

ORIGINAL ARTICLE

COVID-19 preparedness in aged care: A qualitative study exploring residential aged care facility managers experiences planning for a pandemic

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Abstract

Aims and Objectives: The study aims to understand the changing context of RACFs and the role of RACF managers in preparing to confront the COVID-19 pandemic and to provide insights into how the use of visual telehealth consultation might be incorporated to assist with managing whatever might arise.

Design: An interpretive descriptive study design was employed, and data were collected using semi-structured interviews conducted via telephone or videoconference. Purposive recruitment targeted clinical managers responsible for the COVID-19 response in RACFs.

Methods: RACF clinical managers were invited to discuss their responses to COVID-19 including the management of RACF and staff. Semi-structured interviews explored the COVID-19-related challenges, the response to these challenges and how telehealth might assist in overcoming some of these challenges. This study followed Thorne's (2008) three-stage process of interpretive description. The COREQ checklist was used in preparing this manuscript.

Results: Two main themes were identified. The first theme 'keeping people safe' was comprised of three subthemes; fear and uncertainty, managing the risks and retaining and recruiting staff. The second theme was 'keeping people connected', had two subthemes; being disconnected and isolated and embracing technology.

Conclusion: Findings from this study provide valuable insight into understanding the context and the challenges for RACFs and the staff as they attempt to keep residents safe and connected with healthcare providers and the outside world.

Relevance to Clinical Practice: Understanding the experiences of RACF managers in preparing to respond to the pandemic will better inform practice development in aged care in particular the use of telehealth and safe practices during COVID-19. Increased awareness of the challenges faced by RACFs during a pandemic provides policymakers with valuable insights for future planning of pandemic responses.

KEYWORDS

disaster, experiences, interpretive research, long-term care facilities, nursing homes, older patients, patient safety, qualitative study, residential homes

1 | INTRODUCTION

The World Health Organisation declared COVID-19 a pandemic on 11 March 2020 and by September 2020 there were over 30 million confirmed cases, with just under a million confirmed deaths (WHO, 2020). Internationally, governing bodies are warning older people that they are at greater risk of contracting a COVID-19-related illness, leading to poor outcomes (Brooke & Jackson, 2020; Fisk et al., 2020; Werner et al., 2020). Deaths occurring in residential aged care facilities (RACF) have been reported to comprise almost 80% of Canada's COVID-19-related deaths, with 50% in Switzerland (Faghanipour et al., 2020), 42%–57% in European countries (McGilton et al., 2020) and 66% of deaths in Australia. Consequently, it is important to understand the many challenges faced by RACFs whilst they were responding to the COVID-19 pandemic, and to explore ways they may be supported through this difficult time.

1.1 | Background

Regrettably, RACFs were caught unaware by the COVID-19 pandemic. The speed with which the virus took hold left vulnerable older people and RACF residents susceptible to illness and premature death. Most cases of COVID-related deaths in RACFs have been reported to be because of poor preparedness plans and RACF organisational deficiencies in Australia (Marozzi, 2020) and globally (Faghanipour et al., 2020). Prior to the pandemic it was already well recognised that there was a need to address systemic failures in facility design inadequacies and infection control practices given the high rates of transmission of infectious disease in RACFs (Davidson & Szanton, 2020). The importance of pre-emptive pandemic planning for RACFs cannot be understated.

Managers had crucial decisions to make regarding the safest location for residents during the pandemic. Chronically understaffed RACFs now had to face the prospect of the existing workforce contracting COVID-19 and being unable to work (McGilton et al., 2020). Managers of RACFs had very little option but to try to meet the high care needs of RACF residents with a depleting workforce. One option was to transfer residents to acute hospitals for care. There were concerns that if the only plan was to move RACF residents into the hospital system, capacity would be reached within a couple of weeks (Daly & Wearing, 2020). Additionally, Australian and international studies have revealed it is not in the best interests of RACF residents to spend time in emergency departments due to the risk of further injury, unnecessary discomfort and distress (Dwyer et al., 2014; Hullick et al., 2016; Marsden et al., 2018). This strategy would have left the vulnerable RACF resident in a dire situation, unsafe at home and unsafe in hospital, but with no alternative if the RACF could not safely manage their care.

Residential Aged Care Facilities were already grappling with systemic failures prior to the COVID-19 crisis (Davidson & Szanton, 2020). Due to the pandemic, care of the aged in RACFs has now become a public health issue (Davidson & Szanton, 2020), rather

What does the paper contribute to the wider global clinical community?

- Insights can be used to inform the development of strategies for RACF managers who are actively trying to manage risk and maintain communication during a pandemic
- Information to strengthen the development of policy and procedure in the areas of communication and safe practices in RACFs
- Better understanding of the current challenges in responding to the COVID-19 crisis for RACF managers to future proof facilities against new pandemics

than the sole responsibility of the RACF itself. Four public health solutions have been proposed to address the RACF systemic failures including increasing aged care funding (Werner et al., 2020); increasing staffing (Davidson & Szanton, 2020; Faghanipour et al., 2020; Gaur et al., 2020; McGilton et al., 2020); making aged care employment more attractive (McGilton et al., 2020); implementing more helpful technology (Siette et al., 2020). Together, these four solutions present a sound plan but will come at a price. For example, the expected cost of restructuring and fortifying aged care in the USA has been estimated to amount to \$US15 billion (Werner et al., 2020).

One of the potentially less expensive solutions is to consider the implementation of more helpful technology such as visual telehealth to beam expert clinical support care into RACFs. Visual telehealth is a timely and cost-effective means of providing care for RACF residents and supporting RACF staff in clinical decision-making during the COVID-19 pandemic (Davidson & Szanton, 2020; Edelman et al., 2020; Fisk et al., 2020; Gillespie et al., 2020; Hoffman et al., 2020). To date, little has been reported of the way in which pandemic preparedness affects clinical decision-making in RACFs and how visual telehealth has supported or can support this process.

In early 2020 we had commenced a large, funded study focusing on the use of visual telehealth consultation in supporting clinical care decision-making between RACFs and emergency departments. This study was temporarily suspended due to COVID-19 visitor restrictions (Sunner et al., 2020). The research team saw this temporary suspension period as a unique opportunity to engage with as many RACF managers as we could, to understand the pandemic response through their eyes. We wanted to discover what their key issues and concerns were, and to explore with them whether visual telehealth would be of assistance to them as they were preparing for and responding to COVID-19. It is important to increase understanding of the challenges faced by RACF managers in the situation of a pandemic in order to identify strategies they employed in this unique situation to future proof facilities against pandemics. Increasing understanding of their pandemic response may also identify useful

strategies they developed that may also improve current practices in RACFs.

2 | STUDY

2.1 | Aims

The study aims to understand the changing context of RACFs and the role of RACF managers in preparing to confront the COVID-19 pandemic and to provide insights into how the use of visual telehealth consultation might be incorporated to assist with managing whatever might arise.

2.2 | Design

A qualitative study design was employed, and data were collected using semi-structured interviews conducted via telephone or videoconferencing. Thorne's interpretive descriptive methodology was used to guide this study owing to its focus on practice to uncover what is not known about a phenomenon (Thorne, 2008). The Consolidated Criteria for Reporting Qualitative Studies (COREQ) (Tong, Sainsbury, & Craig, 2007) has been followed in reporting this study (File S1).

2.3 | Setting/Participants

RACFs ($n = 100$) that utilised the aged care emergency service of one Local Health District (LHD) in New South Wales, Australia were targeted for this study. The RACFs were located in metropolitan, rural and remote areas. RACF managers (and relieving managers) contacted for this study were identified from a local database nominating the key managerial contact for each RACF, and/or the most senior role onsite. A purposive sample of RACF managers was selected as the most appropriate key informants as they would have the greatest organisational knowledge of the RACFs' response to COVID-19. Interviews were conducted in early 2020 when all RACFs were in varying states of lockdown that occurred towards the end of the first COVID-19 wave in Australia.

Invitations were sent via email to the managers of 100 publicly funded or privately owned RACFs within the LHD. The decision to invite 100 RACF managers to participate was a pragmatic decision based on the potential number of interviews one researcher could manage within the shortest possible timeframe in a dynamically unfolding COVID-19 situation. Twenty-eight RACF managers responded, with three RACFs electing to have more than one manager participate in the interview. Emails were resent three times, one week apart to encourage participation. This resulted in 28 individual and two group interviews (consisting of 2–3 participants), totalling 31 participants (4 male and 27 female) from 18 RACFs located in metropolitan areas and 10 from rural areas, see Table 1.

2.4 | Data collection

Semi-structured interviews were guided by key questions (see Table 2) exploring the participants' experiences with RACF preparation and the challenges encountered or anticipated. Interviews were conducted between May and June 2020.

Due to pandemic social distancing restrictions at the time, interviews were conducted over a secure videoconferencing platform that included a recording device. Interviews were also recorded on a digital recording device as a backup in case of equipment failure on the videoconferencing platform. Only the researcher (CS) and the consenting participant(s) were present during the interviews, which were conducted in private workplace environments at each location. One repeat interview was attended. The interviews ranged from 15 to 45 minutes in duration. Brief field notes were made by the interviewer to document key points identified in the interviews. The interview recordings were fully transcribed, and participants were offered the opportunity to receive a copy of the transcript.

2.5 | Ethical considerations

Ethics approval was granted by the LHD Human Research Ethics Committee, approval number 2019/ETH12853. Following approval, an information statement outlining the study purpose and a consent form were sent via the work email of the RACF managers.

RACF managers who replied to the invitation email and returned a signed consent form were sent an appointment to participate in an interview. Participation and consent were voluntary. Interviews were transcribed and the demographic details were de-identified to ensure confidentiality and each participant was allocated a pseudonym.

2.6 | Data analysis

NVivo software (QSR International, 1999) was used to manage the data. An inductive approach to data analysis was used according to the three steps outlined by Thorne (Thorne, 2008).

The transcripts were coded independently by three researcher's CS, VP and MG, who then collaborated in the development of representative themes (CS is a PhD in nursing student, VP and MG are experienced nurse clinicians and researchers). Open codes were developed inductively and iteratively by the three coders (CS, VP and MG) reviewing three transcripts each independently. Thorne's (2008) three-stage interpretive descriptive method of data analysis allowed the researchers to check, test, compare and contrast whole components of the data to identify differences, similarities, relationships and patterns to gain an understanding of the RACF managers' experiences responding to a COVID-19 pandemic.

Codes were further refined, and common emerging themes recognised and put through the 'thoughtful practitioner test' (Thorne, 2008, pp. 92–93), where insights from the three coders, who were

TABLE 1 Demographic characteristics of the participants

Number of beds in RACF	RACF	Participant Pseudonym	Rural (R)/Metropolitan (MT)	Organisation type: Single (SO)/Multiple(MO)	Government(G)/Private(P)
1-50	1	Jim	MT	MO	P
	2	Chloe	MT	MO	P
	3	Kate	MT	MO	P
	4	Frank	MT	MO	P
	5	Olivia	R	SO	G
51-100	6	Sonia	R	MO	P
	7	Louise	R	MO	P
	8	Kylie	MT	MO	P
	9	Anna	MT	MO	P
	10	Adrianna	MT	MO	P
	11	Alice	MT	MO	P
	12	Alannah	MT	MO	P
	13	Courtney	R	MO	P
	14	Claudia	MT	MO	P
	15	Esme	MT	MO	P
	16	Katherine	MT	MO	P
	16	Annabelle			
	17	Eva	R	MO	P
18	Rachel	MT	MO	G	
18	Nicolas				
18	Monica				
101-150	19	Alina	R	MO	P
	20	Eleanor	MT	MO	P
	21	Madison	R	MO	P
	22	Amelia	R	MO	P
	23	Brooke	MT	MO	P
	24	Ray	R	MO	P
	25	Emma	MT	MO	P
	26	Talia	MT	MO	P
151-200	27	Daniella	MT	SO	P
	28	Georgia	R	MO	P

Abbreviations: G, Government; MO, Multi-Organisation; MT, Metropolitan; P, Private; R, Rural; SO, Single Organisation.

TABLE 2 Example of participant interview questions

Interview Protocol: RACF Staff Managers
Tell me what you have in place in response to the COVID-19
What are the challenges that you foresee?
How do you think the Visual Telehealth Consultation can assist you with these challenges?
Probing questions, such as 'could you please provide an example' or 'please tell me more', were used to encourage the participants to elaborate and deepen their answers, when needed

expert experienced clinicians from three different clinical backgrounds, were able to provide rich, critical reflection on the data. The coders identified a coding tree consisting of 25 initial codes derived from the data with 11 sub-codes. Themes were then worked

through a process of reflection and inference to create an emerging understanding and qualitative description of participants' contributions (Sandalowski, 2010). Transcripts were then re-read several times by the researchers (CS, VP and MG) and were discussed until a consensus was reached, finally resulting in two main themes and five minor themes as outlined in Table 3.

2.7 | Rigour

Transparency and trustworthiness of the findings were ensured through; keeping an auditable record of how the findings were derived, grounding of the findings in the data and member checking (Bazeley, 2013). Credibility was assured as all interviews were

TABLE 3 Table of themes and subthemes

Theme	Subthemes	Description
Keeping people safe	1. Fear and uncertainty	Concerns related to how to keep the virus out of the RACF
	2. Managing the risks	What was done and how effective was it
	3. Retaining and recruiting staff	Problems keeping staff at work
Keeping people connected	1. Being disconnected and isolated	Alternative pathways to keep in touch with technology
	2. Embracing technology	The acceptance of telehealth and videoconferencing

conducted by CS who has interpretive authority (Thorne, 2008) and extensive experience in the aged care sector in the community and in emergency department care of the older person. At the time of the study, CS was employed as a project manager for the PACE-IT project (Sunner et al., 2020) and was closely mentored, supervised and supported by her research team, who are all experienced qualitative researchers and co-authors on this paper.

3 | FINDINGS

Analysis of the RACF clinical manager interviews identified two interrelated themes. Firstly, Keeping people safe, comprising three subthemes; Fear and uncertainty, Managing the risks and Retaining and recruiting staff. The second theme was Keeping people connected, comprising the following two subthemes; Being disconnected and isolated and Embracing technology. Together these themes encapsulate RACF participants shared perceptions of the changing context during the height of the COVID pandemic and highlight the complexities and the challenges associated with managing an RACF during this time.

3.1 | Keeping people safe

The sudden and unheralded arrival of the COVID-19 pandemic meant that there was an imminent and urgent heightened risk for RACFs resulting in escalating fear and uncertainty. Managers were confronted and challenged by a situation that they had not previously encountered and the path ahead for them was not clear.

In keeping people safe, there were three subthemes identified; Fear and uncertainty, Managing the risk and Retaining and recruiting staff.

3.1.1 | Fear and uncertainty

In the context of COVID-19, participants were concerned that staff were unwittingly bringing the virus into the RACF and also taking it home, potentially exposing residents and their families to harm, as Chloe expressed;

A lot of the staff are saying, the hardest thing is the thought that we might actually be a carrier and not know
(Chloe)

All participants described a perception that staff felt they were in some sort of danger, verbalising that they were also personally feeling nervous, frightened, fearful and scared. Two participants described staff's concerns in the following way;

...they have two fears, bringing the virus in and taking the virus out
(Katherine)

... with the media, I think you know with what's been happening in other facilities that makes everybody quite sort of 'on edge', feeling a little bit stressed about it all
(Amelia)

Participants said staff told them that they were worried about the transmission of COVID-19 amongst themselves, as many were in a *high-risk age group* with co-morbidities. Staff were also concerned for their vulnerable older parents at home and for other members of their family. Amelia shared her view;

I think it just makes everybody feel really nervous about you know what potentially can happen in an aged care facility if there was an outbreak
(Amelia)

The uncertainty of the rapidly unfolding situation was exemplified in the following comment;

... oh gosh, am I going to have to stay here, am I going to be able to go home, you know like if you got an outbreak here, you know you might be stuck and stay here with the residents at night ... there was a lot of fear of the unknown, of what could happen
(Amelia)

Whilst all attempts were made to connect residents and families via tele-communication platforms, families still insisted that they visit the RACF face to face, which put unexpected pressure on staff who had to enforce COVID-19 safe company and government regulations. Lockdown of facilities was adopted to keep residents safe. However, participants described how some residents' families were unreasonable, aggressive and unsympathetic to the rules, with reactions that ranged from verbal outbursts and written complaints to trying to sneak into the facility. One manager (Olivia) was called to diffuse a difficult situation with a relative;

They're getting really shirty (sic) with me because I won't let them in with a four-month-old baby, and the five year old who's got a cold

(Olivia)

Several participants shared the view that visitors and families were 'untrustworthy'. Courtney provided an example where a relative had disembarked from a cruise ship (a major source of COVID-19 infections in Australia) and immediately visited her mother in the RACF. Daniella spoke about how a concerned community member notified the RACF that the relative who visited had contracted COVID-19, but did not report it to the RACF;

That's our biggest risk, is that people don't tell us the truth. They'll want to come and see their mum because they think that's okay, and not appreciating that in communal living, (then) there's a whole other layer of risks

(Daniella)

3.1.2 | Managing the risks

The heightened awareness of potential risk for residents and staff meant that facilities had to rapidly implement ways of managing / negating these risks. Engaging in proactive practices to prepare for a pandemic including procuring PPE supplies, surging the workforce, developing audit tools and guidelines were identified by participants as key strategies to overcome the challenges and keeping residents safe. However, approaches were inconsistent across sites with the inability of some facilities to fully implement plans. Some participants were worried about how they would source PPE with national distributors running low and organisations beginning to stockpile equipment.

Larger organisations were lucky enough to organise 'hubs' within two hours so RACFS would have whatever they needed in an outbreak. A manager said her company went to great lengths to obtain stock from overseas,

they did actually hire a plane, and they went overseas and got stuff and brought it back

(Adrianna)

With one RACFs resorting to sourcing PPE supplies at the local hardware store or online.

Supplementary workforces were suggested as a strategy to combat the workforce shortfalls in the event that RACFs were overwhelmed with COVID-19 cases however recruitment was largely unsuccessful, as Courtney reflected;

... if we do have a COVID outbreak somewhere else, no-one's volunteering

(Courtney)

One manager mentioned that the corporation's preparedness plan was to transfer any resident with COVID-19 to the nearest public hospital. Some RACFS developed self-audit tools to measure how prepared they would be and there were newly written manuals and updated guidelines provided. Some companies had the luxury of appointing additional staff specifically to filter through large amounts of new information, yet others struggled to adequately staff facilities, with no dedicated time to catch up on all the information that was being disseminated. A candid admission by Olivia explaining the information overload experienced with COVID-19 policy/guideline was as follows;

It's a huge document. I still haven't worked my way through the whole thing. It's me, basically. We're a 31-bed facility and I'm the only RN here at the moment

(Olivia)

Most participants were certain that they would not be ready to tackle an outbreak, even with proactive planning, due to the lack of available staff, reflected in Ray's remark;

I don't know if you'll ever truly be ready for this stuff, I think because there's so many unknown's and twists that you get in the middle of it all

(Ray)

Many participants felt that they were fortunate to be in a privileged position, and that they had 'gotten off lightly', and they were able to learn from other sites who were tackling a COVID-19 outbreak. Anna comments;

... the benefit of watching other places go through horrendous times...that's a very fortunate position to be in, to their credit they have been the teachers

(Anna)

3.1.3 | Retaining and recruiting staff

Maintaining adequate staffing levels was at the forefront of all participant's concerns. Many participants acknowledged that rostering was a constant challenge even prior to COVID-19, citing 'burnout' as the root cause of lack of staff in aged care generally. This workforce challenge related to all levels of staff, from managers through to support staff.

Difficulties with filling the roster and retaining staff during COVID-19 was amplified through loss of staff when the facility had a COVID-19 outbreak. One participant reported that they were only be left with five staff to care for 100 residents, a ratio of 1:20.

Georgia and her team were so fearful of losing staff to extended sick leave or forced isolation due to COVID-19 that they went through a hiring process to get extra staff on board. At the time of the interview, many participants reported that they already had staff on leave due to COVID-19 testing, and in isolation awaiting results. Sonia sums up these concerns;

I was really a little bit panicky for a little while because I was making up all these scenarios in my head about what if a lot of staff have to be tested or the community gets it more and I'm losing 50% of my staff. And how am I going to replace them? Like how will it all work? As a manager, that was my biggest worry, losing the staff, which thank goodness it hasn't happened, but obviously it could have happened. That's a big worry because in the end... you can't potentially replace them

(Sonia)

In addition to the mandated sick leave staff had to take whilst awaiting COVID-19 test results, participants reported other reasons for depleted staff numbers. Three reasons identified were exhaustion, being in a high-risk group, or just staff resigning. Recruiting into an environment that is already under strain and close scrutiny, posed further potential challenges for managers.

3.2 | Keeping people connected

Managers were dealing with fear from staff residents and families, residents wanting to see their loved ones but being isolated from them, so managers had to think about how they could use technology to assist them addressing this. The second theme is Keeping people connected, consisting of two subthemes; Being disconnected and isolated and Embracing technology.

3.2.1 | Being disconnected and isolated

Some participants voiced concern about the disconnection that the mandated 14-day isolation caused for a resident's mental health. For example, Chloe told of the following situation;

We had one lady who did go to hospital a couple of weeks ago and she does suffer from mental health problems and I was quite concerned about her being in her room because she didn't want to get out of bed and it took a few days before she would allow the staff to actually get her up and, "come on let's get you in a

chair, let's get you", you know, and sort of perk her up and she's out of her room now and she's really happy but, you know, just the mental challenge for that

(Chloe)

Eleanor described the exposure risk for a resident who required unavoidable, constant isolation due to regular off-site appointments for dialysis;

... we have a gentleman who has dialysis, so he's going to have dialysis two times a week. He's an insulin-dependent diabetic. He also has got issues with his mobility and his weight and he is a bariatric person. So, there's a lot of issues that would affect him if he got COVID

(Eleanor)

Some participants believed this isolation was associated with the development of mental health issues such as depression, and increased episodes of *psychological decline, aggression, or some residents just appeared to be 'mentally struggling'*. One participant observed that isolation proved too much for some, and they had five residents die in a month, whereas normally only five residents would die in a year. The participant's reflected on the effect of isolation on the residents, saying that they;

(residents)...*died of worry* (Alina) or [had] *given up*

(Katherine)

Several participants considered that residents with varying cognitive levels became more withdrawn because families no longer visited them due to the lockdown requirement. A participant described the impact that no family visits has on residents with dementia;

They don't understand why. They get down, they've potentially given up, I think it would have a tremendous impact

(Esme)

Some participants voiced concerns that a further contribution to resident's withdrawal was that the usual conversations with staff were from behind a mask, gown and gloves and conversations were few and far between.

They can become quite depressed if they're stuck in their room on their own, everyone's got to mask up and gown and gloves, you know so ...

(Chloe)

Many residents experienced a lack of any human contact or mental stimulation. There was debate about the availability of formal mental health care for residents, with participants very clear that help was not readily available due to staffing and funding constraints.

3.2.2 | Embracing technology

There were varying degrees of experience with technology and varying levels of confidence and capability across the different sites. The majority of RACFs had various tele-conferencing/telehealth platforms connecting residents and families, allied health and/or GPs, finding it essential to keep communication pathways open. Some participants spoke of utilising new staff positions and roles, specifically aimed at connecting residents, their families and healthcare providers.

So my lifestyle coordinator's become a bit of a 'Zoom' champion

(Tahlia)

Many allied health, physiotherapists, occupational therapists, dietitians, nurse practitioners, geriatricians and speech therapists embraced telehealth by either instructing staff or consulting with the resident directly via visual telehealth consultations.

We've actually got all the physios on Telehealth and our health assistant goes around and does the exercises with them instead of the physio

(Alina)

It was noted that the use of telehealth was now more widely accepted amongst the residents when they were talking to the GP or family via video technology. Several participants reported the resident's response to the use of telehealth as;

We have one lady, she's 103 and we tried to explain to her that she would be able to talk to people on this funny looking thing and she said 'I really didn't think I'd be able to say anything, I thought I'd clam up, but once I got on I couldn't shut up' she said. 'I couldn't stop talking'

(Eva)

Participants also reported far greater acceptance of telehealth use by themselves and the staff, and the many benefits that had been realised;

I love telehealth ... I'm quite happy to keep everyone out of here and dial in to everyone, it'd be great. (Good assistance with) Supra public catheter reinsertion

(Courtney)

Used with a PEG (percutaneous endoscopic gastrostomy) tube it would have been good to talk through that... the resident had to go to hospital

(Alannah)

The benefits of using telehealth for residents included the reduction in transport to another facility for consultation or treatment and

associated costs, assistance in attending difficult clinical procedures, outpatient appointments, educational webinars and videoconferencing for staff meetings. As Tahlia states;

Transport costs to get our residents to and from an appointment is difficult, in particular, a lot of my residents don't like to leave the building, with the dementia, or if we get them out, we can't get them back in. So, I think telehealth has a potential to be very useful in behavioural concerns (when) we can't get them to leave the building

(Tahlia)

Despite varying experiences, some participants spoke of their facilities embracing visual technology and telehealth as a communication tool and had committed to further acquisition of iPads/tablets;

Previously we didn't have anything and now we have seven iPads

(Ray)

Most participants reported that uptake of telehealth by GPs varied considerably, ranging from zero use to highly prepared and proficient. The GP is the primary healthcare provider for RACF residents requiring face to face healthcare delivery. However, face to face visits from GPs exposed the resident to increased risk. Some GPs were still operating private GP practices, seeing many patients who may be unwell, visiting other RACFs or having to be in isolation themselves. For example, Amelia described a situation where;

one of the other GPs had been to Pakistan and of course then had to have 2 weeks of isolation and I don't think he is back at work or I am not quite sure what's happening ... so that's definitely been a challenge

(Amelia)

Participants reported that the facility used telehealth as an alternative to face to face visits, using a variety of different platforms, and that this raised data security and privacy issues.

I think one's using Facetime, which is a bit strange, because they won't send anything via email because of [security] things, but they're using Facetime to do their Telehealth

(Amelia)

The decision to use telehealth was often driven by the GP. However, some GPs did not attempt to adopt telehealth at all, and in fact reduced their contact, opting for no visits or just telephone calls.

GPs were providing wound advice consultations based on emailed photographs and a telephone call. Others physically

visited the RACF but did not personally visit or view the resident. Participants shared their experiences of GPs who really 'stepped up to the mark' by ensuring residents were able to avoid hospitalisation with the adoption of telehealth or by increased telephone consultations. One participant spoke of a particular GP who engaged fully with visual telehealth consultation, doing a weekly round for all her residents;

We embraced Zoom which was wonderful, so with her iPad and my iPad we could walk round the facility...and she could actually talk to her residents

(Brooke)

In contrast, some participants voiced their frustration that several GPs had not adjusted their communication techniques at all, continuing to telephone as they usually would.

The use of telehealth appeared to have a good level of acceptability and the rate at which it was being embraced differed throughout the participant's facilities. However, the common thread was that it was a useful tool to address the communication restrictions thrust upon RACFs in the time of COVID-19.

4 | DISCUSSION

The events that unfolded following the completion of this study in March 2020 were unprecedented in Australia and the world. The many fears and concerns that managers in this study were experiencing became reality for some. The pandemic had devastating effects for many families, residents and RACFs, and it would be remiss not to acknowledge this fact.

This study provided valuable insights in the COVID-19 preparations and response of RACF managers during the first wave of COVID-19 in Australia. Given the unprecedented times currently being experienced and the heightened vulnerability of older people, it was not surprising that the study findings highlight the need for RACFs to rapidly evolve new processes aimed at 'keeping people safe'. One of those processes is lock-down, a term commonly used when referring to one of the more extreme measures most RACFs have implemented to keep the residents and staff safe. As a result, many residents were isolated from the outside world and their loved ones. In some instances, residents at end of life were prevented from seeing their families in person. This forced isolation has negative mental health consequences (D'Adamo et al., 2020; Siette et al., 2020) and intensifies the need for 'keeping people connected' with the outside world and their loved ones. Keeping this connection was identified by participants as an important component of quality care provision for residents. Keeping people safe and keeping people connected were the two major themes in this study.

The study findings resonate with global literature about the chronic shortage of staff in RACFs, even prior to COVID-19. Maintaining a safe level of staffing in RACFs was a major challenge for RACF managers during ordinary times (Quigley et al., 2020; Royal

Commission, 2011). During COVID-19 staff shortages have been exacerbated, with already struggling RACFs losing some of the staff to illness, burnout or mandatory quarantine during the pandemic. Some workers have left the job due to unsafe working conditions (Faghanipour et al., 2020), leaving RACFs critically understaffed and unable to deal with the increased needs of residents (Quigley et al., 2020). The recent inquiry into Aged Care Quality and Safety identified limited provision of staff training opportunities and insufficient information to support staff to do their job effectively, leading to significant staff knowledge gaps about common aged care complaints such as continence, wound care and nutrition (Royal Commission, 2020). The pressure of managing a potential outbreak of COVID-19 in a RACF added substantial stress to an already stretched and under-skilled aged care sector.

Participants expressed mixed feelings when asked if they were prepared for a pandemic. Some were not overly confident that the measures put in place were adequate. Year after year RACFs have constant threats of influenza and gastroenteritis, potential viral threats such as SARS or MERS, yet outbreak management plans continue to be poorly developed. The lessons learned about pandemic preparedness for the SARS or MERs outbreaks for example seem to have been ignored or forgotten (Donnelly, 2020). Aged care authorities believe emphasis should be placed on addressing these issues immediately, in order to build a more robust, flexible, healthcare system for vulnerable older people and implement learnings from this COVID-19 pandemic (Siette et al., 2020).

Participants were concerned that whilst attempting to keep residents safe they may have been causing them harm. The risk visitors posed for residents in unwittingly transporting the virus into the RACF was a major concern for participants. There were stricter lockdown directives for older people, generally with the media continuing to report that older people have much poorer outcomes if they contract the virus (Morrow-Howell et al., 2020). Some participants conveyed their concerns that the fear in some residents was so great that they just gave up. Lockdown for some RACFs meant that visitors were stopped, inadvertently severing an important social lifeline for residents. This isolation left older people more vulnerable and without a trusted advocate (Faghanipour et al., 2020). Residents in RACFs are particularly vulnerable to social isolation, and there is emerging evidence about the detrimental effects on their physical and mental health (Brooke & Jackson, 2020; D'Adamo et al., 2020; Morrow-Howell et al., 2020; Siette et al., 2020).

Older people in our society have a right to safe quality care and RACFs need to have support to be able to deliver this. Telehealth addresses a significant gap in care for RACF residents that will keep them safe in their home, prevent their exposure to potentially deadly pathogens and allow staff to receive quality clinical advice and support with decision-making. However, Telehealth uptake requires significant changes in management effort and redesign of existing models of care. Firstly, implementing telehealth proactively rather than reactively is more likely to generate greater benefits in the long term, and help with the everyday and emergency challenges in health care (Smith et al., 2020). Secondly, there is an urgent need

for rapid and sustained public health interventions (McMichael et al., 2020) linking residents with modern communication technology and staff to support them (Siette et al., 2020). Finally, research should also focus on evaluating the effectiveness of different technologies and policies used to inform future pandemics (Siette et al., 2020) and apply this knowledge. Visual telehealth technology, which is a key component of the model of care being implemented in the larger study (Sunner, 2020), has shown that it can support RACFs in many ways and was highlighted in the two major themes; keeping people safe and connected.

5 | STRENGTHS AND LIMITATIONS

The strength of this study is that it was undertaken in real time as RACF managers confronted a major threat to the health of residents and staff due to the COVID-19 pandemic. They generously gave of their time to participate in this study in order to share their experiences and solutions with other RACF managers who found themselves in similar situations. However, the findings from this study may not be transferable to RACFs in other areas of Australia or internationally as the RACF challenges and responses were context specific, and significant differences in the severity of the COVID event across facilities. It is important to acknowledge that there was a time constraint to undertake the interviews in the peak of the first wave of COVID-19 to understand managers' experiences in real time.

6 | CONCLUSION

These unprecedented times have identified a gap in the aged care sector in terms of protection of vulnerable residential aged care residents. COVID-19 has highlighted the urgent need for better planning and management. Findings from this study provide valuable insight into the most pressing challenges for RACFs and the staff as they attempt to keep the residents safe and alive, maintain and upskill the workforce, keep up with rapidly generated guidelines and introduce new technologies to keep the residents connected with healthcare providers and the outside world.

7 | RELEVANCE TO CLINICAL PRACTICE

Understanding the experiences of RACF staff and residents during the COVID-19 will assist facility managers and policymakers effectively plan, develop and implement strategies to overcome many of the challenges identified. Findings from this study identify a clear need for further support RACFs during the pandemic and beyond. Better awareness by external governing bodies will assist in managing future pandemic responses in RACFs and contribute to keeping these vulnerable Australians safe. In addition, telehealth has been identified as a useful strategy to overcome many of the challenges RACFs experienced during pandemic lockdown.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS

CS, MF and MG contributed to developing the research concept, and CS, MG, MF and AK contributed to the design and method development. CS, MG and VP contributed to the coding and thematic analysis of participant transcripts. CS developed the initial draft of the paper, with significant input from MG and MF. The final draft was significantly and critically revised for relative scientific content by MG, MF, VP and AK. All authors approved the final versions of the manuscript. All authors agree to the content of this paper and were involved in writing and revising this manuscript.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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