Elderly care in the time of coronavirus: Perceptions and experiences of care home staff in Pakistan

Atif Bilal1 | Muhammad Ali Saeed2 | Taimur Yousafzai3

1Department of Management Sciences, SZABIST, Islamabad, Pakistan
2Business Studies Department, Bahria University, Islamabad, Pakistan
3Sir Syed Polytechnic College, Karachi, Pakistan

Correspondence
Taimur Yousafzai, Sir Syed Polytechnic College, F-311, Block-F, Allama Rasheed Turabi Road, North Nazimabad Karachi, Pakistan.
Email: taimurryousafzaii@gmail.com

Objective: The highly contagious and deadly coronavirus disease 2019 (COVID-19) has caused significant disruption in the small care sector of Pakistan. This study accordingly explores the perceptions and experiences of staff providing direct caregiving services to the elderly residents at three care homes during the time of the coronavirus pandemic in Karachi, Pakistan.

Design: Using a qualitative approach, 27 digitally recorded, semi-structured, face-to-face interviews were performed with current and former caregiving staff members. The data were analyzed through qualitative content analysis.

Results: Analysis highlights various kinds of challenges that were faced by the caregivers and their families during the pandemic. The main theme class identified from the data was “living in anxiety and fear.” The work-related decisions made by caregivers at that time were mainly influenced by their familial demands and responsibilities.

Conclusion: Caregivers were at risk of catching the lethal virus through inhalation of or physical contact with infectious particles, but despite that most of them continued to render elderly care services. This study’s findings could be used by government leaders and care home administrations when making coronavirus containment policies, designing economic relief packages, and formulating caregiving training programs in Pakistan or other countries in the world.

KEYWORDS
care home, caregiver, coronavirus, COVID-19, elderly, Pakistan

1 INTRODUCTION

The coronavirus pandemic of 2019 to 2020 is creating havoc across Pakistan. While the virus has not spared a single sector of Pakistan, it has particularly shaken the elderly care sector. In comparison to the general population, a higher percentage of people in care homes have contracted the novel virus and have subsequently died of it. Care homes are facilities where people of advanced age live for long-term period. The staff at these homes assists residents in basic needs and housekeeping, provides companionship and transportation, assesses medical needs, monitors medication, helps in transfer and mobility, and prepares meals and care plans for them. The transmission risk of COVID-19 is particularly high in long-term care facilities because residents cohabit in confined settings and not much space is available to quarantine those who are sick. The caregivers also move from room to room assisting residents which makes it further difficult to limit the spread of infections. The coronavirus enters the care home through visitors and staff, and once entered, it spreads there rapidly, and does not spare anyone—residents, caregivers or support staff—from the risk of infection, hospitalization, or even death. Therefore, during the outbreak, sick leave policy for unwell staff and ban on visitors were enforced in some care homes in Pakistan.

Skin-to-skin touch is the best way to build relation with the elderly and is also the characteristic attribute of caregiving. Nevertheless, touching is not permissible when looking after the vulnerable elderly people in the time of coronavirus. Despite the instructions to
wear layers of protective gear and maintain reasonable distance, caregivers need to provide meaningful, intentional, and frequent touch that is safe and human so as to offer care, connection, and comfort. The caregiving profession craves or thrives on touch, and one way or another, caregivers have to intimately touch the elderly to perform their job. Ethically, while the care workers are obligated to perform caregiving duties such as promotion, intervention, and assessment, along with other things, for the safety and welfare of elderly residents, they are also obligated to apply on themselves the same welfare promotion and maintenance strategies, abstain from non-essential perils to their safety and health, and use medical services whenever needed while conducting their personal and professional activities. However, it is practically not possible to act on these principles when a crisis like COVID-19 is creating havoc across the country.

The outbreak of this highly infectious and fatal novel virus has been regarded as a threat to the survival of the global elderly population, and care workers from all over the world are participating in the war against it. However, the experiences of caregivers who are often exposed to virus-carrying droplets or aerosols from the infected elderly have not yet received scholarly attention. Regardless of some governmental and institutional guidance for safe caregiving, personal experiences teach the most valuable lessons. Considering this, the purpose of the present study is to look into the perceptions and experiences of care workers and also examine their decision-making regarding whether to stay home or work during the coronavirus pandemic in Pakistan. The study provides evidence-based meaningful information for caregiving curriculum development, education, research, policy decisions, and practice for caregivers in elderly care during coronavirus disease.

2 | METHODS

The grounded theory method was used here to report and find meaning in the views of caregiving staff and determine how the perceptions and experiences of caregivers influenced them to stay home or continue work during the COVID-19 crisis. The emergence of the main class of themes, its sub-classes, and the core social processes through techniques like constant comparison, theoretical sensitivity, and theoretical sampling serves as the foundation for this qualitative research.

2.1 | Sample

After getting this study approved from the ethics committee of a Pakistani university, a convenience sample of elderly caregivers was recruited through professional contacts. The supervisors, administrators, and support staff of care homes were excluded from participation in this study because they mostly work at their offices or designated places where physical contact with residents is at minimum. In total, 27 caregivers were recruited for this study from three care homes, nine from each. The socio-demographic characteristics of recruited caregivers are presented in Table 1.

| Key points |
| --- |
| • Elderly care in time of the coronavirus is challenging. |
| • Caregivers highly relied on various safety techniques and strategies to alleviate the risk of infection. |
| • Coronavirus changed the age-old caregiving patterns and work relations. |
| • Staff constantly lived and worked in anxiety and fear, but found their hazardous work as important. |
| • Knowledge, preparedness, and training were crucial for safety and trust, and for managing risks successfully. |
| • Government ministries and care home administration should not overlook the mental and physical trauma faced by the care workers and their family. |

2.2 | Data collection

Semi-structured, face-to-face interviews were conducted with the recruited caregivers that all began with an open question. Caregivers talked candidly and reflected over the topics, and probing questions were added whenever required to get more details and acquire deeper understanding about the issues they face. Theme saturation was noticed after 21 interviews but despite that, six more were performed to confirm saturation. The digitally recorded interviews roughly lasted between 30 and 75 minutes and were conducted during the third and fourth week of April, 2020. Data were collected and analyzed in parallel which paved the way for additional interviews with subjects.

2.3 | Data analysis

The transcribed data were initially examined in a line-by-line manner. Codes were first identified and were then organized and combined into a main class of themes, other classes, and sub-classes. The characteristics and scope of each class were identified until saturation in themes was confirmed. Similarly, the classes and sub-classes were combined till a structure demonstrating the conceptual arrangement or framework of linkages among the main class, other classes, and sub-classes of themes was reached. Throughout the analysis, memo writing was used to record the answers, linkages, and comparisons to analytical questions.

3 | RESULTS

The analysis of the interview-generated data led to the identification of certain themes that are summarized in Table 2. Given below is a detailed description of the themes identified from data.
3.1 | Main class: Living in anxiety and fear

The caregivers described feeling frightened and threatened by the prospect of unknowingly catching the coronavirus through interaction with coworkers and residents, and passing it on to their family or whoever they come in contact with.

All the time we are worrying that God knows who will we touch next. And often I think what am I taking home? I don’t care about myself much, but what about my kids?

The caregivers stated that such feelings resulted in loss of zeal and motivation for their work, and development of workplace phobia. Daily, as I approach the care home, I get anxiety attacks. ... I have no desire to work.

The sub-classes of the main class “living in anxiety and fear” are explained below:

Skills, knowledge, protective gear: At the onset of the outbreak, caregivers did not have a proper understanding about the novel coronavirus, and its control and protective measures.

We were dealing with an unknown bug that none of us had ever seen before or heard of.

The caregivers were insistent on keeping themselves risk-free so they could look after the elderly better. When protective gear was unsatisfactory or unavailable, caregivers withdrew from work.

Some supply of masks and gowns, etc. was there but it was not much and was shoddy also. And when we ran out of it too, we withdrew. ... But this [protest] lasted only 3-4 days. When new supplies came, we were back on track.

Frequent handwashing with chlorinated water and inhaling disinfectant sprays caused discomfort for care workers.

When we started wearing it [gear]. ... My body was sweaty and smelly all the time. ... disinfectants made the eyes burn red. Some with hand eczema literally cried when using the bleached wipes. ... inhaling chemicals made my throat go very bitter and dry.

High risk caregiving: Fighting the mysterious virus, and observing high rate of infection and mortality among residents and even their coworkers, the staff at caregiving facilities was at constant high risk. With no knowledge and preparedness regarding the coronavirus and its complications, caregivers were often looking after the sick elderly who might be COVID-19 positive.
The first time someone here got infected, we all were asking each other that what this corona-thing exactly is, and how is it going to end? It was like blind leading the blind.

**War against virus:** Caregivers drew an analogy between the COVID-19 crisis and a war. They need to use the defense principles and survival tactics of soldiers to defeat the coronavirus in its self-waged war.

The care home resembles a warzone now. ... people wearing protective suits, holding sprays like guns, no unnecessary talks, everyone scared. ... only that the enemy is not visible. ... If we don’t win this war, corona will eat up this whole place.

**Psychophysical symptoms:** On occasions, after a coworker or an elderly became sick or died after contracting the novel coronavirus, just out of fear, the caregivers started showing some of the symptoms and signs themselves. This made them depressed and worried about their survival.

I even isolated myself twice because of light cough.... Every time I touch an elderly, I think ‘okay, this is the moment I get the virus’ ... after he [colleague] also got infection, I felt feverish for many days.

3.2 | **Sub-class: Forces affecting decision to work**

The sub-classes emerging from the class “forces affecting decision to work” are described below:

**Government efforts:** Although the government acted responsibly by supplying protective gear to care homes, it did not provide any emergency incentive, welfare, or allowance to care workers. Caregivers complained that the government’s efforts were fixated at public health institutions only and they did not receive the recognition and state benefits they deserved.

Government says if nurses die due to coronavirus, their families will get Rs. 700,000. But ... what do our families get? Nothing!

**Administrative factors:** The attitude and behavior of the care home administration were both non-motivational and motivational for the caregiving staff’s decision to work.

They [administration] facilitated us by providing the protective equipment. But that’s all. They didn’t do anything like increasing wages or reducing duty hours.

Caregivers criticized the irresponsible actions of the care homes during the nation-wide lockdown period.

Despite lockdown, administration accepted the elderly discharged from hospitals who could possibly be coronavirus positive.

Some caregivers expressed their appreciation for the right kind of training, information, and protective gear provided by care homes that boosted their competence and confidence, and helped them to loosen up.

A laboratorian came here to tell us more about the virus... Every week fresh supplies of disinfectant and gear come. ... they [administration] are doing a good enough job of preparing us.

**Discrimination:** When the coronavirus panic escalated in the country, caregivers were ostracized and shunned in public and residential complexes over ignorant fears that they might spread infection since the elderly they spend time with are rapidly getting infected and succumbing to it. Discrimination led to feelings of sadness, frustration, and fear among caregivers.

Our food delivery orders are often canceled because they are to an elderly home. Once a driver canceled my booking. Why? For the same stupid reason.... We are rejected like lepers.

**Turn to God:** The caregivers turned toward God to endure the difficult, long days of the pandemic. They believed that no equipment, hospital, or government can give them surety of protection, but the divine power of God. Caregivers told that all three selected residences conducted prayer meetings each morning to ask God for mercy.

God is our only hope.... I have made a routine. Every morning I read Quran and ask God for strength, ... and protect me while I am at work, ... and forgiveness for being rude to the elderly.

**Professionalism:** Their decision was motivated by the assessment of their limited options and the job’s benefits to them and the elderly.

I wasn’t thinking about the salary; I was thinking about my duty to serve the elderly who are already neglected by their families.

The caregivers voiced their interest in the profession, affection for elderly, and compassion for the infected ones.

They [elderly] cannot do a thing properly themselves. ... left on their own, loneliness will kill them before coronavirus. ... if I abandon them today, what example do I set for my children?

Many caregivers who left job soon after infections started to spread in their respective workplaces, later regretted.
I acted cowardly, I know. But I thought it was better to quit than to kill myself. ... I really feel bad sometimes.

Family: The COVID-19 emergency caused the caregivers to fear for personal safety and exposing their family to the virus. When ... residents started contracting the virus ... my parents went nuts. They were like 'leave job, leave job' all the time. ... And I did leave it in the end. ... after all, what is more important than your family?

Those who did not work expressed concerns for their family's safety because they did not have access to right protective gear.

Job's benefit was that ... I used to bring home all kinds of protective stuff from there. But when I left the job, our [family's] luxuries ended. ... we were safer in that way before.

Caregivers who continued worked like always were under constant guilt and fear and expressed that physical distance from family members causes them great agitation and pain. Nevertheless, when caregivers educated their families about the coronavirus, they were able to work at peace.

They [family] also got relaxed when they saw how informed I am about the virus. That I will never do anything to jeopardize us. So, every time I got home, they freely came running toward me.

3.3 | End-result class: Decision to work

Despite living in anxiety and fear, those caregivers who decided to work did so for their own idiosyncratic reasons like spiritual duty, sympathy for elderly, passion for job, workaholic nature, professional commitment, and concern for humanity. Other forces that kept caregivers at work were governmental and institutional efforts to provide training and protective gear for caregivers.

If we had fled, they [elderly] would have been left unfed and soiled and lonely. They would have dehydrated.... I can never leave them like that.

The central reason for caregivers’ decision to render services was family support.

My husband’s income alone could not run our house. So what other option did I have? I kept on working just like that.

Some caregivers were pressurized by the care home administration to work. Later, when they received professional gains and social respect, they were pleased to have kept on working during the national crisis.

But they [administration] rejected my leave request and told that if I don't show up, they will fire me.

Later in the interview, the same caregiver said:

The management has promised to make me permanent. ... All the building people who were earlier avoiding me, now call me things like impressed, brave, strong.

The caregivers who decided to carry on experienced major changes in the caregiver–care receiver relationship dynamics.

We don’t care for them [residents] anymore like we always used to. ... I dread touching them. ... now I often ignore their buzzers.

The caregivers discussed that their relationship and work-related behavior with coworkers also underwent many changes due to the coronavirus scare.

We remind each other all the time about safety measures. ... We disinfect each other's things, make sure everyone is properly covered, ... We talk more so we don’t get depressed. ... We have become a family.

While the pandemic helped the caregivers to bond better, it considerably strained and complicated their routine interactions with each other.

First, we used to look at each other with love. Now we look at each other with suspicion that 'oh she coughed; maybe she has coronavirus'. ... We used to drink from the same glass, and now, I am even afraid to borrow a pen.

4 | DISCUSSION

The caregivers of elderly people worked and lived in anxiety and fear when the novel coronavirus was ravaging through the population of Pakistan. Their own lives and those of their families were greatly threatened. Shiao et al.3 recount various concerns for care workers during a 2003 virus epidemic quite similar to COVID-19, also categorizing family as a main source of worry, and social, emotional, and psychological support. Various news reports offer support to this study’s findings, particularly that caregivers felt morally and professionally obligated to continue the care for elderly residents in that time of need.4,5 The caregivers complained of discrimination, stigma, and insults from local community members. Many publications agree that government efforts and institutional influences, along with caregivers’ own attempts to sensitize and educate their families and elderly about coronavirus, help to ease the impact of discrimination (Lin et al., 2020;
An international monetary fund report emphasizes the need for strong governmental intervention through provision of protective gear, policy development, and funding in educational and training programs in coronavirus care.

The caregivers noticed that the coronavirus outbreak changed the age-old caregiving patterns and work relations within no time. However, through proper knowledge, protective equipment’s provision and training, the caregivers regained their confidence and optimism. They were then able to devise innovative methods to care for the elderly residents and support their coworkers while wearing the personal protective coverings and maintaining physical distance from them. Recent news stories from the global elderly care sector confirm this particular finding (Connor, 2015). The study also found a spiritual dimension of caregiving that is critical for maintaining caregivers’ peace of mind. Researchers like Chang et al. concur that spiritual coping indirectly lowers caregivers’ psychological distress through improvement in the quality of the caregiver–care receiver relationship.

This study differs from past works in a way that the factors that influenced caregivers’ experiences and perceptions, and, above all, their decision to stay home or render care during COVID-19 were based on their emotional connections with family, coworkers, elderly residents, and the community. The decision also rested upon caregivers’ value system especially as regards spirituality and professionalism. As a distinctive aspect, the present study’s findings draw attention to the spiritual/religious side of the experiences of caregivers. They indicate how descriptive, behavioral, and internalized dimensions of the faith factor affect caregivers’ decision to continue their job. Past research on caregivers’ attitudes, perceptions, or work experiences during outbreaks or crisis has overlooked this spiritual angle.

Choi et al. advocate that religious support from congregations and personal spirituality influence the decision-making regarding elderly caregiving. This study’s overall findings are congruent with current news regarding the upheaval in elderly housing facilities.

4.1 Limitations

A shortcoming of this research is the inadequate representation of male caregivers’ perspective as the sample was female-dominant. Also, sample was recruited from care homes of a severely coronavirus-hit city (ie, Karachi) only, thereby overlooking the experiences of care workers in other parts of Pakistan. The study’s focus was limited to staff providing close, one-on-one care to the elderly in assisted-living facilities. It did not explore the happenings in care homes in time of the COVID-19 upheaval from the viewpoint of their kitchen, cleaning, or maintenance staff.

4.2 Policy implications

Government leaders and care home administrations could use the suggestions this study offers to amend work policies in order to accommodate caregivers’ family concerns in times of crisis. They could do so by providing (if needed) special housing, financial compensation, education, and public or written appreciation of caregivers’ family members. Schools that offer geriatric care courses could include this study in their curricula to better educate and train students as regards caregiving during deadly virus outbreaks. The study stresses on the need that not only caregivers but their families also should be included in compensation and protection policies and plans, and given access to materials for personal protection. Besides, spiritual dimensions, ethical considerations, and psychological or emotional implications of coronavirus caregiving should be addressed. In simple terms, caregivers should not be pressurized to work, periodic psychological counseling and debriefing should be arranged for them, and multi-faith prayer rooms should be provided where they can practice their faith and draw comfort from it.

5 CONCLUSIONS

The unparalleled and unprecedented COVID-19 crisis caused great devastation in Pakistan, and particularly deteriorated the structure of its small caregiving sector that was based on respect, consideration, and compassion. The role of caregivers in looking after the marginalized and vulnerable elderly living in long-term care homes cannot be overstated. They constantly lived in anxiety and fear when the virus was rampaging across the country and turning care homes into funeral homes. Their family was the foremost reason behind whatever work decisions they made in that time. The novel virus changed the very nature of the relationships and interactions caregivers had with coworkers and elderly residents. Supply of protective gear and training gave caregivers confidence that they can serve and be safe at the same time. When making coronavirus containment policies or designing economic relief packages, government ministries and care home administration should not overlook the mental and physical trauma faced by the care workers and their family. This study’s findings could also be used in planning, or making work and educational policies regarding future virus outbreaks in Pakistan or other parts of the world.

COMPLIANCE WITH ETHICAL STANDARDS

CONFLICT OF INTEREST

- The authors declare that they have no conflicts of interest.
- Funding
- The authors received no funding for this study.
- Ethical approval
- All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.
DATA AVAILABILITY STATEMENT
The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions

ORCID

Taimur Yousafzai https://orcid.org/0000-0001-6320-3866

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