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Original Study

This Was My Crimean War: COVID-19 Experiences of Nursing Home Leaders



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A B S T R A C T

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Objective: To describe professional and personal experiences of nursing home care leaders during early waves of the COVID-19 pandemic.

Design: Qualitative interpretive description.

Setting and Participants: Eight sites across 2 Canadian provinces. Sites varied by COVID-19 status (low or high), size (<120 or ≥120 beds), and ownership model (for-profit or not-for-profit). We recruited 21 leaders as participants: 14 managers and 7 directors of care.

Methods: Remote Zoom-assisted semi-structured interviews conducted from January to April 2021. Concurrent data generation and inductive content analysis occurred throughout. Sampling ceased once we reached sufficient analytic variation and richness to answer research questions.

Results: Most participants were female, ≥50 years of age, and born in Canada. We found 4 major themes. (1) Responsibility to protect: Extreme precautions were employed to protect residents, staff, and leaders' families. Leaders experienced profound distress when COVID-19 infiltrated their care homes. (2) Overwhelming workloads: Changing public health orders and redeployment to pandemic-related activities caused administrative chaos. Leaders worked double shifts to cope with pandemic demands and maintain their usual work. (3) Mental and emotional toll: All participants reported symptoms of anxiety, depression, and insomnia, leading to ongoing exhaustion. Shifting staff focus from caring to custodial enforcement of isolation caused considerable distress, guilt, and grief. (4) Moving forward: The pandemic spotlighted deficiencies in the nursing home context that lead to inadequate quality of resident care and staff burnout. Some leaders indicated their pandemic experience signaled an unanticipated end to their careers.

Conclusions and Implications: Nursing home leaders faced mental distress and inordinate workloads during the pandemic. This is an urgent call for systemic change to improve working conditions for leaders and quality of care and quality of life for residents. Nursing home leaders are at increased risk of burnout, which must be addressed to mitigate attrition in the sector.

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It certainly makes me think about legacy. . . .

This was my Crimean war.—Participant 12

Nursing home leaders, such as managers and directors of care, carry multiple key responsibilities, including managing human and financial resources, developing staff competency/skills and ensuring quality and

safety standards.¹ Leadership retention in nursing homes is a long-standing problem,^{2–5} exacerbated by COVID-19 pandemic challenges.⁶ Prepandemic, leaders already reported increasing indicators of burnout, including emotional exhaustion and cynicism.⁴ Despite this, leaders rose to pandemic-related challenges,^{6,7} but at significant personal and professional cost—just as Nightingale's nursing sisters experienced in the Crimean war of the 1850s, battling lack of sanitation and supplies and overwhelming numbers of war injured.

Qualitative findings indicate that mounting responsibilities and ethical dilemmas push some hospital nurse leaders to consider alternative careers.^{8,9} Most COVID-19 nursing home research focused on experiences of frontline staff: extreme workloads, exposure to suffering, fear of contagion, and needs for leadership support to mitigate traumatic stress.^{3,10,11} Unique experiences of leaders have

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had little attention. Recent surveys^{11,12} have not distinguished leader experiences from other nursing home staff. Research has focused on outbreak management⁷ and vaccine program implementation¹³; COVID-19's impact on residents, staff,¹⁴ and care quality¹⁵; and perceived challenges¹⁶ and innovative solutions.^{17,18} We do not know how the pandemic experience altered nursing home leaders' career plans. Given staffing shortages prepandemic, loss of nursing home leaders is an ever-growing concern.¹⁹

Canadian Context

Of the 500,000 Canadians living in residential care settings, 425,000 live in nursing homes, retirement homes, and assisted living homes. Of these, 225,000 live in 2076 residential nursing homes²⁰ providing 24-hour residence and health services (generally comparable to skilled nursing homes in the United States). Ownership models, services provided, and cost coverage differ substantially by jurisdiction.²¹ Many of Alberta's 186 homes, for example, are privately owned (27% private for-profit, 27% private not-for-profit).²² In the first pandemic wave, Canada experienced the highest COVID-19 nursing home mortality globally as a percentage of the total population (81%); estimates place current mortality at 43%.²³ More than half of nursing homes reported critical staffing shortages.²⁴

A strong narrative describing experiences of nursing home leaders during the pandemic is thus far missing. A critical first step is solid qualitative reports that explore leaders' daily experiences and professional and personal impacts. The strong person-centered care ethos among contemporary nursing home leaders was likely jolted by pandemic conditions, with potentially serious consequences and existential conflict. These important narratives are scarce and, within the Canadian context, nearly nonexistent.

The purpose of this research was to explore nursing home leaders' experiences during the pandemic, to identify challenges and areas for immediate and longer-term intervention. Secondarily, we sought to identify areas of impact to inform a subsequent survey. Our research question was, What were the experiences of nursing home care leaders during the COVID-19 pandemic?

Methods

This study was nested within a larger mixed methods (interview, survey, resident administrative data) investigation of COVID-19's impact on nursing home staff and residents. *Interpretive descriptive design*²⁵ provided flexibility and clinical focus to access variation across staff. Staff demographic data differed substantially by occupational group (eg, socioeconomically, culturally, language). Interview responses for leaders were sufficiently rich and distinct from other occupational groups to warrant this separate analysis and reporting. This study was approved by the University of Alberta ethics board (Pro00037937).

Setting and Participants

We interviewed 21 leaders as participants: 14 nursing home managers and 7 directors of care (Table 1). Interviews were conducted as nursing homes rolled out COVID-19 vaccination programs (January–April 2021). Leaders were recruited from 7 purposively selected nursing homes in Alberta (within our ongoing Alberta cohort of 35 homes) and 1 in British Columbia, Canada (within our BC cohort). Those cohorts were randomly selected and stratified by ownership model (profit status) and size.^{26,27} We identified the COVID-19 status of cohort homes. Homes with high intensity status had at least 1 severe COVID-19 outbreak between March and December 2020, with

Table 1
Characteristics of Interview Participants and Their Nursing Homes

	n (%)
Managers and directors, n	21
Individual characteristics	
Age, y	
<30	0
30–39	3 (14.3)
40–49	5 (23.8)
50–59	9 (42.9)
≥60	4 (19.0)
Female	19 (90.5)
Highest level of education	
Diploma or certificate	5 (23.8)
Bachelor's degree	14 (66.7)
Master's degree	2 (9.5)
English as an additional language	7 (35.0)*
Born outside Canada	8 (40.0)*
Employment context	
Current role	
Care or program manager	14 (66.6)
Director of care	7 (33.3)
Time employed in current role, y	
Range	0–19
Mean	8.5
Time employed at current nursing home, y	
Range	3–38
Mean	14.9
Working full-time hours	
Prepandemic	19 (90.5)
During pandemic	19 (90.5)
Professional background	
Nursing	17 (81)
Other	4 (19)
Nursing home size	
Small or medium (<120 beds)	9 (42.8)
Large (>120 beds)	12 (57.2)
Nursing home ownership model	
Not-for-profit	16 (76.2)
For-profit	5 (23.8)
Nursing home COVID-19 status [†]	
Low intensity	14 (66.7)
High intensity	7 (33.3)

*n = 20, missing 1 leader response.

[†]Low intensity: no or small outbreaks (sustained <3 months and few resident cases); high intensity: at least 1 severe outbreak (sustained ≥3 months and/or cumulative positive cases reached ≥50% of nursing home capacity/beds).

continuous outbreak status ≥3 months and/or cumulative positive cases reaching ≥50% nursing home capacity.

We emailed invitations and information letters to nursing home directors of care and asked them to share the invitation widely. Participants were volunteers. Verbal consent was recorded before interviews. We continually evaluated the sample to identify when we had reasonable variation in data and could answer the research question with a rich analysis.²⁵

Data Collection

A senior qualitative researcher trained and supported 5 interviewers. Paired interviewers were responsible for interviews within specific subsamples. Interviews occurred in a private space, lasted 40 minutes, and were recorded via telephone or Zoom video-conference.²⁸ We used a continually evolving semistructured interview guide (Table 2). We deliberately followed the participant's lead to start the conversation and their preferences during interviews while monitoring for signs of discomfort. We used interviewing techniques intended to minimize risks of triggering distress for participants, particularly in homes hardest hit by COVID-19.²⁹ Although some participants were emotional, none asked to stop the interview. To end each interview with a positive tone, we asked participants to reflect on

Table 2
Interview Guide Domains and Probes

Regarding the Individual	What has been your experience during the pandemic?
	How has COVID impacted you personally? Good changes as well as less desired changes. How has the pandemic impacted your mental health? Positive/negative as well as effective strategies to cope. How has your physical health been impacted by the pandemic? Probe for exercise, strategies to promote. How has COVID impacted your family or social life? Probe: in domains of family time together, new routines, positive aspects, as well as negative impacts. What strategies have you used to get through this experience? What helps you relax and stay well?
Regarding the facility and workplace	What was it like in the facility when COVID first started (first wave vs now)?
	How has the work you do changed in response to COVID protocols?
Other questions	Has this COVID experience changed your career plans in long-term care? Has it impacted your desire to remain in this sector? Have there been any positive changes throughout the course of the pandemic? If our research team could take one message to decision makers about COVID's impact on long-term care homes, resident care and your work life, what would it be? Is there anything else you want to tell me or that you think we need to understand?

Participants were invited to start the conversation in any area of personal, staff, resident, or organizational impact. Participants were additionally asked to reflect on their perception of pandemic impact on others, specifically their staff and residents. Those data were not included in this study.

positive changes from the pandemic. We listed mental health resources for any participant who needed referral to additional supports. Interviewers created debriefing notes, describing the participant and their main experiences, and methodological notes to continuously refine the interview protocol.²⁵

Data collection and analysis occurred concurrently. Interview data were transcribed verbatim, then cleaned and deidentified by the researcher who interviewed the participant. That person was also the primary analyst. Data were managed and coded with Quirkos 2.4.2.³⁰ We analyzed data with inductive content analysis techniques.³¹ All transcripts were analyzed by at least 2 research team members. The entire team coded the first 10 interviews for congruence. Concurrent data collection and analysis facilitated refinement of interview protocols and coding frames. Twice-weekly collaborative team meetings maintained common direction and resolved interpretive differences. We reported regularly to the larger team (representatives from the Alberta health authority's long-term care section, the continuing care branch of government, nursing home managers, clinicians, researchers providing interpretations and guidance).

Results

Participants (Table 1) identified their role as Care or Program Manager (67%) or Director of Care (33%). Mean number of years worked in their current role was 8.5. Most were female (91%), >50 years old (62%), born in Canada (60%), and identified English as their first language (65%). All reported working at one nursing home before and during the pandemic, with 91% working full-time hours. Just more than half (57%) worked at nursing homes of ≥ 120 beds; 76% worked in not-for-profit homes. Participant characteristics and employment context did not differ by owner-operator model (private vs publicly funded).

Participants identified positive changes from the pandemic: team cohesion, staff personal and professional growth, and personal relations with staff through assuming frontline duties. They noted long-needed changes around care processes, funding, full-time staffing, and technology facilitating family contact with residents. Our analysis identified 4 major themes around pandemic impact on their work and themselves personally, especially stressors experienced: (1) responsibility to protect, (2) overwhelming workloads, (3) mental and emotional toll, and (4) moving forward. Table 3 lists representative quotes by theme.

Theme 1: Responsibility to Protect

Nursing home leaders felt overwhelmingly responsible for protecting residents, staff, and their own families. This led many to

promote infection control, for both themselves and staff, well beyond public health precautions. Leaders described suspending social interactions within their own households and asking staff to do the same (quote 1). Leaders were acutely aware that their actions, and those of their staff and families, could be fatal for residents in their care (quotes 2 and 3).

Infection control added considerably to staff workloads. Staff distress resulted because they lacked time to provide usual resident comfort. Despite leaders' best efforts, COVID-19 spread into most nursing homes. One-third of participants experienced 1 or more severe outbreaks before their interview (quote 4). When first outbreaks hit, leaders reported feeling devastated by their inability to protect staff and residents (quote 5). Leaders feared infecting others and took even more stringent measures to protect their families and communities. One leader described foregoing medical treatment to avoid infecting other health settings (quote 6). Another spoke about isolating in her basement while, upstairs, her father told her young son that she was not home (quote 7). This led to physical and mental exhaustion. After months of working to protect those around them, leaders reported frustration with people who flouted public health restrictions (quote 8).

Theme 2: Overwhelming Workloads

Frequent, short-notice updates to public health orders caused administrative chaos in nursing homes. Leaders universally reported being consumed by planning, implementing, and changing care processes to keep up with government orders (quote 9). Orders requiring all nursing home staff to work only at 1 site significantly affected staffing. Visiting hours were aggressively restricted and few in-person visits by family permitted. Recreational activities were eliminated, and most residents were required to stay in their rooms for up to months. Leaders described learning of new nursing home mandates simultaneously with the public through media announcements, frequently late on Fridays. They scrambled to implement new measures, often by next day. They described wasting time, money, and resources reworking internal processes to comply, only to learn of changes a day later (quote 10). Leaders described "change saturation" that compromised longstanding, trusting relationships with families. Some suspected they appeared disorganized and indecisive (quote 11).

During outbreaks, most leaders worked for many weeks without time off. When staff became ill, some leaders filled frontline roles (quote 12). Others chose not or could not if organizational policy prohibited filling in for clinical staff to reduce COVID-19 spread. Escalating this overwhelming workload was the universal challenge of finding and (harder still) retaining staff in a system that was chronically, severely understaffed *before* the pandemic and that had staff

Table 3
Representative Quotes From Interview Participants

Quote no.	Quote From Nursing Home Leader	Participant no.
Theme 1: Responsibility to protect		
1	I'm being so cautious, I don't want to be the one to bring Covid into this building, and I really think that you need to act with integrity and practice what you preach. We're saying to our staff, you know, "send your husband to the grocery store if you can" and "don't be hanging out at the arena with your kids" and "just keep to your bubble. Don't carpool. Don't do this. Don't do that. And stay home for Christmas." And so, you try to practice that yourself.	P06
2	It's a lot of responsibility, that if you go somewhere and unknowingly get yourself exposed, you have no symptoms, and you come to work, that you really can conceivably kill a lot of people.	P04
3	It's been a challenge with working in long-term care. Particularly for my family. Because as soon as Covid started, I was like, "You guys are—you're locked down. You're not going anywhere." Not only because of the provincial guidelines but because if they get something, I bring it here [facility], it just really kind of weighs on you.	P10
4	It just went through here, like it blew through. We do a hand washing program. . . we had the hand sanitizer. . . we always follow PPE. . . Nothing seemed to matter because within 48 hours it was completely through my unit.	P22
5	The actual day we got the first positive results. That was disheartening. You literally felt like there was, I describe as a kick in the stomach. We had worked so hard keeping COVID out. It was a moment in time, and the first time in my career, that I literally broke down. I broke down, literally. I cried and I cried, and I cried. Because you started seeing your staff, you started seeing your residents dying, and that feeling of being overwhelmed. I can describe it as a feeling of despair.	P18
6	When our unit was on full outbreak, I mean I couldn't see my daughter, my son, my grandkids. I didn't want them to come anywhere near me. I didn't want to go into a grocery store. I was supposed to go for X-rays, I wouldn't go for them because – and for physio, because I just didn't, I never knew if I was a carrier. You know?	P22
7	When we had an outbreak, my mom moved out because of her health condition. So, it was only me, and my dad, and my boy. But it was so hard. . . . Being on isolation I didn't tell my son that I'm still home. I was in the basement. So, I told him that I'm at the hospital; otherwise he won't stay away. And it's so hard for me to hear him but I can't go to him, can't see him. And then when you walk in the house, he asks, "Is COVID still there?" Like every single day.	P17
8	They have no right to put me at risk when I've already battled it. . . . I've already been to hell. You're not going to put me there again!	P22
Theme 2: Overwhelming Workloads		
9	One of the things I found most challenging about this is that the rules change [so fast] your head just spins.	P04
10	I spent probably most of late Thursday and Friday booking our staff into their second dose of their vaccine. And that was, it took a long time. We've organized them all. We've got lists and checklists and we've done the whole thing. And yesterday I got an email saying that all the vaccine second doses are cancelled.	P04
11	Quit doing that on Friday afternoons, because the public expects, if you say there is going to be outdoor visits, they expect them the next morning!	P06
12	There were a few mornings I'd come in when I should have six health care aides and two LPNs [licensed practical nurses] and there was myself and two health care aides to run this floor of 34 patients sick with COVID. It was traumatizing! It was probably the worst experience of my 40 years in nursing.	P22
13	We have no casual pool. It's gone. If people want to go on vacation, they can't, there's nobody to replace them. And when you're trying to hire in a market where you have this restriction of "well, you can only work in one place." And everybody's trying to hire whoever is graduating. It's been very difficult, and I do recognize, I do see the burnout.	P01
14	We were burning them out by working them hours and hours every day, well beyond what they were scheduled, they were burnt out. Like they didn't see it in themselves, you know? Like some of that was a challenge too.	P11
Theme 3: Mental and Emotional Toll		
15	You don't understand. We're here, we're coming into this place every day. Scared spitless. . . I've never felt that level of anxiety.	P07
16	I just feel tired all the time but don't sleep well. Like you're tired but you go lay in bed and then you don't sleep, and things run through your mind. It's been hard.	P10
17	It just feels like it's 24/7/365 and I feel tired. It just never stops or goes away.	P12
18	I just don't know if I have it in me to do this again. The adrenaline gets going and the amount of work we accomplished in hours a lot of days. . . or on a Saturday night, we're still here! I don't know if I can mentally handle that again.	P11
19	That's my ethical dilemma. . . as a manager I follow the rules and make sure they are all followed, infection control, social distancing, but when I actually look at my residents as people, I am asking myself, did we do the right thing for them?	P21
20	Not being able to give [family members] a hug and console them, and we're looking at each other through the masks and everything, seeing the tears coming down their eyes and I'm trying to stay strong for my staff. You're crying inside, you're crying for their loved one.	P22
21	There are still a couple of our staff members out with post-COVID related symptoms, very serious ones. Those. . . are the ones that [colleague] and myself, we carry lots of guilt over and we can't change it, but I mean, they were staff that we redeployed.	P11
Theme 4: Moving Forward		
22	We've got to be mindful of how we really want to treat our elderly. What type of level of care do we want to provide for our elderly moving forward? I think the government has to stop and have a clear look at that.	P18
23	Adequate funding so that we can actually provide the care that these poor people need, not just during COVID.	P05
24	If we don't learn, if we don't change things from this, then it's just going to be a repeat. There's no reason we won't repeat it again.	P04
25	I believe the things that I've witnessed, and been part of, will impact me for the rest of my life. I think it's made me move up my retirement date to tell you the truth.	P11
26	I'm out of here. I don't care. I don't care if I can't afford it. . . . I just don't care. Not that I don't care about the people here, but in all of my years of nursing, I have never worked this hard.	P07

resigning or reducing working hours to protect themselves. Government policies aggravated this, requiring nurses and care aides to work in only 1 nursing home; calling on staff to move to full-time hours depleted numbers of casual and agency staff (quote 13). Solutions such as refusing vacation time, mandating overtime, and asking for extended shift hours all contributed to frequency and incidence of staff sick leave and absenteeism and to mounting worry by leaders about safe staffing levels (quote 14).

Theme 3: Mental and Emotional Toll

All participants had increased strain on mental health, reporting symptoms of anxiety, depression, and insomnia (quotes 15 and 16). They described exhaustion and monotony as the pandemic persisted (quote 17). With new pandemic waves, leaders questioned their ability to carry on (quote 18). They handled pandemic work during business hours and regular work on evenings and weekends, foregoing

socializing, recreation, and rest. Leaders grappled with their decisions and measures they had enforced under government orders. Several referred to prisonlike conditions in their nursing home and struggled with ramifications for residents of infection control protocols (quote 19). They expressed profound guilt and sadness for family members unable to visit declining or dying loved ones (quote 20). They expressed significant sustained guilt when staff became infected (quote 21).

Theme 4: Moving Forward

The central message from participants to decision makers, across all interviews, was to do better for our older adults and for those who care for them: “Don’t forget about long-term care.” (P01). The pandemic forced governments and the public to see, hear, and feel problems that had been worsening for years (quote 22). Many leaders expressed concern about postpandemic loss of focus on nursing homes by legislative, policy, and service leaders and about need for adequate funding (quote 23), fearing inaction (quote 24). With pandemic workloads and stresses, some leaders considered retiring months or years early (quotes 25 and 26). Others, typically early-career leaders, saw their work and organization as their calling regardless of personal cost.

Discussion

The first COVID-19 wave devastated Canada’s nursing homes, with the proportion of resident deaths vs total country deaths higher than any other country.¹⁹ Participants in this study were terrified that COVID-19 would spread to their nursing home residents and did everything in their power to prevent infection. Some leaders avoided care units, fearing cross-contamination, but leaving staff and residents without sufficient resources and vastly diminished person-centered care. Others stepped into frontline roles, risking infection spread among staff and residents. Their heightened remorse and despair when outbreaks struck added to cumulative stress. They perceived that strictly curtailed care violated their values about care quality and led to deterioration among isolated residents. They described symptoms of anxiety, depression, and guilt unique to their leadership role. They held the burden of responsibility for consequences of isolating residents, barring families from being with dying loved ones and putting staff in harm’s way.³²

Our results resonate with findings from surveys of frontline nursing home staff¹¹ and interviews with hospital leaders⁹ reporting frustration with ever-changing guidelines, heartbreak and grief, and feeling overwhelmed, exhausted and helpless. Leaders attempted to minimize distress in front of their residents, families, and staff, relying on peer support, but this became less sustainable over time. Ahokas and Hemberg³² interpret similar reports by care leaders as “moral distress.” Inner conflict was palpable when leaders in our study described trying to reconcile severe isolation practices with person-centered care for quality of life. Such conflict and moral distress contribute to leaders’ burnout and potentially to intentions to leave, with real possibilities of adverse impacts on quality of care.³³

Emerging literature indicates that grief associated with isolating residents, inability to maintain care processes and rituals around resident death, constant uncertainty, self-blame about infection, and guilt about reduced quality of care can lead to prolonged, complicated grieving that parallels that of residents and families.^{34,35} This pandemic forced broader acknowledgment that health care providers cannot ignore self-care,³⁵ but leaders in our study did not enact this message during the first pandemic year. This study provides evidence of detrimental impact from this pandemic on mental health and emotional well-being of nursing home leaders.^{10,36–39}

Leaders described exhaustion from implementing and communicating continuously changing, often conflicting, government guidance. Mounting administrative duties and unprecedented staffing challenges pushed leaders to and beyond capacity. Inability to take leave and dramatically increased work hours with pandemic workloads intensified exhaustion and anxiety.³⁴ These findings parallel recent research reporting managerial perspectives on logistics of pandemic preparedness, policy and program implementation, and promising practices spurred by pandemic conditions.^{7,13,16–18,40,41}

Our findings relate to those of White et al¹² although methods and data differ. Our study was conducted in early 2021 and White collected data in early 2020. White reported on a convenience sample of nursing home staff recruited online. We used (virtual) interviews with volunteer leaders from 8 purposively selected homes within our ongoing cohort. White analyzed survey data from 4 open-ended questions to 152 nursing home employees; 60 self-identified as having supervisory or management responsibilities but were not necessarily managers. Although White et al did not report manager data separately, they highlighted challenges similar to ones we report: navigating regulatory changes, administrative burden, concern for residents, burnout, and workforce strain. Participants in White’s early 2020 survey reported significant concerns about personal protective equipment. Our participants did not note PPE shortages, which had dissipated by early 2021. White also reported issues with public blaming of staff and lack of recognition. We saw some of the latter, but public blaming of staff did not emerge in our data. Our findings add to those of White et al, indicating similarities between countries and differences between pandemic stages. Retaining nursing home leaders is clearly a significant concern in both the United States and Canada.

Nursing home leaders were expected to carry both regular and pandemic-related duties and heavy workloads while witnessing and addressing reactions of residents, families, and staff. In early 2021, no end was in sight, creating an unsustainable situation. Reports of impact on health care staff still contain little on leaders in nursing homes (or elsewhere). We urgently need to clearly identify unique needs of leaders and strategies to support their health and their ability to fulfill their responsibilities. Our results add depth to survey-generated findings and those of White et al while contributing Canadian perspectives on nursing home leaders’ experiences.

The COVID-19 pandemic stretched the nursing home sector and many of its leaders to breaking. One recent survey of nursing home managers (n = 301) found that 1 in 5 considered quitting their profession often or very often during the pandemic.⁴² This is consistent with career-ending dilemmas, which many of our participants revealed in *why* they considered leaving the sector. Leaders in our study were, on average, within 5–10 years of retirement. As the pandemic wears on and more leaders consider options, the sector is at considerable risk of an exodus that would jeopardize operational effectiveness, care quality, and resident quality of life.

Strengths and Limitations

Our results are from an unambiguous leader sample in nursing homes, not rolled into findings from multiple groups. Responses were likely influenced by interview timing (January through April 2021), immediately after Canada’s prevaccination period (March 2020 to early 2021). Follow-up interviews with leaders would deepen understanding of their experiences in later pandemic phases. Pandemic restrictions necessitated virtual data collection. We experienced intermittent technical difficulties with Internet bandwidth and lack of participant familiarity with the videoconferencing platform, which may have affected interview quality. Staffing and pandemic realities necessitated brief interviews.

Conclusions and Implications

This study describes mental and emotional distress and overwhelming workloads experienced by nursing home leaders during Canada's prevaccination waves of COVID-19. Leaders' reports reflect deeply committed people under unusually high stress, juggling safety of their residents, their staff, their families, and themselves under difficult conditions. Their descriptions of their experiences suggest that leaders, critical to successful nursing home operations, feel guilt from not controlling the uncontrollable during the pandemic. They are exhausted from unrelenting workloads and at risk of leaving their jobs and profession prematurely. Leaders see system authorities and policy makers as critical to ensuring resources for adequate staffing and action, to properly support leaders in their roles and under unique pressures.

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