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Too Close for Comfort? The Social Health of Geriatric Nurses During the COVID-19 Pandemic in Germany

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Abstract

Background: The first COVID-19 lockdown in spring 2020 had detrimental effects on both the residents and staff of long-term care facilities in Germany. Regulations to prevent the spread of the virus closed off facilities to visitors, creating social and physical distancing of residents and changing the daily routines of residents and nursing staff alike. Using a grounded theory approach, this study explores the impact of COVID-19 regulations on the social health of geriatric nurses in long-term care facilities in Saxony-Anhalt, Germany.

Methods: We conducted semi-structured interviews after the first lockdown (June/July 2020) and during the second lockdown (November 2020–March 2021) with 13 nurses, primarily those in management positions.

Results: We found that COVID-19 regulations changed the relationship between nurses and residents in important ways. First, nurses became primary caregivers and proxies for the relatives and professionals (e.g. hairdressers, physiotherapists) with whom residents typically interact. Second, strict regulations regarding hygiene, physical and social distancing, and visitors contrasted sharply with nursing as a holistic practice and profession. Third, although nurses had to remain distanced from residents, they simultaneously developed greater emotional closeness. This dynamic affected the social health of both groups, raising important ethical questions about nursing responsibilities and emotional capacities in geriatric care during times of extended crisis such as the pandemic.

Keywords: COVID-19 Pandemic, Social Health, Long-Term Care, Nursing Ethics, Role of Nursing

1 Introduction

In March 2020, with the beginning of the COVID-19 pandemic, the work of nurses came into focus and nursing was named a critical occupation. In Germany and other countries, members of the public and politicians applauded nurses for their important work during the pandemic.[1] With growing concern about residents in long-term care institutions, geriatric nurses also received increased attention. Older adults were quickly referred to as a "high risk group" in need of specific precautionary measures, particularly in terms of interpersonal contact.[2] Although adults above the age of 65 represent a highly heterogeneous group,[3] it was true that age was associated with an increased risk of severe COVID-19.[4] In Germany, 70% of hospitalized patients and 95% of those who died from COVID were aged 60 or older.[5] Since the beginning of the pandemic, 293,461 cases of COVID-19 have been reported in care homes in Germany. Of these, 209,434 affected people aged 60 or older, and the median age of COVID-related death is 81 years.[6] Residents in long-term care facilities comprised a large share of hospitalizations

1 Koebe et al. 2020.
2 Ayalon et al. 2021.
3 Ehni/Wahl 2020.
4 Gaertner et al. 2021.
5 Schilling et al. 2020.
6 Robert Koch-Institut (RKI) 2022.

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and deaths, both of which increased dramatically between March and May 2020.[7] According to a comparative international analysis, the death rate relating to COVID-19 in long-term care had reached 28% in Germany in January 2021, despite strict regulations to prevent infections in nursing homes.[8]

In spring 2020, the German government established regulations to contain the spread of the novel coronavirus. Federal states were responsible for implementing these provisions regionally, while accounting for local needs and circumstances. Thus, Saxony-Anhalt established social distancing in long-term care facilities in April 2020, when it officially stopped all visits. With the exception of palliative care staff, everyone else (including relatives, friends, therapists, hairdressers, and other nonessential professionals) were forbidden from entering nursing homes.[9] In addition, nursing staff and residents were required to practice physical distancing by wearing face masks and observing strict protocols for hygiene and disinfection.[10] As there is still uncertainty concerning successful treatment options, especially for immunocompromised and older people with chronic diseases, the threat of COVID-19 transmission via increasingly asymptomatic vectors remains high for the residents and nurses in long-term care facilities, and for their families.[11]

Despite the desire to contain the virus and reduce risk to the most vulnerable, the long-term impact of social and physical distancing on the residents and staff of closed facilities such as nursing homes is difficult to ascertain.[12] First, social and physical distancing are not clearly defined concepts and tend to be used interchangeably.[13] Second, empirical studies on the effects of distancing are rare. Most studies fall within the category of gray literature or policy recommendations, as shown in an international review.[14] What is clear is that the visiting restrictions (particularly complete bans) place a high toll on residents, for whom digital social interaction may not be suitable or available.[15] The toll on nursing staff, though unclear, is also likely to be high.

Altintas and colleagues argue that emotional exhaustion was a key factor affecting the nursing profession in France during the pandemic as the workload (a) increased considerably and (b) shifted toward medical care, leaving less time to spend with residents in terminal stages.[16] The situation was similar in Germany with regard to workload, along with challenges relating to information about pandemic-specific rules, and being left out of the decision-making process.[17] International and German studies show that many nurses expressed a desire to leave the profession during the pandemic,[18] but there are no solid statistics on how many did so.

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7 Kohl et al. 2021, p. 4.
8 Comas-Herrera et al. 2021.
9 Landesregierung Sachsen-Anhalt April 2, 2020.
10 Landesregierung Sachsen-Anhalt April 2, 2020; RKI 2020.
11 Fine/Tronto 2020.
12 Sims et al. 2022.
13 Sims et al. 2022.
14 Sims et al. 2022.
15 Barnett/Grabowski 2020.
16 Altintas et al. 2022.
17 Hering et al. 2022.
18 Schulze et al. 2022; Falatah 2021; Phelan et al. 2022.

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The German federal employment agency offers some clues in its statistics relating to nursing vacancies (as recorded by employers) compared to the number of nurses who registered for unemployment benefits. Although the agency identified a nursing shortage prior to the onset of the pandemic (i.e. many more vacancies than unemployed nurses), the nursing sector in Germany grew more than other professions during this period.[19]

1.1 Professional Nursing Education in Germany

Prior to the pandemic, German professional nursing consisted of three independent educational tracks based on a three-year vocational program combining theory and practice in (1) pediatrics, (2) gerontology, or (3) general nursing.[20] To make the profession more competitive and attract more nursing apprenticeships, Germany (in 2020) combined the three tracks into one generalist program spanning the whole of life. The new degree program was viewed as a success.[21] In 2021 alone there was a 5% increase in nursing apprenticeships.[22] In an effort to support staff salaries and other provisions for long-term care services, German legislation has been enacted to provide financial support at federal and state levels. Differences in salaries between hospitals and long-term care were a particular concern.[23] Nursing homes feared that the generalist nursing program would lead to nurses applying for jobs in hospitals instead of in long-term care. For this reason, from September 1, 2022, geriatric nurses will be paid the same wages negotiated for hospital nurses.[24]

1.2 Financing of Long-term Care and its Relevance for Nursing Care

An important change in long-term care provisions was the transition from a "deficit" model to determine the level of care (such as, acute or long-term medical care) (*Pflegestufen*) to a "degrees of care" model (*Pflegegrade*) that takes into account factors such as cognition and psychological resources of older people.[25] Federal nursing care insurance covers the costs of nursing and care based on the degrees of care an older person needs. There are five degrees of care, with degree one being the lowest and five the highest amount of care needed by an individual. The financial support increases with every degree of care. However, nursing home costs are higher than the payments from the nursing care insurance cover and this gap is financed by contributions from the insured resident.[26] This financial contribution is the same for all residents, regardless of the degree of care required.[27]

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19 Bundesagentur für Arbeit 2022.
20 Bundesministerium für Familie, Senioren, Frauen und Jugend (BMFSFJ) 2017.
21 BMFSFJ 2022.
22 Statistisches Bundesamt 2022.
23 Statistisches Bundesamt 2021.
24 Bundesministerium für Arbeit und Soziales 2022.
25 Klie 2016, p. 130.
26 Neubert/Neubert 2022, pp. 39–48.
27 Neubert/Neubert 2022, pp. 39–48.

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The paradigm shift to degrees of care reflects, in some ways, the holistic and person-centered ethics of professional nursing in Germany. An important nursing task is to understand the individual circumstances of each resident to determine their specific care needs.[28] To understand patients' needs, proximity between caregiver and care-receiver is vital.

To better understand the importance of proximity in the long-term care setting, we turn to Malone's differentiation between "proximal" and "distal" nursing.[29] Proximal nursing recognizes nursing care in terms of a shared practice of meaning and values between patients (in our case residents) and nurses. Distal nursing understands nursing care as the management and execution of technical tasks aligned with objective measures, such as medical diagnoses and treatments.[30] Distal nursing cannot be reconciled with more holistic forms of care, often leading to a form of functional care guided by the principle of efficiency and expressed by means of rationing and prioritization (such as providing care with fewer nursing staff).[31] In practice, nursing care is proximal and relies on proximity, yet close physical and social/emotional contact was difficult to maintain under pandemic regulations.[32] Measures to contain the virus called for either maintaining adequate distance or engaging in close contact only when using protective gear. The no-visitors policies in place at long-term care facilities transformed nurses into residents' most important social contacts. As proximity between nurses and residents increased in daily routines, so the social health of nurses declined.

1.3 The Concept of Social Health

When considering social health, it is critical to understand that the concept refers to all social relationships a person engages in personally and professionally.[33] According to Huber and colleagues, social health involves "people's capacity to fulfil their potential and obligations, the ability to manage their life with some degree of independence despite a medical condition, and the ability to participate in social activities including work".[34] More than in other professions, the relationship between residents and nurses uniquely relies on close bonds (social and physical) between the person being cared for and the person providing care.[35] This relationship is not equal. Residents depend on nursing staff to take care of them and support them in their daily activities (such as bathing, eating, dressing, maintaining relationships, and so forth). Many residents are unable to make autonomous decisions or communicate their wishes and needs adequately.[36] Nursing in long-term care facilities therefore entails a special responsibility among nurses to ensure residents' well-being. Prior to the pandemic, this responsibility was shared with family and friends of residents and other professions. The pandemic changed all this, in addition to making nurses a risk (to residents) as a potential carrier

28 Bobbert 2002; Senghaas-Knobloch/Kumbruck 2006; Kleinman 2013.
29 Malone 2003.
30 Malone 2003.
31 Primc 2020.
32 Halek et al. 2020; Lob-Hüdepohl 2021.
33 Paul et al. 2021.
34 Huber et al. 2011, p. 2.
35 Paul et al. 2021.
36 Birnbacher 2020.

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of contagion, and placing them at risk from residents, who were already more susceptible to infection.[37]

This paper analyzes the impact and unintended consequences of the pandemic's containment measures on the social health of nurses in long-term care facilities. By highlighting the nuances of geriatric care during times of crisis (such as the COVID-19 pandemic), we offer deeper insights into ethical and practical challenges facing the nursing profession.

2 Context of the Study

The study is part of a larger project, "CoronaCare", that investigates the impact of the COVID-19 pandemic on social health in the unique context of nursing staff and residents in long-term care facilities in Germany.[38] In cooperation with the Institute of Social Medicine and Epidemiology at the Brandenburg Medical School Theodor Fontane and the Institute of Social Medicine and Health Systems Research at the Otto von Guericke University Magdeburg, CoronaCare is funded by the Federal Ministry of Education and Research (BMBF No. 01KI20117).

The Magdeburg research team conducted seven semi-structured interviews in long-term care facilities with nursing staff and residents from November 2020 to March 2021. The HeiCo study (Pflegeheime in der COVID-19 Pandemie: Nursing Homes during the COVID-19 Pandemic)[39] conducted six semi-structured interviews in July/August 2020.[40] A semi-structured approach allowed participants to speak freely and without interruption.

Both studies were approved by their respective ethics committees (CoronaCare: Ethics Committee of the Brandenburg Medical School Theodore Fontane, No. E-01-20200605; HeiCo Study: Ethics Committee of University Hospital Halle an der Saale, No. 2019-006, and both in cooperation with the trust office of the Faculty of Medicine at Otto von Guericke University Magdeburg).

Using a grounded theory approach[41] to the shifting meaning(s) of social health during the pandemic, we draw on these two corresponding datasets (n=13) (HeiCo and CoronaCare).

2.1 Recruitment and Data Collection

The research team recruited participants from prior contacts and nursing home websites in Saxony-Anhalt. We contacted nursing home directors to request participation. Although some declined due to pandemic-related time constraints, others agreed to be interviewed or recommended other members of the nursing staff. Those who expressed interest received detailed information about the study and a consent form. Interviews were scheduled only after participants returned signed consent forms. The trust office of the Otto von Guericke University Magdeburg stores all signed forms securely. As pandemic regulations made it impossible to conduct the interviews face-to-face, we conducted them via telephone. Interviews lasted

37 Paul et al. 2021.
38 Paul et al. 2021.
39 HEICO-Pflegeheime in der COVID-19 Pandemie 2020.
40 Bieber et al. 2022.
41 Corbin/Strauss 2008; Charmaz 2006.

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20–60 minutes (mean: 35 minutes). All interviews were audio recorded, transcribed, and pseudonymized. Data was then transferred to the management program, MAXQDA. To facilitate comparative analysis of data from the HeiCo and CoronaCare studies, questions about the social dimensions of care from the HeiCo study were integrated into the interview guide of the CoronaCare study. The authors analyzed the data and translated quotes from German into English.

2.2 Sample Description

The 13 interviewees in this analysis include eleven women and two men, primarily in management positions. Nursing home directors may have geared our recruitment efforts toward those in supervisory roles, and away from the wards, out of concern for reputation management. Some nursing homes had already been criticized for resident deaths due to COVID-19, despite implementation of protocols to contain the virus. Even those in management positions were in close contact with the wards and often engaged in care work due to the shortage of nurses.

German nursing homes are organized by size (number of residents), space (housing structure: one building or smaller buildings such as a campus structure), and organizational structure (not-for-profit, private or public). Our aim was to recruit a sample of nursing homes in rural and urban areas, with differences in size and type of organization. Half of the nursing homes were located in rural areas and half in an urban setting. Only one nursing home was publicly funded; the others were equally divided between not-for-profit and private organizations. Seven nursing homes had between 50 and 100 residents, five had 100 to 150 residents, and only one had fewer than 50 residents. Whereas the nursing homes in rural areas consisted of groups of smaller buildings in a campus structure, the urban ones were housed in one building with different sections or wards.

Seven participants in this study were nursing home directors (NHDs). Nursing managers (NMs) are responsible either for a number of wards or specific areas, such as a group of residents in a nursing home. Five participants were nursing managers and one participant was a geriatric nurse (GN) without management duties. Most of the staff were either general nurses or gerontology nurses and averaged 20 years in the profession. Only one participant was not a nurse, but a manager of activities (MA) for residents who had extensive engagement with residents.

2.3 Methodological Approach and Data Analysis

Grounded theory facilitates analysis of qualitative data to discover and describe social phenomena.[42] To develop a grounded theory of nurses' social health during the pandemic, we analyzed how actors make sense of and assign specific meaning(s) to their social world. During

[42] Corbin/Strauss 2008; Charmaz 2006.

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the initial analysis, an open coding process explored the data without preconceived assumptions, so as to remain open to meanings that emerged.[43] Emergent themes were then classified in terms of their properties and analyzed more closely. We reviewed the interview data line by line to detect the deeper meaning participants give to their actions and to understand the processes involved.[44] As analytical categories (codes) emerged, we reflected on the initial themes and impressions.[45] Finally, the properties, categories, and subcategories were fully defined (via axial coding) to structure and refine the overall analysis.

For example, one of the themes that emerged quickly was the end to visiting. It had a bearing on all policies that had to be implemented by nursing homes shortly after the beginning of the COVID-19 pandemic, so it was often used as a point of reference to describe changes in the work and responsibilities of the nursing staff (example property: residents developing feelings of loneliness and sadness). Whereas the properties use original phrases from the participants (in parentheses), the codes are analytical (example: nursing staff as proxies for family and friends). The category (example: impact on social health) presents the different outcomes for nurses (example: emotional support for residents increased). The table presents parts of the analysis for this article.

Table 1. Impact on social health for nursing staff in long-term care

Themes	**Properties**	**Codes**	**Category: Impact on Social Health**
End to visiting	Time for chores (It got so quiet)	Change in the experience of time	Fewer work interruptions
	Residents developed feelings of loneliness and sadness	Nursing staff as proxies for family and friends	Emotional support for residents increased
	Questioning social distancing of residents (It was like a prison)	Restriction of residents' autonomy	Suffering with residents increased
	Self-help (Using private smartphones)	Less contact between residents and family & friends	Finding solutions to increase social contacts for residents
	Residents need more attention (How to pass time)	Nursing has to substitute for professional and voluntary services	Spending more time with residents
	Continued explanation of regulations (Everything takes longer)	Special case: residents with dementia	More time for residents with cognitive decline

[43] Charmaz 2006.
[44] Charmaz 2006.
[45] Charmaz 2006.

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Hygiene measures	Face masks, keeping a distance	Becoming unrecognizable	Continuous explanation of regulations
	Change in how nursing tasks are performed	Questioning policies to accommodate difficult care situations	Suffering with residents

3 Results

Although the COVID-19 pandemic was framed in epidemiological and biomedical terms, especially at the onset, the consequences of containment measures were manifest in everyday social life.[46] When nursing homes were closed to visitors during two pandemic lockdowns in March 2020 and from November 2020 to March 2021, the regulations caused considerable uncertainty for the residents and nursing staff in Saxony-Anhalt. No one knew how long the prohibition would last, and physical distancing confined residents to their rooms without the usual distractions of time spent with other residents or visitors, and with no access to the variety of social spaces throughout the facility. With passing time, physical distancing turned into social isolation for some residents.

For nursing staff, the nature of time itself changed. Once busy with daily routines, the lockdown led to massive slowdowns because, at first, no one from the outside disrupted the nurses' work. Chores that were long overdue could finally be accomplished. At that point, no one knew how long the regulations would last. What is more, the relationship between nursing staff and residents changed as staff became the only people with whom residents could interact. At first, nurses appreciated the emotional closeness they developed with residents. However, as they came to terms with the reality that they could not fulfill residents' needs for sociality and intimacy, the management of residents' social health became a detriment to nurses' well-being. In the following we will show the challenges that geriatric nurses were confronted with during the pandemic: the impact of the regulations on the individual autonomy of residents, the physical and social isolation inside the nursing homes, supporting contact between residents and families, and caring for residents with dementia who did not understand the regulations.

3.1 A Break From Routines: Time to De-stress and Connect With Residents

During the first pandemic lockdown in March 2020, it seemed that the world came to a halt. Everyone who could, worked from home, and all social venues, such as concert halls, theaters, and restaurants, closed. No one knew how long this situation would last and nurses initially found solace in the sudden tranquility of the nursing homes. Without visitors, nurses finally had time to work through their long to-do lists of unfinished chores. A nurse manager compared the new slower-paced setting to their usual work environment:

[46] Paul et al. 2021.

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> In the beginning it got so quiet. Sometimes it's crazy, when three therapists come at once and you have to get the residents ready for therapy. They might need to use the bathroom first, and for other residents you have to search (for them if they are not in their rooms). In the beginning (of the pandemic), everyone (nursing staff) was enjoying the fact that no relatives and visitors would come. It was less stress. (NM_02_F_HeiCo)

The new situation highlighted that visits were stressful events that disrupted nurses' work and took time away from other important tasks. In addition to the initial stress reduction, nurses enjoyed the closeness they developed with residents. A nurse manager explained:

> During the first lockdown [...] it wasn't as difficult for the residents. We did connect with them. I would say it was a good togetherness. We were all in the same situation, and no resident could receive visitors. The nursing staff and residents became close because they had to spend time with each other. (NM_01_F_CC)

During the first lockdown, the once busy nursing home slowed down and social connection between residents and nurses seemed to grow. This intimacy with residents underscores a holistic understanding of care that was difficult to achieve prior to the pandemic.

3.2 Residents' Autonomy in Question: "It Was Like a Prison"

Long-term care facilities varied in how they enforced pandemic protocols. Some were stricter than others, depending on the cost/benefit analysis of curbing viral transmission weighed against the potentially negative impact of lockdown measures on the social health of residents and staff. One nurse manager compared the pandemic setting to a prison:

> The house was completely closed off. No one (visitors) was supposed to get in, and no one (residents) was supposed to get out [...]. It was like a prison; you know, when they have yard exercise. The administrative staff work until 4 o'clock in the afternoon; and then, it was our (nurses') turn to attend to the doorbell. It is a two-story house, so every time the bell rang, one of us had to go downstairs. It was a lot more work than before. Before (the "no visitors" rule) people would just come and go. (NM_02_F_HeiCo)

The nurse understood that the restrictions were in place because of the dangers posed by the virus, but she questioned whether the prison-like response was the best way to handle it. In addition to nursing care, support for the activities of daily living came to include strict management of contact between residents and the outside world, including running to the door to receive the onslaught of packages, flowers, and mail for residents as friends and family members did their best to maintain contact.

Confinement was another component of the prison-like ethos. Residents were not only confined to the facility, but they were also confined to their rooms. The constraint on movement from one area to another for meals, activities, or socializing meant that the social connection among residents was radically diminished. A nursing home director explained the effect on residents and nursing staff:

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> It wasn't that they (the residents) couldn't go to the meals, it was that they missed the socializing, the contacts with the others. Usually at breakfast, they chat with each other; that didn't happen anymore. The group activities got canceled. The therapists and the volunteers for daily activities didn't come. […] The effect (of the lockdown) on the residents was that they constantly asked for their relatives. It was very stressful for us (nurses) after a while. (03_M_NHD_CC)

Pandemic restrictions resulted in a significant increase in nurses' obligations to support residents' social health all day, every day. Helping residents to maintain some degree of contact among each other and with their family and others was crucial for residents' well-being, and an added stressor for nurses.

3.3 Beyond the Call of Duty: Nurses Innovate to (Digitally) Connect Residents With Family and Friends

Nursing home residents communicated with relatives and friends in a variety of ways during the pandemic. During good weather, some residents went outdoors to meet up with friends or relatives at a gate or through a fence. Such options were more limited in the winter months and for residents who were less mobile. For the most part, communication options for residents relied upon the ability of nursing staff to access digital devices, such as cell phones, tablets, and laptops. If these were not available in the facility (and often they were not, or the facility lacked a reliable internet connection), nurses sometimes shared their own cell phones. However, for residents with dementia, digital devices were confusing because they could not grasp the concept behind them. For some residents, the telephone in the room was the only lifeline to the outside world. Residents who did not have phones in their rooms had to rely on nurses to bring them a phone if someone called the home for them. A manager of activities for residents explained some of the difficulty:

> In the spring (2020), the residents met their relatives outside; that worked because of the warm weather. Right now, it's different (winter 2020); no one wants to sit outside for a chat drinking a coffee. It makes everything more complicated. We hope that we can keep it so that one person (a relative) can come twice per week, of course with advance notification. (5_F_MA_CC)

Helping residents and their families and friends to maintain contact during the pandemic required continuous effort and innovation. Some nursing staff recounted how relatives would constantly call the nursing home to speak with their loved ones. A nursing home director described how some nursing staff took matters into their own hands to make the processes more efficient:

> During the first lockdown, we implemented video chats with relatives so that they could see each other and chat a little. It was an initiative by the nursing staff, and they used their private cell phones with Face Time and WhatsApp chat to make it possible. They made appointments with the relatives for the calls. That's how we made it through. (7_M_NHD_CC)

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This example demonstrates how nursing staff responded to the social needs of residents and their relatives.

3.4 An Added Stressor: Supporting Residents With Cognitive Impairment: "Everything Takes Longer"

Nurses often commented on the specific needs of residents with different stages of cognitive impairment. Residents with varying stages of dementia needed the most time and support from nurses to handle the stress of masking, distancing, and lockdown measures. At times, nursing homes deviated from pandemic regulations to make special accommodations, such as requesting an exception to the "no visitor" rule during times of crisis. Unfortunately, this subpopulation of residents often experienced heightened anxiety and an increase in cognitive decline after visitors were banned. Nurses observed with empathy and concern and tried to help them to feel more at ease.

A nursing home director described how the mask mandate affected some residents:

> It is difficult for our residents with dementia to recognize the faces of the nursing staff behind the mask. Many knew the names of the nursing staff (before the pandemic), but now (with masks on) they orient themselves by the hairdo, voice, body length, and so forth. I am tall and easily recognized around the house, but residents in the later stages of dementia don't even recognize their relatives anymore. I am surprised that they trust us. No one can tell what they think when someone with a mask who looks different from before is standing in front of them. That's difficult in a caretaking situation. (7_M_NHD_CC)

Trust is important in a caring relationship. Not knowing if the resident trusts a nurse adds stress to daily nursing tasks such as administering injections or medication or helping with taking a shower. The resident might refuse the injection or might fall in the bathroom. Residents can injure themselves or the nurses.

When verbal communication fails, nonverbal communication is paramount. A nurse manager explained: "With the dementia residents, much (of the communication) is touch, to caress someone's arm and to put one's arm around them." (1_F_NM_CC)

Residents with cognitive impairment needed more time and attention from nurses to help them feel secure. In fact, these residents needed additional time for everything that involved COVID-19 precautions, in part because they did not understand the regulations (wearing masks and respecting social distancing), the lockdown, why they had to be separated from other residents, why their family members were not visiting them, and the testing that started in fall 2020. A geriatric nurse explained a typical testing scenario:

> The residents participated in testing. It's complicated testing residents with dementia because they don't understand. […] You explain and clarify, and they say *yes, yes*, but when you put the test swab in their nose it becomes uncomfortable, that's very complicated for them. (19_F_GN_CC)

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The emotion management involved in caring for residents with dementia and implementing pandemic measures that confuse them and cause discomfort requires calm, a trusting relationship, and patience on the part of the nurses. This emotion management was time consuming and became more difficult the longer the pandemic lasted.

Many residents with cognitive impairment either did not respond in the same way to their relatives after the lockdown as they had before, or did not recognize them at all. Some participants explained that the residents' dementia seemed to progress faster without social contact. For some residents, the impact of the visitor stoppage had dire consequences. In fact, some residents refused food and fluids when their relatives were no longer allowed to visit. This was the gravest consequence told by two members of the nursing staff from different nursing homes:

> We had one resident with dementia who stopped eating and drinking after a while. Quickly we got an exception to the visitor regulations. The son and the daughter came for a visit, and we could see in the mother's face that she was happy. She didn't recognize her son, but she knew that he belonged to her and from that day she started eating again. […] She had visits twice a week before (the pandemic) and she felt that something was different. The residents recognized that (the differences). They suffered, and we did too. I had a lot of anguish, and we were all tense. We were asking ourselves: How long will it last? (NM_02_F_HeiCo)

This excerpt shows the huge emotional stress that residents and nurses alike endured during the COVID-19 lockdowns. For residents, social connection with family and other loved ones is so important that without it, a life-threatening situation can develop. For nurses, the emotional consequences were that their relationships with the residents became too close and they could not fulfill the residents' social needs. The regulations on social and physical distancing during the pandemic were the factor that caused the social needs of residents to grow enormously and nurses were not able to compensate for other social contacts. On the one hand, the pandemic forced a closer and more holistic care relationship between residents and nurses. On the other hand, nurses were overwhelmed by the social demands of residents, and the conflict of not being able to satisfy those demands led to a decline in nurses' social health.

Limitations

Study limitations include the small sample size, the self-selection of participants, who primarily represent managerial roles rather than nurses in wards, and data collection via phone interviews as these necessarily could not provide comprehensive insights into the lived experiences of nurses in their everyday setting.

4 Discussion

In addition to medical uncertainty, the COVID-19 pandemic brought with it sudden and far-reaching changes to everyday life across social institutions. Nursing homes, in particular, were not well prepared to manage the developing and ongoing crisis.[47] At the start of the pandemic, German nursing homes lacked basic personal protective equipment (masks and gowns) to

[47] Phelan et al. 2022.

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minimize transmission.[48] The initial political response was to isolate nursing homes by stopping visits and introduce physical distancing for residents.[49] For residents, this meant physical separation from each other and from family, friends, and volunteers and professionals who routinely entered the home for therapy and other activities. For nurses, it meant continuing to care for residents as before, while also tending to residents' social health in new and encompassing ways. Nurses tried to make up for residents' social losses caused by the absence of visitors and social activities, while adhering to regulations aimed at limiting their own and residents' exposure to the virus. Within the closed environment of the nursing home, nurses and other staff were at high risk of infection.[50]

At the start of the pandemic, the break in normal routines gave nurses an opportunity to work without disruption from visitors. This meant that long lists of unfinished tasks could be completed, suggesting that the pre-pandemic workload for nurses had been too high. The serenity that initially offered a reprieve to nurses soon gave way to a new set of responsibilities designed to manage the unintended consequences of residents' social isolation. Nurses' daily routines now included communication and relationship management to compensate for the lack of social services and interactions with relatives that previously ensured residents' engagement in social life.[51]

As the pandemic continued, residents needed more time and attention from nurses. Unable to replace the familiar social bonds created throughout life with family and friends, nurses suffered alongside the residents as their own social health declined. Social health as we defined it encompasses all social relationships, both personal and professional. The pandemic situation exposed the issues detrimental to the social health of nurses in long-term care institutions. In particular, ethical considerations, a higher workload due to COVID-19 regulations, and being fully responsible for the social contacts of residents had implications for nurses' understanding of their work and for their social health.

Nursing staff had to make far-reaching ethical decisions, for example applying for an exception to the visitor ban and risking letting the virus into the nursing home. The German Ethical Council (Deutscher Ethikrat, DER) states that such decisions should hold human rights in high regard and always consider the rights of the individual to be as important as the rights of others to avoid infection. In other words, measures to contain the virus should not overturn human rights.[52] However, the regulations at the beginning of the pandemic led to social isolation of residents, with negative consequences for their psychological and mental well-being.[53] All the regulations in nursing homes severely restricted older adults in their last years of life.[54]

The nurse who compared the nursing home during the ban on visitors to a prison questioned the ethical foundations of pandemic regulations in nursing homes. Her perspective on how nursing home residents should live (including who they see, where they spend time, and what

48 Dichter et al. 2020; Deutscher Pflegerat 2022.
49 Landesregierung Sachsen-Anhalt April 2, 2020.
50 Schweickert et al. 2021.
51 Kohl et al. 2021.
52 Deutscher Ethikrat 2020.
53 Deutscher Ethikrat 2022.
54 Elsbernd et al. 2021.

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they do) differed greatly from what occurred during the pandemic. It showed a high degree of empathy and, at the same time, revealed the limitations of nurses' work. Decision-making by nursing staff is a complex process and moral concerns about care ethics lead to burnout[55] and can call into question nurses' professionalism.[56] As a result, the increased physical and emotional workload led to higher rates of sick leave during the first visitor ban.[57]

By the summer of 2020, when the visitor ban was lifted, new visitor regulations were developed that required more work. Visitors had to be tested, special visiting rooms prepared, personal protective equipment provided, along with other protocols specific to each facility. When infection rates decreased, residents and staff still had to abide by strict containment protocols.[58]

Nurses tried to connect residents with their families and friends as best they could during the pandemic. Nursing homes in urban areas were better able to use digital services to promote social interaction, but this was not the case for most of the facilities in rural parts of Saxony-Anhalt, highlighting the ongoing digital divide in Germany. With few other options, some nurses used their personal smartphones to help keep residents "socially close" to their relatives and friends. Despite being innovative and pragmatic, this approach was questionable in terms of data protection laws and ethical considerations. Now nurses had contact numbers of residents on their personal phones and relatives of residents had the personal phone numbers of nurses. The use of personal smartphones as a way of supporting residents' social contacts could have expanded nurses' working hours to a 24/7 shift. Additionally, digital solutions were not at all useful for residents with high cognitive decline.

Nursing home residents with cognitive decline posed the greatest challenge for nurses during the pandemic. This subpopulation of residents required the most time and patience from nurses to feel secure and cared for. Without the usual intimacy with friends and relatives, those with dementia suffered severe emotional losses that nurses could not adequately replace, especially over an extended period. There was some evidence to suggest that residents with dementia may have benefited from the sense of calm and quiet that resulted from the ban on visitors.[59] However, our data revealed that for some, the total isolation from loved ones (even those they no longer recognized) resulted in apathy, further decline, and a refusal to eat or drink. Compared to prior years in Germany, the death rate increased significantly during the first lockdown for nursing home residents with dementia.[60]

Recognizing that self-determination and quality of life for residents are the most important goals of long-term care, some argue that measures to control the spread of infections should protect residents but not lead to their isolation.[61] With this aim in mind, residents' participation

55 Goethals et al. 2010.
56 Jones et al. 2022.
57 Drupp et al. 2021.
58 Kohl et al. 2021; Deutscher Ethikrat 2022.
59 Sporket 2020.
60 Kohl et al. 2021.
61 Deutscher Pflegerat 2022.

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in individual and group activities should be possible throughout times of pandemic, and nursing homes should remain open to visitors.[62] The nurses we interviewed were deeply affected by the suffering and discomfort they observed in their patients during the pandemic. As caregivers who rely on empathy to anticipate and act upon the needs of their patients, the nurses we interviewed felt emotionally exhausted. Although emotional exhaustion among caregivers was evident during the first lockdown,[63] the second lockdown lasted longer and resulted in increased workload due to testing responsibilities, vaccinations, and ongoing visiting issues as nurses continued to be the primary social support for residents.

The difficulties arising from a nursing shortage that predated the pandemic were magnified by COVID-19 and the ripple effect it caused.[64] The ever-increasing workload, high burnout, emotional exhaustion, and daily stress of nursing care during the pandemic describe the experiences of many nurses, especially those in long-term care facilities. We argue, however, that the decline in nurses' *social health* describes more precisely the way the relationship between residents and nurses transformed during the pandemic: It became too close for nurses to provide the level of comfort residents needed. Put simply, pandemic regulations thwarted the type and level of care that nurses held paramount, undermining the ethical commitments they made when entering the profession.

5 Summary

The COVID-19 pandemic revealed important ethical dilemmas and other challenges to providing person-centered care for the residents of long-term care facilities. In addition to the effects of the pandemic on residents' physical and social health, the social health of the nurses themselves was on the line. If social health encompasses all relationships, then the relationship between caregiver and residents represents a key factor for nurses in long-term care facilities. Unlike an acute setting – where patients come and go in hours, days, or weeks – nursing home residents are most often long-term. Thus, the relationship between nurses and residents is likely to have a strong impact on the social health of both parties. Yet, our research shows that strains on this relationship during times of crisis (notably the COVID-19 pandemic and the logistical and ethical dilemmas it posed) had deleterious effects on nurses' social health. To support the provision of care and the health of caregivers themselves, additional research is needed to investigate how social health and other aspects of nursing practice were transformed by the pandemic. Additionally, the German Nursing Council developed guidelines for long-term care institutions in the fall of 2022 to prepare for the next wave of COVID-19 infections.

62 Deutscher Pflegerat 2022.
63 Altintas et al. 2022.
64 Hower et al. 2020; Rothgang et al. 2020; Wolf-Ostermann et al. 2020.

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