho-social impact of lockdown on families of older care home residents (Palattiyil *et al.*, 2020).

Methods

A total of 33 Scottish care homes were recruited through convenience sampling by different members of the research team who had working relationships with care homes from across the three different universities. Of

these, 15 expressed interest in taking part in research conversations about how staff had adapted their practice and approaches to keeping families connected with their relatives. However, after two or three failed email/telephone attempts in contacting these 15 care home managers only four managers, who were seen to have a strong relationship with the universities, finally responded.

Being aware of the demands placed on staff during the first wave of the pandemic, we discussed possible approaches with care home managers. We agreed that a relaxed informal group interview approach was required or 'cafes.' The 'cafes' were done virtually because of restrictions imposed by lockdown. Staff were invited to bring their morning coffee and chat to us 'on-line' with either a number of staff coming at once (like a group interview) or one staff member at a time if work was busy. We particularly wanted a range of staff who were actively involved in the process of communicating with relatives of residents during lockdown.

The sessions were undertaken using an electronic platform ZOOM and audio recorded. A liaison staff member facilitated the sessions – arranging the venue for the ZOOM call, informing staff of the time and place, and ensuring that technology was working. A topic guide for the sessions was developed by the research team to guide key areas of questioning (see **Table 1**) – the tone of the questioning was influenced by anecdotal evidence and stories from social media that indicated innovation.

Ethical approval was secured from the University of Edinburgh; staff received written information and a

Table 1: Topic guide of the creative practice café sessions.

Initial opening question [encouraging staff to tell their story in their own words]

I would love to hear your story about what you are doing differently to keep your residents connected with their family and friends and how that has helped them stay involved in decisions relating to care and support?

Prompt questions to use to navigate the story:

- *What was it that you did differently or tried out?*
- *Why did you start doing it in this way?*
[Thinking: what was the motivation for change, who's idea was it, resident led, staff led, family initiated or a partnership approach to solution finding with the family?]
- *What technology or kit did you need to do this?*
[Thinking: what equipment/kit did you need to do this and is this readily available within the care home environment?]
- *Who else was involved in this and how easy was it to get their input?*
[Thinking: who has been involved?]
- *Have you heard from others about how this has impacted them (family, colleagues, people being supported)?*
[Thinking: how do you know this has been a success so far? Feedback?]
- *What's the most important thing about what you have been doing that you would want to share with others?*
[Thinking: what was core to making a difference – was it a relationship, a person, a leadership approach, a piece of technology, a support group..?]
- *Did you try anything else, that perhaps didn't work out so well, that you could share with us so that others can learn from your experience?*
[Thinking: others can learn from things that don't work out or could perhaps gain some tips about what else they might need to think about if wishing to try something similar]

consent form prior to the interview. Verbal assent to audio recording was gained from each participant as they joined the online session.

Participants

Four care homes participated within five creative practice café-style sessions (two within one of the care homes). Facilities taking part ranged from a small independent ‘for profit’ organisation to that of a large corporation. All facilities employed nurses on-site alongside other allied healthcare professionals. Only one nursing care home had no deaths from COVID-19 (see **Table 2**). Each organisation was given an identifier code: CC for creative café, followed by CH (care home) with its number and page on the transcript [for example: CC_CH03.p14]. In total 21 staff members participated in these sessions.

Data Analysis

Audio recordings were transcribed verbatim, checked for accuracy by the facilitator (research team member) and anonymised prior to analysis. A preliminary coding frame was developed from the project research questions. JH and SN coded each transcript independently by reading and re-reading transcripts formulating codes which were then grouped under categories and finally major themes. These were then circulated and checked by JH, TH-L and RI for member checking and review. This simple content analysis of the café data featured a mixture of deductive and inductive coding.

Findings

Three major themes were derived from the data, namely: 1) the emotional impact of lockdown on relatives through the eyes of care home staff; 2) different ways of communicating – availability of technology and use; 3) creative practice to enhance staff communication and teamwork.

The emotional impact of ‘lockdown’ on relatives – staffs’ perception

At the beginning of the pandemic with a strict ‘no visiting’ rule, both staff and families had clarity. As the prolonged nature of lockdown went on, many families became desperate especially when their relative was very frail and

dying. Because care homes are independent of the NHS there was opportunity, to a limited extent, for independent providers to modify the rules prompting some care homes to allow ‘window visits.’ Five months into lockdown (July), government rules were relaxing to allow ‘garden visits’ to be managed as appropriate locally. What was possible at each of the study homes varied; some had facilities in a separate building for face-to-face visits ‘inside’ whilst others organised ‘garden visits’ – with some having to buy and erect gazebos which were not useable on windy days.

At the beginning of the pandemic, there was a strong sense across all the study homes that staff felt families needed considerable reassurance. In addition to the media highlighting various difficulties faced by care homes, when a study care home was known to have COVID-19 this reflected in increased phone calls to staff.

Prior to i-pads/tablets and other devices with different types of software being purchased in response to the situation, staff mostly used emails and phone calls. Some relatives were phoning more than once a day wanting reassurance. Families were asking more questions and wanted more detailed information than usual because ‘they couldn’t see for themselves.’ One study home created a spreadsheet of all family details and scheduled regular update phone calls with family.

‘... you know [they were phoning] several times a day, and it was different members of the family and things. So, we set up a system, ours didn’t always go every three days. We gave the relatives a choice because some people, you know ... they get more nervous, especially during COVID; they wanted a bit more reassurance.’ [CC_CH07.p6]

‘.... you are hearing constantly like [Respondent 3] says on the media, death tolls, death tolls, death tolls and that’s really scary when you can’t see your family and you don’t know what’s happening.’ [CC_CH25.p7]

Once technology was set up and families could see virtually through a screen how their relative was, this gave reassurance and anxiety eased.

Table 2: Context of study homes (numbered as per the wider project) and staff members taking part.

Type of care home (CH)	CH03	CH04	CH07	CH25
	72-bedded Independent ‘for profit’	29-bedded ‘for profit’	80-bedded Large ‘for profit’ corporate	180-bedded part of a charity organisation
Context of healthcare	On-site nurses & physiotherapist	On-site nurses & physiotherapist	On-site nurses	On-site nurses, physiotherapist, OTs
No. of deaths	25% deaths (COVID-19 +ve or presumed)	No deaths from COVID-19	31% deaths (majority from COVID-19 +ve or presumed)	20% deaths (COVID-19 +ve or presumed)
Staff who attended sessions	Manager Activities team × 2 Charge nurse Physiotherapist	Manager Deputy manager Nurse Nutritional support worker Senior care worker	Charge nurse Nurse Senior care worker Care worker	Manager Staff × 6

Some staff interpreted the anxiety and fear of families as a result of feeling robbed of time being spent with their relatives.

'I think there's a kind of grieving process in many ways, because I think they maybe feel they've been... if you've got a family who's very close, they may feel they've been robbed of time with them...'
[CC_CH04.p13]

In the study home that had escaped the pandemic, the emotional response of families was more frustration at not being able to visit. Some families whose relative had a bedroom on the ground floor would pass things through the window and this made staff themselves, in a COVID-free study home, fearful causing some strong negative comments re 'window visits.' There was also a sense of disparity between those residents who had a room on the ground floor versus those whose room was on the 1st or 2nd floor so could not get window visits.

Anxiety turns to frustration

After nearly six months of lockdown, staff felt previous anxiety and fear had turned to frustration with some families with boundaries being pushed.

'They're still arriving 'en masse' and get a bit naughty, and you're trying not to be too restrictive, but they're not getting it really that this is all about footfall, and like it or not we're at more risk.'
[CC_CH03p.6]

Staff told us that relatives felt frustrated over wearing masks – some felt their loved one couldn't understand them through a mask when they did visit. In one study home when staff were reuniting a married couple who lived in separate houses, the wife with advanced dementia was unable to recognise her husband with a mask on; so, they took a calculated risk to take off the husband's mask.

Balancing clinical care and organising visits and on-going communication with families in light of no extra care support has been exhausting for staff. However, family visits were very important with many residents being 'lifted' by such a visit giving them something to look forward to each week.

'And I know this one lady, in particular, her one garden visit each week with her daughter – that's what keeps her going, I think, looking forward to that.'
[CC_CH03.p5]

'[Visits] have been really successful and the residents always gush about the time that they got to spend with their families, so that's been lovely hearing that. And you can definitely see an improvement with your residents ... when they've had a visit that day.'
[CC_CH25.p9]

New admissions during lockdown

Anyone coming into a care home during the 1st wave of the pandemic posed a risk to those residents living there.

This included new residents being admitted. Government guidelines were patchy although there is now much more solid advice (UK Gov, 2020). During the research period, all new admissions to a care home would need to be in isolation for 14 days. If a care home had a COVID-19 outbreak then new admissions were not allowed for 28 days. All four study homes commented on the emotional difficulties of admitting new residents during COVID-19. New residents not only arrived in a strange place that they had never seen before but then had to isolate. There was no initial sit down with the family, so staff had the difficulty of building relationships over the phone or by ZOOM:

'I feel it's hindered the building of relationship with the new residents that came in during COVID-19, because you know we're not meeting the families. We're not getting that initial kind of sit down and let's have a chat.... There are a few family members that I couldn't actually say I know what they look like, because I haven't physically seen them...'
[CC_CH07p.8]

During a couple of the cafés, staff spoke about the importance of physical/eye-to-eye contact with families to get to know them; without this contact it created a barrier to person-centred care planning.

Different ways of communicating – availability of technology and use

At the pandemic outset, study home staff used phone calls and emails to communicate individually with families of residents. All managers wrote regular electronic newsletters to families (blind copied) – generally fortnightly – to allay anxiety as the crisis unfolded. The regularity of these newsletters reduced after the first six months.

Once the more sophisticated communication devices were in place, staff and residents used a mixture of Facebook, Facebook Messenger, Facebook Workplace, WhatsApp, ZOOM, Skype to communicate with families alongside what might be seen as the more traditional practices of letter writing and phone calls. One of the study homes were donated i-pads through a contact; others had to buy a couple of i-pads for each floor [CC_CH03; CC_CH04]. These were then shared amongst the residents with the necessary de-contamination before each use; a few residents already had their own smart phone. However, CH025 had already introduced an electronic care planning package; as a result, they had all the tech they required at the point of lockdown.

Communication was being used in three ways: firstly, the more old-fashioned/formal contact using emails and for those who were not being accustomed with Skype/Facebook Messenger, the art of letter writing. Staff from the activities team helped residents write letters to families/friends who would then write back, with letters being read and re-read. One lady in CC_CH07 who was writing one letter a day prior to COVID-19, was now writing three letters each day!

Secondly, there was communication via social media – shared with a community of stakeholders via the care homes' Facebook pages. Staff from a couple of study

homes spoke of how pictures of activities were uploaded three times/week. Families were encouraged to go to the website and use the webpage as a 'window into the home' to see that life was still going on and that their relative was safely cared for.

CC_CH25 used Facebook Workplace and set-up different groups within the separate 'houses.' Families of each 'house' were then invited to join the group – reaching 700 or more relatives across the different house groups during the lockdown period.

'Our Director of Care puts all the Coronavirus updates and guidance and changes in visiting and things on [Facebook Workplace].... so that relatives can access it really easily, plus it gave them another way of being able to maybe message and speak to myself or speak with the director.... But yeah we've found that has been very, very successful during lockdown.' [CC_CH25.p2]

Thirdly, there was the direct one-to-one contact between residents and their families, and occasionally staff and families, via Skype, What's App, ZOOM and Messenger. Staff felt families were very reassured by 'seeing' their relatives.

Younger care staff were important to make it all happen; they had the 'know how' regarding technology although staff in one study home mentioned that some found talking to families face to face emotional.

'I think the credit has to go to a lot of the care staff who have been keeping up to date with the Zoom, with the WhatsApp, with that kind of technology, and actually introducing that to some of the residents themselves.' [CC_CH04.p5]

More deliberate relationship-based care

Technology appeared to create a more deliberate relationship-based care between staff and relatives as staff were not just bumping into them while visiting as they would have done pre-COVID-19. Technology provided an increase in individualised person-centred communication done alongside the clinical care. ZOOM chats were generally planned in advance but also flexible.

'... if somebody was a wee bit down or something, we would say "do you want to give such and such a wee phone?" and then we'd message them on the Messenger and say "are you free for a wee chat; your mum would like to blather?" and obviously if we'd got a spare ten minutes just go and do that with them.' [CC_CH07.p1]

Majority of residents required help setting up a call and/or continuing a call, so it was time consuming for carers. However, because carers joined conversations with the resident and the family, these carers were now speaking more with the relatives than pre-COVID-19:

'Yes, we'd all be in on the conversation, and they'd be asking us stuff as well, and it was nice just to get

that wee bit of time with them, and it was nice for them. It gave them some peace of mind I think.' [CC_CH07.p10]

'The communication is greater than it ever was before, and it was really good then, but using all the different facilities that we have, whether it be ZOOM, whether it be Skype, they want to see your face, they want that communication...' [CC_CH03.p3]

Pre-COVID-19, the younger care staff had rarely joined in conversations between family and the resident; this was now a new role which they liked and as a result felt more valued.

Technology has been 'for all' not just the residents and families. Staff being more familiar with ZOOM and WhatsApp, etc, meant they connected with each other both for meetings as well as for relaxation and peer support – one group spoke about how they had an origami demonstration by one of the staff [CC-CH25.p12]. Technology has continued to play an important role even after visiting face-to-face was re-started as often residents would only get one visit/week so needed the on-going interaction through technology.

As a result of the media reporting on care homes, more connections were being made within local communities. Three out of the four study homes spoke about support from children from local schools sending cards – it was the task of the activities team to respond to them:

'...lots of stuff coming in from local schools and children and groups that just want to be seen to be supporting the home.... We were receiving them probably when the home was at the height of the lockdown and when things were really, really stressful for everybody in the home and people were still learning and adapting to the situation and they were just bringing so much light and joy into the home.' [CC_CH25.p5]

Different ups and downs of technology

There was considerable positivity towards the impact of technology:

'They think it's absolutely astonishing that there's technology you can actually see your loved one, and they've really enjoyed that.' [CC_CH04.p5]

However, there were downsides; some residents with advanced dementia just could not quite make out the technology:

'We have one lady who lives with dementia, and her son started to do ZOOM chats, but she wasn't coping with it. She couldn't understand it and was becoming quite distressed by it; and, then, just was walking away because she just couldn't understand.' [CC.04.p6]

Nonetheless, there was a sense that the positives outweighed the negatives, with staff in many ways feeling

they were an extension of the family with signs of deeper engagement which they really wanted to emphasise. And movingly, an extension of the family at the point of death. One participant recounted how they had written to the family following the resident's death saying:

'.... "for that few hours I became an extension of your family holding his hand on your behalf." I don't know where the words came from, but I did feel that.' [CC_CH03.p11]

Creative practice to enhance staff communication and teamwork

There was considerable evidence of technology mediated creative practices both in terms of residents living and dying within the home.

Living

To enable a creative and collaborative approach required 'all hands-on deck.' Besides the frontline care workers, this included activity team members alongside physiotherapists and occupational therapists, where employed. They reported that they now had more direct involvement with families.

There were examples of residents being enabled to create Wordclouds (freely available from the internet) where a word image is created using words spoken/written in relation to a meaningful topic (the more often a specific word is used the bigger and bolder it appears within the created Wordcloud). One moving example was as follows:

'The two residents were in different houses, so they obviously couldn't see each other for quite a long time, so [doing the Wordcloud] kept them connected. And when I went in to see the wife, she was in tears and normally she doesn't communicate well verbally, but she could see... it was all their memories from their life in the picture and she was reading it out and she was telling me all the things and obviously she'd got all her memories and everything. So, it was amazing and the family were absolutely delighted with it and they commented on the Facebook Workplace because I'd posted the pictures on the family group and stuff, so they were absolutely delighted with it.' [CC_CH25.p9]

There was an example of undertaking a video of a newly admitted self-isolating gentleman dancing with staff. The family were thrilled. Carers and the activities team were working together to support relative and family communication.

There was evidence of a greater awareness of holistic care. In CC_CH25, staff spoke about the important role that ZOOM had provided with the opportunity for church services being linked to the home. ZOOM also provided the opportunity for clinical staff to do six-monthly reviews with families – to discuss care needs and the future.

One memorable moment for a staff member was the celebration of a resident's 100th birthday under lockdown with the family in Spain:

'One of my residents had her hundredth birthday... and they were in lockdown as well.... the family in Spain had set up a big massive ZOOM call, and we had phoned [to set it up] on the iPad, and they had all these screens up, so she could see all her family....that was really good.....'

Prior to COVID-19 the son would phone once a week...

'...but he was phoning every single day during lockdown, like video calling... He was on a video call with her last night as well, so they obviously still communicate through video call after we've had it set up and everything.' [CC_CH07.p15]

This type of creative practice did not just apply to those still living in the home but applied to the end of life when residents were dying.

Dying

Many families living abroad were not able to fly back during lockdown. However, the advantage of technology meant that families could speak with their relative during the dying period and say their 'goodbye' over the phones....

'I would take my mobile phone and hold it to the resident's ear, put it on loudspeaker and the families could say their final words to mum or dad or whoever.' [CC_CH03.p10]

Staff found this extremely emotional:

'...not something I should have been privy to, people's final conversations with mum or dad saying goodbye. Normally the relatives would be in the room having this in private.....And then once that relative had done that I would find their sister phoning me up, "Oh, my brother says you went and did this. Could you go and do it for me?"' [CC_CH03p.10]

As a result of staff being off-sick during the pandemic, it created a change in staffs' role. A member of the activities team in one study home was asked to sit with a dying resident to make sure they didn't die alone. She had never done this before but was the only person available that day – and, in fact, took on the role to sit with three dying residents. She felt it a privilege.

Staff went out of their way to support, communicate and engage with families whose relative was dying – despite their huge clinical load. The saying 'goodbye' for this family was poignant with the newly born great-granddaughter:

'... her newest great-granddaughter, just a few weeks old, came all the way from [one of the islands] ... The lady was dying... we turned her bed around so she could face the window and they held the baby up... she actually waved to the baby which was so lovely, and it was so moving for her granddaughter,

because she could see that her grandmother saw her baby.' [CC_CH04.p13]

The upholding of rituals was important even during the pandemic to make time for a respectful farewell:

'... the hearse was coming up through the home [on the way to the funeral], and some of the carers from the units were able to go out, obviously socially distanced, just to show their respect. I think a lot of families took a lot of comfort out of that, because they were able to meet with their families, see the people that had been looking after them, especially if they'd been in our care for years, just like a farewell to them, and that was nice, and it was respectful. I think that was appreciated, and that was different...' [CC_CH07.p12]

The study home became a 'hub' for final farewells for friends/extended families not allowed to attend the funeral; this had never happened before.

On the Facebook Workplace platform in CC_CH25, there was lots of support between families – particularly when a resident had died:

'We find that all the relatives have been putting on "sadly today we lost my dad" and then everybody's been able to do it, just like you would do on Facebook, that supportive, "we're really sad to hear that your dad... he was a real character"; lots and lots of that going on as well as all the cheery stuff.' [CC_CH25.p4]

Whether caring for those who were living or dying, it would appear that COVID-19 had changed communication patterns. There was a sense of greater pro-active communication between staff and relatives as a result of lockdown:

'We'll continue to use different ways of communicating. We learnt differently and we learnt fast.' [CC_C0H3.p17]

There was a sense of the whole team pulling together leading to flatter hierarchies. A greater appreciation and valuing of mixed-skill set across the wider team as a result of the pandemic [CC_CH25; CC_CH07; CC_CH03]. This pulling together helped build confidence with families and made them a stronger care team.

Discussion

This small but in-depth qualitative study has brought to the fore the importance of recognising, fostering and nurturing relational compassionate care (Dewar and Nolan, 2013) within long-term care. It also highlights the pivotal role that care home staff have in facilitating and maintaining the centrality of family relationships for older people living and dying in care homes brought into stronger focus as a result of lockdown during the COVID-19 pandemic. The findings provide insights into staffs' own needs

through the moving accounts given by them and their compassion, which pays due attention to their needs for recognition and support to do their best within unprecedented conditions. Whilst some of the staff accounts need no further comment, we draw on some themes from the care home research literature to make sense of the findings in terms of what we might learn going forward.

In a study by Condelius and Anderson (2015), the family members' perception of the quality of care and their satisfaction with care was informed by the amount of information and involvement given by staff; a lack of communication caused worry and mistrust. In our study, staff were aware of family anxiety and the daily/weekly fluctuations reflected the frequency of phone calls. Establishment of technology-based communications with families and their relatives was helpful. Facilities already using electronic care planning found this easier than those relying on paper records. Electronic care planning meant that staff had access to the technology and were familiar with its use. The PCS software (<https://www.personcentred-software.com/gb/>) allowed families to log-on to the daily care record at any time fostering a sense of real involvement, transparency and genuine relationship-based care.

The active provision of opportunities to be engaged in residents' daily life and involved in the 'little things' has been highlighted as what counts (Ryan and McKenna, 2015). The giving of 'time' to the resident and the family in building and maintaining a caring relationship could have been jeopardised by the pandemic but the data we collected revealed that every effort was being made to maintain this high on the agenda and technology greatly assisted.

In all study care homes, we noticed a sense of staff investing in time to not only allay fears but to continue to build relationships through technology. As a result, it was the front-line care workers and activities teams who built deeper relationships with families. This was challenging for some but the reciprocity in care with family members keeping in touch directly benefitted residents' wellbeing (Hoek *et al.*, 2020; Ryan and McKenna, 2013).

Investment in transition processes so that residents, their families/friends and staff can increase day-to-day familiarity and build a sense of community can help in conditions of separation, extreme or otherwise (Davies and Nolan, 2006; Eika *et al.*, 2014; Port, 2004; Ryan and McKenna, 2013). Staff in our study referred to the dynamics of trying to maintain continuity. They described steps taken to match their personalised knowledge of the resident and their family to address and reassure relatives in response to frequent enquiries introducing flexibility where there was little flexibility in their immediate environment.

There is a need for all care home staff, and professionals in general, to make transitional care more explicit in order to facilitate healthy transition processes. Reflecting on the care home as a place of safety can help to build trust between relatives and staff at times of transition (Katz *et al.*, 2013); building a sense of trust and decision-making to manage the tensions when relatives become frustrated, as in our study, will depend on having invested

in these relationships beforehand. Being aware of the consequences of placement and offering increased support, especially for those with dementia during the difficult phase of transition, has been associated with loss for their family member (Chene, 2006). Staff in our study experienced these challenges of families' relatives being admitted to the care home during the pandemic and responded very compassionately in making personalised adjustments often using their own personal resources to fill in any gaps.

There is, however, little evidence about whether health and social care policies recognise the importance of this on-going relationship and the importance of families well-being. Developing a better understanding of the associations between family wellbeing and care home use is therefore critical for policy makers and providers to achieve more holistic systems of care (Eika *et al.*, 2014) especially during crises when care homes have to close their doors because of infections such as the norovirus and notwithstanding the ongoing COVID-19 pandemic.

Addressing factors which contribute to the optimal conditions for engaging family members and the structures and processes to build partnerships between those visiting older residents and care home staff has been highlighted (Bennett *et al.*, 2015; Holmgren *et al.*, 2014). In our study, care staff were imaginative in their small actions, mostly informal (Hoek, 2020), to foster exchanges between family members mostly using technology where they took steps to personalise their meaning and impact. Two examples from our study were where staff initiated telephone calls when the resident appeared low; and, staff developing the care home presence on common e-platforms such as Facebook and Facebook Workplace. How staff create a homelike environment in a closed situation also involved enhancing their own relationships with residents, between themselves as staff, and enabling family members to connect with each other, thus creating an 'inside-out' community. In a study by Canham *et al.* (2017), care home workers referred to these gestures as 'becoming a family' where such relationships and connectedness may flourish through story sharing between residents, family members, and staff.

Our study highlighted how staff became more closely involved in the more existential and traumatic experiences of individual residents dying experiences. Some care home research has found that an emphasis on functional aspects of care and the duties to care can lead to a culture which denies recognition of residents wishes around dying and relegates any support to the periphery of care (Hafford-Letchfield *et al.*, 2020). In our study, staff were more directly involved in supporting the residents, and exercising great compassion, and to some extent acting in a proxy role for relatives. Increasingly, even before the pandemic, care homes were being seen as 'de facto' hospice (Connolly *et al.*, 2014) which the last nine months has brought into sharp focus. It could be argued that care homes that had undertaken courses in palliative and end of life care pre-COVID-19 – all of which was the case in our study – might have stood a better chance to cope with the multiple deaths many care homes have recently faced.

Coping with this increasing number of deaths in care homes, highlights the need for more frequently discussed and embodied support for staff about dying and facilitating a deeper understanding of the impact on families. Regular debriefing sessions for care home staff have been found not only to help team cohesion and communication but also develop practice-based learning on palliative and end of life care (Hockley, 2014; Hockley *et al.*, 2021 in press). The depth of grief some care staff have experienced as a result of residents dying during the pandemic, many of whom had been in their care for many months/year/s, will be on-going (McGilton *et al.*, 2020). It is care home staffs' ability and commitment to facilitate lines of communication with families that plays a substantial part in families' emotional well-being.

Strengths and limitations

This study provides very rich data in relation to staffs' experience of supporting families at an unprecedented time in the history of care homes. There was a good mix of different types of study care homes from across the independent sector; however, out of the fifteen we had anticipated, sadly only four care homes took part. A major reason for this was due to the project taking place during the 1st wave of the COVID-19 pandemic where care homes were suddenly coming under pressure because of further outbreaks. A further limitation was that all study care homes had on-site nurses; whilst the majority of care homes were struggling, those without on-site nurses were also having to learn new skills in relation to PPE/barrier nursing so more under pressure and less likely to take part. Nonetheless, there was a mixture of different frontline staff and managers, of those who did take part. Finally, we were unable to do more formal focus groups as we did not want to impose on staff when we knew they were extremely busy. Such limitations highlight the difficulty of engaging care homes in research activity.

Conclusion

This study highlights how staff in care homes with on-site nurses found ways to use digital technology to communicate during the COVID-19 pandemic which, from the staffs' perspective, allayed some fears and anxieties felt by families. Despite the huge clinical load for staff, technology enhanced communication between families, residents and indeed staff, building greater relationship-based care. It highlighted the important role both informal and formal carers have in supporting the emotional well-being of residents living and dying in care homes. However, this was only made possible with frontline care staff stepping up to take-on such responsibilities and the professional leadership empowering them to do so – and is unlikely to occur in all care homes. Care homes without such resources might find it difficult to put in place some of the scope that this study revealed. The disparity of resources between care homes with on-site nurses and those without needs attention. Going forward, the pandemic, and in some part this study, has highlighted the important role of technology in care homes not only in terms of communication but also care planning and data management.

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Competing Interests

The authors have no competing interests to declare.

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