



# Triggers of mental health problems among frontline healthcare workers during the COVID-19 pandemic in private care homes and domiciliary care agencies: Lived experiences of care workers in the Midlands region, UK

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## Abstract

COVID-19 was first reported in China and later spread across the world causing panic because there is no cure for it. The pandemic has adversely affected frontline health workers and patients, owing to poor preparedness. The study explored the triggers of mental health problems among frontline healthcare workers during the COVID-19 pandemic. An exploratory qualitative approach was utilised in the study. Forty individual semi-structured interviews were held with frontline healthcare workers. A thematic approach underpinned by some aspects of interpretive phenomenological analysis (IPA) and the Silences Framework (SF) was utilised. The research found that triggers of mental health problems among frontline health workers in private care homes and domiciliary care agencies are fear of infection and infecting others, lack of recognition/disparity between National Health Service (NHS) and social care, lack of guidance, unsafe hospital discharge, death and loss of professionals and residents, unreliable testing and delayed results and shortage of staff. It is important to support frontline workers in private care homes and domiciliary care agencies.

## KEYWORDS

care homes, coronavirus, COVID-19, domiciliary care, fear of infection

## 1 | INTRODUCTION

COVID-19 has claimed at least 302,115 lives since its outbreak in China in December 2019 (European Centre for Disease Prevention & Control, 2020). The World Health Organisation (WHO) declared the outbreak a Public Health Emergency on 30th January 2020 posing a high risk to countries with vulnerable health systems (Sohrabi et al., 2020). More than 4,405,680 cases and 302,115 deaths due to the disease had been reported across the six continents of the

world at the time of writing this report (European Centre for Disease Prevention & Control, 2020). The report from WHO probably reflects only a fraction of the actual number of infections as most countries only conduct tests on people with serious symptoms. There is currently no cure for COVID-19 (World Health Organisation, 2020). This has the potential to cause anxiety and depression among healthcare workers.

As of 14th May 2020, more than 1,072,144 people had been tested for COVID-19 across the UK (Peto et al., 2020). Although the

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incidence and mortality rates were reducing, there were no guarantees that the disease will not resurge in the absence of effective vaccine and treatment. According to preliminary data, the burden of the disease has shown tendency to differ by gender, race and socioeconomic status (Niedziedz et al., 2020; Wu & McGoogan, 2020). The COVID-19 virus has a significant impact on everyone, particularly the frontline healthcare workers. It has also drastically affected the social and economic set up of communities. With respect to healthcare workers, it is understandable that frontline health workers are potentially at risk of contracting the disease owing to their exposure to coronavirus patients. For many healthcare professionals, this may be a time of increased pressure and stress (Geurts et al., 1998). Furthermore, the situation was complicated by discharges of patients with COVID-19 from hospitals into care homes with shortage of PPE (Ng et al., 2020).

Beyond the stress inherent in COVID-19, there is a myriad of challenges that may affect both healthcare professionals and patients. Many healthcare professionals were faced with shortages of PPE and other medical supplies needed to carry out their duties.

COVID-19, inadequate testing, limited treatment options and other emerging concerns may have been sources of stress and had the potential to overwhelm the health systems (Pfefferbaum & North, 2020). At the time of writing this article, information regarding triggers of mental health problems among frontline healthcare workers looking after patients infected with COVID-19 had not yet been reported in the English Midlands region. Nevertheless, evidence suggested that healthcare professionals on duty during COVID-19 pandemic may have experienced distress because of the changing nature of guidelines, and increased pressure during care delivery.

Given that most COVID-19 cases were now being looked after in care homes and domiciliary care settings, this study explored triggers of mental health problems among frontline healthcare professionals. The study chose to look at private care homes and domiciliary care agencies because of the severe impact the sector was experiencing compared to the entities run by the National Health Services (NHS).

## 2 | METHODOLOGY

The study utilised an exploratory qualitative approach (EQA) (Hennink et al., 2020). The utilisation of EQA was meant to better understand the topic as opposed to offering a final solution to the matter under investigation (Gorynia et al., 2007). The method has a potential to identify possible areas for further investigations (Lockett et al., 2005).

### 2.1 | Data collection and recruitment

The data were collected using semi-structured interviews. The interview guide was constructed by literature from previous primary and secondary research studies of pandemics (Robinson, 2014). A pilot

#### What is known about this topic?

- COVID-19 is untreatable
- The World Health Organisation declared COVID-19 a Public Health Emergency on 30th January 2020.

#### What this paper adds

- Challenges experienced by frontline healthcare workers during COVID-19.
- Current gaps in healthcare.
- Possible solutions to the challenges experienced by frontline healthcare workers.

study involving five research participants was carried out to test the feasibility of the interview protocol. Following the completion of the pilot study, the five research participants were invited to comment on the suitability of the interview schedule. None of the five research participants suggested any changes to the original interview schedule. Forty semi-structured interviews were held with frontline healthcare workers. The researchers sent letters and information sheets to the nursing homes and domiciliary care agencies inviting their frontline workers to take part in the research study. All the participants had worked in either nursing and residential homes or domiciliary care for more than 10 years. It was important to recruit a heterogeneous sample with respect to the length of time they had spent working in nursing and residential healthcare or domiciliary care to elicit shared understanding of the life before and during the COVID-19 pandemic. Only those individuals who had agreed to take part in the research study had their names and telephone contacts forwarded to the researchers to organise interview dates and time. The interviews were held and recorded through Teams, an online platform. The interviews lasted for 30 min.

### 2.2 | Data analysis

All interviews were transcribed verbatim. A thematic approach underpinned by some aspects of interpretive phenomenological analysis (IPA) guided by the four phases of data analysis in the Silences Framework was utilised (Callary et al., 2015; Serrant-Green, 2011). The Silences Framework is normally used to research sensitive issues among marginalised groups, however, this research only borrowed the phases of data analysis in the Framework as opposed to the utilisation of the whole framework. The four phases of data analysis in the Silences Framework detailed below were ideal for data analysis in this research study as it provided opportunities for confirmation and verification of the findings, thereby enhancing credibility (Kornbluh, 2015). *In phase 1*, the researchers read the transcripts repeatedly to identify and ascertain the accounts of experiences that were important to the research participants. The themes identified were supported by quotations from research

participants. This formed the bases for the first draft of themes. *In phase 2*, the researchers first took the draft to the research participants for verification of the themes and quotations used to support them. *In phase 3*, the draft from phase 2 was taken to the collective user voice group; this was a group of people who worked in nursing and residential home-care or domiciliary care services but had not taken part in the research study. The idea was to subject the findings to a critical associative eye (Serrant-Green, 2011). *In phase 4*, the researchers analysed the draft from phase 3 to form the final output of the research study which was presented as the main findings of this study. Figure 1 below shows the four phases of data analysis utilised for data analysis.

Representation of the phases of analysis (Serrant-Green, 2011).

**2.3 | Ethical considerations**

The research was vetted and approved by the University Ethics Committee. All the research participants read the information sheet and signed a consent form, which granted them the right to withdraw from the study at any time without giving reasons. The research participants were given a list of mental health support services in the local area for support should they become affected after taking part in the study.

**3 | RESULTS**

The research study found that the triggers of mental health among frontline healthcare workers during the COVID-19 pandemic included fear of infection and infecting others, lack of recognition/disparity between NHS and private healthcare conditions, lack of guidance, unsafe hospital discharges, loss of professionals and residents through deaths and shortage of staff. The table below shows the profiles of 40 research participants who took part in the research study (Table 1).

**TABLE 1** Profile of respondents

Variable	Range	Frequency (%)
Age in years	25-35	16 (40)
	36-45	8 (20)
	46-55	8 (20)
	55+	8 (20)
Gender	Male	10 (25)
	Female	20 (75)
Job sector	Care homes	20 (50)
	Domiciliary care	20 (50)
Work experience	15 years	20 (50)
	12 years	10 (25)
	10 years	10 (25)
Total number		40 (100)

**3.1 | Fear of infection and infecting others**

Research participants reported fear of infection and infecting their residents and families. This was particularly severe for those who had vulnerable family members. Participants described the fear as being relentlessly at the back of their minds. High level of stress and anxiety was also described, stemming from the dilemma of performing their duty of care while in fear of cross infection.

I always felt depressed throughout the day as I was fearing to be infected by COVID-19 and in turn take it home to my child who has asthma.

A female mental health nurse

when you walk into work ... you don't know what you will find... PPE was running out quickly and you are caught up in between your duty of care and your family safety.

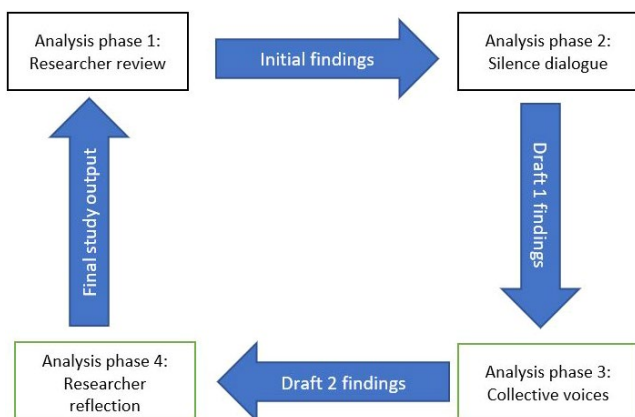
A male health care assistant

**3.2 | Lack of recognition/disparity between NHS and private healthcare conditions**

The research participants felt that frontline health and social care workers (HSCFWs) were not being recognised as contributing to the healthcare system. This impacted on their morale. The participants also attributed lack of recognition to causing delays in receiving PPE and testing. This resulted in panic and anxiety.

They are clapping for all keyworkers now, but it was all about the NHS to start with. I understand that they are at the core-face of it all, but social care is part of the same system.

A female adult nurse



**FIGURE 1** The four phases of data analysis in The Silences Framework

We should have been amongst the first to be tested because we are also exposed to the community...you can imagine the panic and anxiety of staff, relatives and all.

A male adult nurse

It is scary to lose someone close ....I lost my friend top COVID-19 and I have never been well since then but there is nothing I can do its worse when you lose a resident.

A male mental health nurse

### 3.3 | Lack of guidance

The participants reported that they found it difficult to work without specific guidance from central government which caused stress. They also cited frequently changing guidance as creating doubts in operational procedures and triggering anxiety.

Unfortunately, there have been so many changes on the guidance to COVID-19. Being diabetic the government has placed responsibility on my employer to make suitable safe working arrangements which is difficult.

A female learning disability nurse

I am really worried with ever changing information from government on how to act during this pandemic.... Honestly it really makes me anxious.

A male domiciliary support worker

I recently lost a family member who also was on the frontline. It is so hard when we cannot even get together to mourn a loved one how we would normally do..... I love my job, but I did not sign up for this..

A female adult nurse

### 3.6 | Unreliable testing and delayed results

The participants reported a problematic testing process. Some experienced unreliable testing where a resident received a false-negative test result, tests were lost and some results went missing. There were also delays in results of tests being returned.

We had one resident who tested negative and then on a second occasion tested positive.... We had the results of six residents lost and no one would accept responsibility for it.

A female nursing home manager

### 3.4 | Unsafe hospital discharges

The participants reported feeling under pressure to accept hospital patients who had not been tested at the start of the pandemic outbreak. This raised fear in the staff team as there was no way of knowing who was infected with COVID-19.

We had one resident whom we sent to hospital with suspected COVID-19, they discharged him without testing on the same day.

A male mental health support worker

I had a resident on shift that I thought might have symptoms, I called the paramedics and when they checked him, they said there was nothing to worry about.....The next day we took the resident to hospital and it turned out he had COVID-19.

A female health care assistant

A few staff have now been tested but the results have not come back after seven days, so they are still off work...They could have been back sooner if they were following self-isolation guidance.

A male domiciliary care manager

### 3.7 | Staff shortage

The participants reported that staff shortages were a source of stress and anxiety, particularly where they were covering shifts with agency staff and could not prevent exposure. Sickness rates increased and others used their leave entitlements causing staff shortages and leaving others physically and mentally drained.

We have been using agency staff to maintain staff numbers, but we don't know where else they have been working and this brings so much anxiety.

A female mental health nurse

### 3.5 | Loss of professionals and residents through deaths

Loss of colleagues and patients left HSCFWs fighting mental battles and turning to spiritual belief systems as coping mechanisms. They expressed a sense of being overwhelmed by the real risk of dying and leaving dependents behind. This caused high levels of anxiety.

People are going off sick with other things and taking annual leave. What can we do? We are dealing with a virus that is so new that nobody knows how to tackle it, I felt the situation could get out of control and so draining physically and mentally.

A male support worker

## 4 | DISCUSSIONS

When people are affected by a pandemic which is untreatable, there is bound to be fear and anxiety (Wheaton et al., 2012). Such fear and anxiety can adversely affect their mental health and well-being. Most of the research participants reported relentless fear at the back of their minds including uncertainty over whether their personal safety needs would be met because of PPE shortages. This triggered high levels of stress and anxiety because of the dilemma of performing their duty of care while in fear of cross infection. Such a phenomenon is not new with untreatable infections or pandemics as demonstrated in the early days of HIV and swine flu (Bogart et al., 2008; Jones & Salathe, 2009). It is, therefore, important that care homes and domiciliary care agencies have a robust mental health supporting policy for their staff in times of pandemics like COVID-19 (Holmes et al., 2020). Such a strategic policy can help in improving the mental health well-being of frontline staff in the organisations in question. More importantly such support needs to be reflected and supported by the central government to ensure sustainability, effectiveness and practicability.

Recognition and support of staff in healthcare plays an important role in their motivation, sense of achievement and security (Sultan et al., 2018). The theory of recognition is not new in employment psychology and has been used widely to increase efficiency in goal attainment for different organisations (Grant et al., 2009). The research participants reported lack of recognition for their contribution in the healthcare system compared to their counterparts in the NHS as evidenced by the central government designating certain days and times for recognition of the NHS frontline workers' contribution to the healthcare system, initially side-lining the private healthcare workers (Abbasi, 2020). This sentiment projected through the public made staff in private care homes and domiciliary care agencies feel unappreciated and dejected, sometimes leading to stress and anxiety (Crowe et al., 2018). There is need for the central government to publicly appreciate and strengthen the working relations between private and public care systems with a scope to provide a united front in times of pandemic like COVID-19.

Effective and clear guidance is key to reassurance and confidence of staff during a crisis in any organisation (Bryson, 2018). Such guidance can prevent worries and anxiety among staff and can boost confidence and morale. The absence of clear guidance can equally bring instability and poor mental health well-being on the part of staff. The research participants reported ever changing guidance from the government to prevent and manage the COVID-19 pandemic in their respective workplaces. They also cited frequently changing guidance as creating doubts about operational procedures, triggering anxiety and fear that they may have already been infected by COVID-19 through poor practice. It is, therefore, important that there is clear guidance coming from central government to all care organisations (Kinlaw et al., 2009). Such guidance should be a product of comprehensive consultation among central government, responsible institutions and care stakeholders culminating in clear

guidelines and subsequent national policy to manage pandemics like COVID-19. Such a scenario can circumvent the problems associated with ever evolving guidance, including negative effects on the mental health and well-being of staff due to poor protocols for prevention and management of pandemics. More importantly there is need for the central government to establish an independent agency that provide clear and direct guidelines in times of pandemic specifically to the private care entities and the NHS. Although there some advisory and inspection agencies like the Care Quality Commission (CQC), none of them is specifically meant for pandemic control and management.

Prevention of infection during a pandemic like COVID-19 is vital for staff and patients (Latiff et al., 2012). This can only be possible through a good testing and tracing operation within a health system to prevent the spread of infections. The research participants reported feeling under pressure to accept patients discharged from hospital who had not been tested for COVID-19 including some who had tested positive. This scenario was more depressing for staff in care homes given the shortage of PPE and ever evolving guidance protocol on COVID-19. This caused stress and fear on the staff with no option but to accept the discharges that they deemed challenging to be cared for under the current situation in care homes. There is need for a clear discharging policy from the hospital to the care homes during pandemics like COVID-19 to prevent further infection of staff and other vulnerable individuals in care (Brown et al., 2020). This can also reduce the levels of panic and fear among staff and individuals under care (Louie et al., 2009). More importantly there is need for a clear channel of communication and consultation between hospitals and care homes to make sure that all issues raised are pursued and exhausted in line with approved protocols of safe discharge and infection control.

Death and loss of someone close can bring feelings of stress and anxiety including other possible mental health triggers (Smith, 2018). Furthermore, poor support following the loss of someone close can have a long-lasting impact on the mental well-being of the affected individual (Ogińska-Bulik, 2015). The research participants reported fighting mental battles and turning to spiritual belief systems as coping mechanisms for loss of work mates and residents. They expressed a sense of being overwhelmed by the real risk of dying and leaving dependents behind. There is need for the central government, in conjunction with private care entities, to provide onsite loss and grief counselling services for staff working in healthcare (Wilson et al., 2005). More importantly staff experiencing grief because of death and loss should get immediate support to protect them from chronic depression and anxiety (Whitebird et al., 2013). This can prevent loss of working hours and mental health breakdown among frontline workers in care homes and domiciliary care agencies.

While testing is key to management of a pandemic, quick release of results and sharing with other key stakeholders can provide efficiency in curtailing the pandemic (Gardy & Loman, 2018). More importantly, timely release and sharing of results can equip staff and organisations with appropriate strategies to manage the pandemic. The research participants reported a problematic testing process

with sometimes delayed or unreliable results while others struggled to get testing in their care homes. This scenario put the staff under immense pressure, waiting for a long time to know their results and the results of residents. Some research participants reported high levels of anxiety working in such a difficult and complicated situation. There is need for a robust testing policy for pandemics like COVID-19 supported by quick release and sharing of results with key stakeholders to effectively manage the pandemic and reduce anxiety including fear among staff and individuals under care (World Health Organization, 2018). Immediate support for the mental health and well-being of staff in healthcare should be located within their workplace.

Shortage of staff in healthcare can cause unnecessary stress to both staff and the individuals they look after (Laschinger et al., 2006). Furthermore, staff shortage during pandemic periods like COVID-19 can make social distancing and shielding hard to enforce, resulting in infection of other residents. The research participants reported high levels of staff shortage during COVID-19 due to self-isolation, delayed testing and results. The fewer staff who turned up for work felt drained and overwhelmed causing moments of stress and anxiety that impacted on their mental health and well-being. The replacement of staff off sick by agency staff brought more fear and anxiety among the workers and residents, as agency workers meet different people in the different places they work. As part of pandemic preparedness, the central government through the ministry of health need to support care homes financially to establish bank workers who are guaranteed certain working hours to alleviate shortage during pandemic periods. More importantly there is need for the government to revise remuneration for care workers to attract more people to the profession. This will increase staff and prevent them from working long days resulting in burnout and possible mental stress.

#### 4.1 | Implication for practice

More support for staff working in healthcare is needed at workplaces to prevent stress, anxiety, and other mental health problems. The government need to support and acknowledge healthcare workers working for private organisations and the NHS equally. Clear policies on acquisition of PPE for both private and public care entities need to be put in place as part of an initiative to prepare for a pandemic like COVID-19. There is a need to develop a robust, reliable public health surveillance system that can support rapid testing, dispatching and sharing of pandemic results like COVID-19.

#### 4.2 | Limitations of the study

This research only considered frontline healthcare workers from the English Midlands region. A more comprehensive research including other regions of England may enhance comparison and generalisation of the problems faced by frontline workers in private healthcare organisations. The study utilised a qualitative approach. Research

utilising a mixed method in future may enhance exploration of issues from different epistemological and ontological positions.

## 5 | CONCLUSION

Support is needed for frontline workers in private care homes and domiciliary care to reduce and prevent the impact of mental health problems in workplaces. More importantly, central government needs comprehensive policies that cater for PPE supply and other forms of support for professionals working in private healthcare organisations.

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### CONFLICTS OF INTEREST

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