Ethical challenges experienced by care home staff during COVID-19 pandemic

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Abstract

Background: Care homes have been disproportionately affected during the COVID-19 pandemic. Practical challenges of enacting infection control measures in care home settings have been widely reported, but little is known about the ethical concerns of care home staff during the implementation of such measures.

Objectives: To understand the ethical challenges perceived by care home staff during the early months of the COVID-19 pandemic.

Research design: An exploratory qualitative study.

Participants and research context: A purposive sample of 15 care home staff in different roles and ranks in Hong Kong was recruited to take part in semi-structured interviews between June and August 2020.

Ethical considerations: Ethical approval for this study was obtained. Participation was voluntary and anonymous. Participants had the right to withdraw from the study at any time without reprisal.

Findings: Three themes were identified: unclear legitimacy regarding infection control measures, limited autonomy in choices over infection control measures and inevitable harms to residents’ well-being. While the participants expected that they would have legitimated power to implement infection control measures, they were resistant when their right to self-determination of testing and vaccination was infringed. They also felt...
trapped between ethical duties to protect care home residents from infection risk and the anticipated detrimental effects of infection control measures.

Conclusions: The findings of this study reveal tensions among the ethical obligations of care home staff in response to a public health emergency. They highlight the importance of strengthening ethical sensitivity and ethical leadership in identifying and resolving the challenges of pandemic responses.

Keywords
Care homes, COVID-19, ethics, infection control, long-term care

Introduction
Care homes are generally underprepared for the spread of infection within their facility. Global statistics indicate a disproportionately high rate of COVID-19 infection and related deaths among care home staff and residents. Older adults residing in care homes are more likely to be living with frailty and functional impairment that warrants personal care than their home-living counterparts, and thus are more susceptible to infections and poor clinical outcomes. The design of congregate housing for communal living in care homes increases the risk of contamination and cross-infection, and medical support is not comparable to that available in hospital settings. The threat of an infectious disease outbreak in care homes is further exacerbated by the long-standing problems of understaffing and limited care competencies. These factors underscore that pandemic responses in care homes are complex interventions influenced and shaped by contextual factors at societal, organizational and personal levels.

Background
Although guidance for preventing COVID-19 outbreaks in care homes was swiftly rolled out by professional bodies and policymakers in response to the pandemic, care home staff encountered many challenges in the implementation of infection control measures. One challenge was the frequent changes of regulations and policies for infection control, among which some recommendations were contradictory, leading to confusion. Care home staff were overwhelmed by the increased workload due to infection control measures and frustrated by the difficulties of isolating or maintaining social distancing among care home residents, particularly those with cognitive impairment or behavioural problems. Staff burnout was aggravated by inadequate resources, including personal protective equipment, and an unstable workforce. Some care home staff also perceived that their previous training had not prepared them for infection control and expressed concern about public blaming and the negative media coverage of their work performance.

The COVID-19 pandemic created an unprecedented crisis in healthcare services, including those in care home settings, resulting in dilemmas and public mistrust. To overcome this, pandemic preparedness informed by ethical values is of paramount importance to guide practice. Thompson et al. (2006) developed an ethical framework for pandemic planning, based on the experience of SARS, which delineates various ethical values including the duty to provide care, equity, individual liberty, privacy, proportionality, protection from harm, reciprocity, solidarity, stewardship and trust, and an ethical process to inform decision-making for pandemic planning. Cousins et al. (2020) identified a set of ethical values for supporting care home residents with dementia during the COVID-19 pandemic and highlighted that ethical care practice would be beneficial to both care recipients and providers. Hartigan et al. (2021) conducted an in-depth ethical analysis regarding
visitation restriction during the pandemic and illustrated how care providers can plan for care practices in a balanced and logical manner through the lens of ethical values.

Studies have explored the ethical challenges experienced by nurses in hospital settings during the pandemic. Peter et al. (2022) noted the tensions that nurses in Canada experienced when managing various competing ethical responsibilities and maintaining their moral identities. Jia et al. (2020) identified that nurses in mainland China experienced ethical challenges concerning patients’ rights and welfare, breaches of professional ethics and lack of competency among co-workers. However, the challenges so far reported in the context of care home settings are mainly practical in nature. Little is known about the ethical tension experienced by care home staff during the pandemic.

**Study context**

In Hong Kong, the government issued guidelines regarding infection control in care homes soon after receiving information from the National Health Commission of China about a cluster of pneumonia cases in Wuhan in January 2020. The situation was relatively well controlled in the community in the early months of the pandemic, with only sporadic cases in care homes. Given limited evidence about the effectiveness of various infection control measures, scepticism arose about the relevant policies. Misinformation on social media further jeopardized public trust in infection control measures. The vaccine uptake rate of the public, including care home staff and residents, remained low although the government had purchased sufficient doses of vaccines to ensure availability. It is against this background that we would like to explore the ethical challenges experienced by care home staff in the course of providing care, with the aim of informing ethical care practices.

**Methods**

The aim of this study was to understand the ethical challenges perceived by care home staff regarding the provision of care during the early months of the COVID-19 pandemic. We conducted an exploratory qualitative study between June and August 2020, soon after the first wave of the pandemic in Hong Kong, when no new local cases were reported and the government gradually relaxed infection control measures. The period of a decreasing trend in the number of infected cases is defined as the ‘post-peak period’ of a pandemic. The World Health Organization recognizes that identifying the lessons learned from pandemic responses during this period is an overarching task in preparation for another wave of the pandemic.

**Study participants**

Participants were recruited in Hong Kong from one government-funded care home and two privately operated care homes with around 100 beds per home. Eligible participants were staff members of any rank who had worked in the care homes for at least 1 month during the pandemic. We used purposive sampling to maximize variation in the roles and positions of the participants in our sample and thus capture a fuller picture of the phenomenon of interest.

**Ethical considerations**

Ethical approval for this study was obtained from the Survey and Behavioural Research Ethics Committee at The Chinese University of Hong Kong (SBRE-19–735). The purpose and nature of the study were explained to the participants, and confidentiality was assured. Participation was voluntary, and participants had the right
to withdraw from the study at any time without reprisal. Written consent was obtained for participation in the study and audio-taped interviews.

**Data collection**

In-depth semi-structured interviews were conducted in individual format with managerial staff and in group format with other frontline staff members. Individual interviews ensure a private space for participants to express themselves frankly, whereas the group dynamics in focus group interviews enable researchers to collect diverse views about complex social situations. The participants were divided into groups based on their rank and place of work. Each group comprised two or three participants to ensure the genuineness of the participants’ responses while observing social distancing. The interviews were conducted in Chinese by the first author using an interview guide with open-ended questions. The guiding questions were as follows: “Could you describe the challenges you encountered when working in a care home during the COVID-19 pandemic?” “How did you or your care home resolve these challenges?” “What was your experiences of these strategies?” Data collection and analysis were conducted concurrently to enable us to seek more information from the participants and sharpen the focus of subsequent interviews. We also attempted to explore disconfirming evidence to identify rival themes or interpretations. Data collection continued until data saturation (i.e. the point at which no new data were found). All interviews were audio-recorded and transcribed verbatim into Chinese for analysis.

**Data analysis**

Inductive and data-driven thematic analysis was conducted according to the guidelines proposed by Braun and Clarke (2006). First, the first author read the interview transcripts multiple times to become familiar with the data, and then generated the initial ideas for coding. The first three authors discussed the initial codes identified in the data related to ethical issues and explored possible patterns by comparing and sorting the codes. The codes were then used to label segments of text that captured the phenomenon of interest. The relevant codes were collated into themes, and the first three authors reviewed the coded extracts against these themes to ascertain the coherence between the data and themes. Exemplar quotes were selected to provide rich descriptions of the themes. The other three authors, who were not involved in data collection, then reviewed these candidate themes for clarity and relevance to the research question. The research team then refined the themes by scrutinising the data until a consensus was reached. This recursive analysis aimed to ensure that any issues or concerns identified by the participants were mapped out from the data and reflected accurately in the themes.

**Rigor**

We adopted a systematic approach to guide the qualitative analysis. The researchers involved in data collection and analysis had relevant methodological skills and experience. They held regular meetings to discuss the interview process to ensure a consistent focus. The transcripts were checked against the audio recordings to ensure accuracy. Throughout this process, we reviewed the emerging themes, revisited the data and reflected on our perspectives and assumptions to avoid idiosyncratic interpretations of the data. Researcher triangulation was achieved by presenting the analysis to different researchers through a peer debriefing process to ensure the external validity of the findings and interpretations. All audio-recordings, transcripts and analysis notes were kept for auditing purposes.
**Results**

Fifteen staff members, including three care home managers, three nurses, two social workers and seven personal care workers, participated in the study (Table 1). Their work experience in care home settings ranged from half a year to 18 years. The three themes identified were as follows: unclear legitimacy regarding infection control measures, limited autonomy in choices over infection control measures and inevitable harms to care home residents’ psychosocial well-being.

**Unclear legitimacy regarding infection control measures**

Several participants recalled that, at the early stage of the pandemic, the government’s advice on infection control measures, such as the use of face masks and social distancing, was merely a recommendation, leaving individuals to choose which preventive measures to adopt. This placed the participants in a difficult position when applying the measures in care home settings.

One care home manager said:

> Why didn’t the government officially announce a visitor restriction? The care homes were asked to determine their compliance with the guidelines at their own discretion. Many family members did not understand and were uncooperative. We were exhausted from dealing with these conflicts… until the government stated explicitly that “no visitation is allowed”, then we had the “power” to ban visitors [to the care home]. (H5)

Another care home manager shared that it was difficult to control care home residents’ behaviours. Although his care home had provided additional services for helping residents to buy daily necessities, some residents insisted on having outdoor activities as usual. The participant stated:

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**Table 1. Characteristics of participants.**

| Code* | Age, years | Gender | Care home | Rank | Work experience in care home setting, years |
|-------|------------|--------|-----------|------|--------------------------------------------|
| H1    | 60         | F      | A         | Personal care worker | 17               |
| H2    | 47         | F      | A         | Personal care worker | 4                |
| H3    | 53         | F      | A         | Personal care worker | 11               |
| H4    | 31         | F      | A         | Nurse            | 2                |
| H5    | 36         | F      | A         | Care home manager | 7                |
| H6    | 58         | F      | B         | Care home manager | 15               |
| H7    | 40         | F      | B         | Nurse            | 13               |
| H8    | 52         | M      | B         | Social worker    | 18               |
| H9    | 59         | F      | B         | Personal care worker | 4              |
| H10   | 58         | F      | B         | Personal care worker | 2              |
| H11   | 52         | M      | C         | Care home manager | 8                |
| H12   | 54         | F      | C         | Nurse            | 8                |
| H13   | 42         | F      | C         | Social worker    | 6                |
| H14   | 53         | F      | C         | Personal care worker | 2             |
| H15   | 47         | F      | C         | Personal care worker | 2             |

Footnotes: Care home A is government-funded; Care homes B and C are private-operated.
I could not stop them [residents] from leaving the care home if they were used to going out independently… During those days, we continued to advise them to wear masks in public areas. We all understand that it is hard to tolerate wearing a mask in such hot weather. Before the regulation on the wearing of masks, we could do nothing as there was no liability. (H6)

**Limited autonomy in choices over infection control measures**

Due to the nature of their work as care home staff, the participants noted that they were required to take preventive infection control measures, such as nucleic acid testing and vaccination. As the pandemic progressed, nucleic acid testing capacity for SARS-CoV-2 expanded and became routine practice in care homes for all staff members. Despite this, the participants were concerned that their right to make choices about such measures was infringed.

One social worker did not appreciate care home staff being required to undergo regular viral testing as a surveillance measure:

Initially, the testing only targeted those who presented with relevant signs and symptoms and vaccination was on a voluntary basis, but then every one of us had to undergo frequent testing, unless you were vaccinated. You don’t have a choice if you want to keep this job (H13).

Some participants also expressed concerns about the efficacy of the vaccination and serious reactions to the vaccine. One personal care worker explained her hesitancy about vaccination:

We [care home staff] are a specific group being identified. However, vaccination is risky. Some people died or had facial palsy afterward. Many of us are not that young. We have medical histories of the “three highs” [hypertension, high cholesterol and high blood sugar] and so we are at risk of complications and death [after vaccination] … We doubt if we should get it [the vaccine]. There were news reports that some people still got infected after getting the shots. (H14)

**Inevitable harms to residents’ psychosocial well-being**

During the pandemic, rehabilitation services and group activities were suspended to minimize social contacts among care home residents, and between care home residents and people outside the homes, including allied health staff who are not core care home staff but rotate across different care homes. Many participants acknowledged the detrimental effects of social distancing, visitation restriction and cancellation of social activities on the psychosocial well-being of the residents. A nurse noted that:

All the social activities we usually organised were suspended during that period due to social distancing measures. You could clearly see deconditioning [among the care home residents], particularly those with dementia. They became dull and unresponsive. Some of them were not willing to eat because their children were not allowed to come in. (H4)

Given the limitation on personal contact, the care home staff resorted to using videoconferencing to help care home residents keep in touch with their families or inform family members about the residents’ conditions. However, some participants noted that such means were ineffective because their internet access or manpower was limited. It was also difficult for care home residents with cognitive impairments to meaningfully connect with family members through these means.
Discussion

Our study explored the ethical challenges experienced by care home staff in Hong Kong during the early months of the COVID-19 pandemic. The major issues pertained to the balance between the right to choose and beneficence in the implementation of infection control measures in care homes, and between the intended good and anticipated harms due to infection control measures in care homes.

One major cause of tension was rooted in the ambiguity regarding the powers of care home staff to control care home residents’ behaviours. This phenomenon is consistent with the findings of Peters et al.’s study (2022) that ethical concerns emerged when stakeholders were not involved in the process of planning infection prevention and control measures.18 The participants noted that precautionary measures, such as the use of face masks and limiting visits to care homes, were only encouraged on a voluntary basis in the early months of the pandemic.28 This approach is in line with libertarian paternalism, which guides people to promote their welfare without limiting their choices.29 Libertarian paternalism, highlights the balance between individual liberty and paternalistic beneficence, has gained attention in public health in recent years.30 However, our findings suggest that allowing flexibility in the uptake of infection control measures placed care home staff in a difficult position. Menard et al. (2020) argued that the effects and sustainability of health-promoting measures grounded in an altruistic or self-determined approach are insufficient for the management of public health emergencies that require collective action.31 Our participants seemed to be powerless to impose preventive measures when the care home residents or their family members had the autonomy to determine whether to follow the recommendations.

The limitations of liberation paternalism prompt the question of whether a paternalistic approach would be ethically justifiable for infection control. Paternalism was defined as overriding the liberty of action of another person for his/her own best interests, regardless of his/her consent, given the ethical principle of beneficence.32 This approach has been discounted in contemporary healthcare practices, including care home settings, because person-centred care that respects individual uniqueness, needs and preferences is highly valued.33 Nevertheless, given that care home residents are vulnerable to being infected and the ensuing risks of health complications, enforcing infection control measures using a paternalistic approach to protect them from harm due to infectious disease is indispensable, despite the impingements on their freedom and autonomous decisions. According to Sjostrand et al. (2013), overriding the preferences or actions of care recipients in this circumstance can be justified as promoting their future autonomous life.34 From a utilitarian perspective, the paternalistic approach can also achieve greater good for the greater number in such public health challenges.35 To this end, mandatory implementation of infection control measures for maximising the collective good of care home residents should be considered ethically acceptable.36

Paradoxically, the participants had reservations about adopting a paternalistic approach when their own autonomy was infringed. In this study, the participants were resistant to being required to undergo repeated viral testing and vaccination. The discrepancy in their views about the autonomy of themselves and the care home residents may be interpreted from a pluralistic perspective acknowledging that different ethical values, perspectives and decision-making frameworks co-exist.17,37 While the participants consider paternalistic measures to control care home residents’ behaviours for the sake of their health are ethically permissible, they did not appreciate such an approach when their own right to decision-making about the uptake of infection control measures was affected. However, such measures are intended not only for the health and welfare of the care home staff but also that of the residents. Healthcare providers are presumed to have ethical obligations to promote the welfare of care recipients.38,39 Hence, mandatory vaccination as a condition of employment for healthcare providers, who may become vectors of transmission, seems justified to safeguard care recipients.39–42

However, Rodger and Blackshaw (2022) argued that it is premature to roll out a vaccine mandate before less restrictive measures have been attempted.43 A stepwise approach was proposed by Ginbilini (2019) on
the basis of the least restrictive principle, suggesting that vaccination mandates for healthcare providers should be preceded by non-coercive strategies, such as persuasion, nudging or providing incentives for vaccine uptake. Providing balanced evidence-based information about the vaccine to clarify the myths and misconceptions underpinning vaccine hesitancy might also be helpful. Redeploying staff to non-clinical duties, requiring them to take leave or suspending them from employment are other non-prescriptive alternatives to preserve healthcare providers’ right to choice regarding infection control measures. Nevertheless, the right of healthcare providers to exercise autonomy should not breach their moral obligation of non-maleficence at the cost of public health.

Another ethical tension arose when the participants felt trapped between ethical duties to protect care home residents from infection and to prevent the anticipated detrimental effects of the infection control measures on the residents’ psychosocial well-being. The participants attempted to enable care home residents to maintain social connection with family members through videoconferencing, but the effects varied depending on the digital literacy of the care home staff, residents and their family members. Proportionality, one of the underpinning values in the ethical framework that guides decision-making for pandemic planning, sheds light on how to strike a balance between these two mutually exclusive ethical duties. Proportionality suggests that measures that restrict individual liberty should be proportionate to the intended good. Instead of confining care home residents within a limited space, various activities that might support them to meaningfully engage with others should be organized to reduce their sense of loneliness and abandonment during a pandemic. Flexibility in family visitation policy should also be considered in terms of proportionality if the benefits would outweigh the harms.

Limitations

We acknowledge several limitations of this study. First, it was conducted just after the first wave of the COVID-19 pandemic in Hong Kong, at which time the situation was relatively well controlled, with few care home residents or staff infected. Only one participating care home in this study had residents who were infected. The views of the care home staff might have changed when, later, the situation became out of control in the subsequent waves and over half of the confirmed cases and two thirds of deaths were care home residents. Second, the qualitative nature of the study means that we cannot establish causality between the responses to the pandemic and the number of infected cases in care homes. Third, participation bias cannot be ruled out because all participation was on a voluntary basis. Fourth, the interviews were conducted through Zoom, a videoconferencing platform, due to social distancing measures. This method might have affected the quality of the interviews as it was hard for the interviewer to conduct observation of non-verbal communication during the interview and, sometimes, the interviews and recording were disrupted by an unstable internet connection.

Conclusion and implications

This study explores the ethical challenges experienced by care home staff in Hong Kong during the early months of the COVID-19 pandemic. Our findings reveal the tensions among ethical duties to protect care home residents from harm and safeguard the rights and welfare of residents and staff when implementing infection control measures. While the participants expected that they would be legitimated to implement infection control measures, they were resistant when they realized that their own rights to self-determination regarding vaccination and testing were infringed. These contradictory experiences uncover the complexity and pluralism of ethical concerns regarding pandemic responses in care home settings. More guidance is needed to strengthen both the ethical sensitivity of care home staff to challenges in the context of pandemic and to develop ethical leadership to devise appropriate care practices to address these challenges.
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