



Relatives experiences during the COVID-19 pandemic: A qualitative study set in Spanish locked-down nursing homes

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Abstract

Aim: To describe the experience of relatives of residents with dementia residing in locked-down nursing homes during the first outbreak of the COVID-19 pandemic, concerning their relationships with nurses and the nursing care applied.

Methods: A qualitative descriptive study was carried out and purposive sampling was applied. Participants were first- and second-degree relatives of residents with dementia, who lived permanently in a nursing home and who were admitted prior to the COVID-19 pandemic. Sixteen participants, of which 10 were women (mean age 57.1 years), participated in the study. Data were collected through in-depth interviews and reflective notes, using a digital platform. An inductive thematic analysis was carried out. This study was approved by the University Research Ethics Committee and followed the COREQ guidelines. The Guba and Lincoln criteria (credibility, transferability, dependability, and confirmability) were applied for quality control.

Results: Families' relationships with nurses before the first wave relied on closeness and involvement in care. Families had difficulty maintaining a close relationship with nurses due to turnover and lack of time. The nursing care applied in the first wave resulted in limited family access to the nursing home, limited contact time with residents, and limited close physical contact.

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Conclusions: The first outbreak has affected the relationships among relatives and nurses in nursing homes. Changes should be made in the organization of care within nursing homes in order to adapt to restrictions due to the pandemic.

KEYWORDS

COVID-19, dementia, family, nursing care, nursing homes, qualitative research

1 | INTRODUCTION

The family is an essential support for the care and support of people with chronic neurological diseases such as dementia (World Health Organization, 2020a). Dementia is defined as a chronic, progressive syndrome of cognitive impairment and behavioral disturbances that interferes with activities of daily living (World Health Organization, 2020b). Currently, 47 million people worldwide suffer from dementia and the number is expected to triple by 2050 (Emmady & Tadi, 2021). Dementia is a major public health burden which significantly increases the costs of care for both the individual and society. Dementia has significant social and economic implications in terms of direct medical and social care costs, and the costs of informal care. In 2019, the estimated total global societal cost of dementia was US\$1.3 trillion. This amount is equivalent to 1.1% of the world gross domestic product (GDP) (World Health Organization, 2020a). In addition, families are exposed to disruptive behaviors in some types of dementia and to caregiver overload (World Health Organization, 2020a, 2020b). Even for nurses working in nursing homes, it involves continuous adaptation, development of competencies and overcoming continuous challenges (Piirainen et al., 2021).

Currently, approximately 32 million persons with dementia live in the Americas and the Asia-Pacific, accounting for two-thirds of the world's dementia population (Sun et al., 2020). Within the countries of the Asian region (South-East Asia and the Western Pacific Region), only Japan, the Republic of Korea, Indonesia, have national dementia plans (Sun et al., 2020). A universal healthcare system, >14% of the population 65 years of age or older, or high-income were factors related to having a national dementia plan. Inconsistencies included development of information systems for providers of long-term care (Indonesia, Japan), undergraduate and graduate education and training for healthcare professionals (Japan), and dementia as a public health priority (Republic of Korea) (Sun et al., 2020). In Europe, different dementia care strategies exist and vary according to the economic resources and the organization of health and social care in each country (Alzheimer Europe, 2018). All countries shared the need for coordination of social-health care and

other support in the community setting, and between different levels of health care (primary care with specialized care-hospitals). In relation to the care of patients with dementia in residential and long-term care, there are differences between European countries. Some countries encourage the development of special dementia units (Greece), others enhance the use of community care in their homes, and the use of shared housing (Norway and Sweden), in others, institutionalization in nursing homes oriented to a friendly environment is an essential link in dementia care (Malta) (Alzheimer Europe, 2018). In Spain, nursing homes are the main option for the social and health care of people with dementia (Institute for the Elderly and Social Services [IMSERSO], 2018), offering accommodation and maintenance services through multidisciplinary teams led by nurses, who are responsible for the physical, psychological, functional and social care of residents (Spanish State Official Newsletter, 2018). Moreover, families play a fundamental role in the admission, planning, follow-up and care of the resident (Palacios-Ceña et al., 2019). Family members in Spain who assume the care of older people, are mostly daughters and/or wives, with a small proportion of other members such as siblings and grandchildren (Crespo Lopez & Lopez Martinez, 2007, 2008).

On March 11, 2020, the WHO declared COVID-19 a pandemic, caused by the new coronavirus, known as SARS-CoV-2 (World Health Organization, 2020b). Like many other countries, due to the rapid progression of the virus, the Spanish government declared a state of alarm, limiting the free movement of people and establishing the confinement of the population, including older people in nursing homes (Spanish State Official Newsletter, 2020a; Spanish State Official Newsletter, 2020b). Previous studies show how the COVID-19 pandemic had a great impact on the older population with dementia (Meyers et al., 2021), with an increased risk of infection and death in hospitals and nursing homes (Rutten et al., 2021), and decreasing home care and use of resources (Vislapuu et al., 2021). Due to the risk posed by the residents (Fang et al., 2020), nursing homes adapted their organization to implement measures to reduce the risk of contagion (Spanish State Official Newsletter, 2020b), such as confinement and restriction of visitors. Confinement has been associated with increased

stress and worsening cognitive ability in residents with dementia (Paolini et al., 2021). In addition, restriction of visits has been one of the measures applied internationally in nursing homes (Palacios-Ceña et al., 2021; Verbeek et al., 2020). This restriction has affected the well-being of families and residents who have experienced the separation of their loved ones with uncertainty (Paananen et al., 2021; Verbeek et al., 2020).

A key aspect of the well-being of families and residents during the pandemic was the relationship built with nurses (Palacios-Ceña et al., 2021). Previous studies show how nursing home professionals, including nurses, presented difficulties when adapting their care to the demands of the pandemic, hampering the direct care of patients and reducing any form of physical contact, while establishing creative interventions to make up for this distancing between nurses, residents and families (Palacios-Ceña et al., 2021). At present, qualitative studies that have addressed the experiences of families and elders who have lived in nursing homes during the COVID-19 pandemic are scarce, with most focusing on the perspectives of professionals working in nursing homes and long-term care facilities (Palacios-Ceña et al., 2021). In addition, The International Alzheimer's and Related Dementia Research Funder Consortium (Meyers et al., 2021) recommends further study of the effect of the pandemic on people with dementia and their families, especially during the confinement period. Therefore, what was the perspective of family members who had their loved ones with dementia living in a nursing home during the first wave of COVID-19? How was their relationship with the nurses in the nursing home and the care provided by them? The aim of this study was to describe the experience of relatives of residents with dementia who lived in locked-down nursing homes during the first outbreak of the COVID-19 pandemic (March 14 to June 21, 2020) concerning their relationships with nurses and the nursing care applied.

2 | MATERIAL AND METHODS

2.1 | Design

A descriptive qualitative study was conducted (Creswell & Poth, 2018; Korstjens & Moser, 2017). The recommendations established by The Consolidated Criteria for Reporting Qualitative Research (COREQ) were followed (Tong et al., 2007). The study was approved by the Clinical Research Ethics Committee of Universidad Rey Juan Carlos (code: 1001202101421; data: February 22, 2021). Informed consent and permission to record the interviews were obtained from every participant. Furthermore, the study was conducted in

accordance with the principles articulated in the Helsinki Declaration (World Medical Association, 2013). The present study led by a nurse researcher (DPC) and conducted by an interdisciplinary team of health science professionals (two occupational therapists, three physical therapists) working with older people and long-term care.

2.2 | Context

The present study was conducted during the first wave of COVID-19 (March 14 to June 21, 2020). In Spain, the lockdown was activated at the national level, restricting the movements of all citizens (Spanish State Official Newsletter, 2020a). In nursing homes, it meant that families were forbidden to enter and could not visit their loved ones under any circumstances, only nursing home professionals could enter (Spanish State Official Newsletter, 2020b), and families depended on nurses for information on the state of health of their loved ones. At the discretion of the management team of each residence, only one family member could be allowed entry once a day, for a very limited period of time, with restriction of physical contact to their loved one, maintaining a safe distance and wearing individual protective equipment.

2.3 | Participants, sampling strategies and sample

Purposive sampling was applied, which consists of going to places and/or contexts where relevant information is expected to be obtained to answer the study question (Moser & Korstjens, 2018). In qualitative studies there is no formula for the prior calculation of the sample size, as there is no intention to extrapolate the results or calculate statistical significance. To determine the number of participants, the criterion of redundancy of information was used (Moser & Korstjens, 2018), in which the inclusion of more participants or data collection phases does not provide further relevant information to the study. Ultimately, a total of 16 participants were involved in this study.

Inclusion criteria: (a) a family member who had a loved one who was living permanently in a nursing home (in this study, the term "residents" is used); (b) the family member was either a first-degree relative (father/mother, son/daughter, father-in-law, mother-in-law, son-in-law and/or daughter-in-law) or second-degree relative (grandchild, brother/sister, brother/sister-in-law), as established by the Spanish Civil Code; (c) residents admitted prior to the official start of the COVID-19 pandemic in Spain

(before March 14, 2020) (Spanish State Official Newsletter, 2020a); and (d) residents diagnosed with dementia by a neurologist. In Spain, the Civil Code (Spanish State Official Newsletter, 1889) establishes the degrees of kinship between the family members, in order to establish the rights and obligations that the law establishes for each individual in relation to care and protection. Family members of residents who were temporarily in the nursing homes, those who had been admitted after the first wave of the pandemic and third- and fourth-degree relatives were excluded.

Recruitment took place during March and April of 2020. This consisted of the researchers, together with the director of the residence, identifying the families that met the inclusion criteria and contacting them by telephone. The families that agreed to participate were consecutively enrolled in the study.

2.4 | Data collection

Data collection between May and June 2020 was conducted through in-depth interviews with open-ended questions and reflective notes made by the researchers (MSPJ, CJA) (Creswell & Poth, 2018; Moser & Korstjens, 2018) (Table 1). The interview question guide was developed based on previous studies, without conducting a pilot test (Palacios-Ceña et al., 2021).

In Spain, due to the social distancing measures and lockdown due to COVID-19, the data collection was carried out using the Microsoft Teams platform. The online platform enabled the option to record the interview in audio and/or video. All participants gave consent for the recordings and were informed that only the investigators had access to these recordings. Interested participants were emailed the informed consent and information sheet a few days before the interview. The participant returned the signed consent form by email prior to the interview. In addition, on the day of the interview, the participant was again asked for verbal confirmation for permission to audio-record (required) and video-record (if desired) the interview. All participants chose to conduct the interview with audio only, and with the camera turned off (no video recording). Confidentiality was assured by consecutively numbering each interview and removing identifying information from the transcripts. All audio recordings and transcripts were saved on a password-protected computer with restricted access only by the researchers. Pseudonyms were used to report the results to maintain confidentiality. An interview was scheduled for each participant. The mean duration of the interviews was 55 min. Sixteen interviews were conducted, one for each participant.

TABLE 1 Semi-structured question guide

Area to be researched	Question to be asked
Relationship with nurses	How is your relationship with the nurses in the nursing homes? And with nursing care? What is most relevant or important to you?
Barriers and facilitators of the nurse-family relationship	What barriers and/or facilitators do you encounter in building a relationship with nurses? What barriers and/or facilitators do you encounter in accepting nursing care? What is most relevant to you?
Relationship with residents	What has your relationship with your loved one been like during confinement due to the pandemic? What is most relevant to you?
Barriers and facilitators of the resident-relatives relationship	What barriers and/or facilitators do you encounter in maintaining a relationship with your family member? What is most relevant to you?
Impact of the COVID-19 pandemic	Do you think the pandemic has affected your relationship with professionals and your loved one? What has been most relevant for you? How have you experienced having limited access and contact with your loved one during the confinement throughout the first wave of the pandemic due to COVID-19? What has been most relevant for you? Could you indicate those moments or situations that have been critical and that you have experienced intensely?

2.5 | Analysis

An inductive thematic analysis was performed (Creswell & Poth, 2018; Moser & Korstjens, 2018). Each interview was transcribed verbatim. This material was analyzed together with the researcher's notes. A thematic analysis was applied by distinguishing relevant content to identify codes, which were then grouped into clusters with common meanings (categories). The final result of these categories were the themes that describe the participants' experiences. The thematic analysis was conducted separately for the interviews and the researcher's notes. Also, double, and independent coding was performed by

TABLE 2 Sociodemographic data of participants and residents

	Participant gender	Participant age	Degree of kinship with resident	Years living in nursing home	Overall decline GDS-FAST of resident	Time since diagnosis of dementia	Duration of interview (min)
P1	F	52	First	5 years	6	2014 (7 years)	61
P2	F	51	First	6 years	6	2014 (7 years)	58
P3	F	61	First	4 years	6	2008 (13 years)	46
P4	F	58	Second	7 years	6	2014 (7 years)	59
P5	M	63	First	12 years	6	2008 (13 years)	57
P6	F	61	Second	12 years	6	2008 (13 years)	55
P7	M	54	First	6 years	6	2014 (7 years)	42
P8	F	56	First	6 years	6	2014 (7 years)	41
P9	F	57	First	3 years	5	2016 (5 years)	50
P10	M	57	First	5 years	5	2012 (9 years)	61
P11	M	54	First	5 years	5	2012 (9 years)	45
P12	F	61	First	6 years	6	2012 (9 years)	66
P13	F	43	First	6 years	6	2011 (10 years)	68
P14	F	73	First	6 years	6	2011 (10 years)	70
P15	M	60	First	11 years	6	2010 (11 years)	63
P16	M	59	First	5 years	6	2015 (6 years)	45

two investigators (DPC, MSPJ) from the research team. The independent coding consisted of two investigators performing coding separately and without sharing coding files. After completing their coding, they then met to discuss, compare and for a round of refinement. Subsequently, the result of each analysis was integrated into an analysis matrix and, through analysis meetings between the researchers (DPC, MSPJ, CGB, RMMP), final themes were identified (Creswell & Poth, 2018; Moser & Korstjens, 2018). In the case of differences in opinion, theme identification was performed based on establishing a consensus among the research team members. No qualitative software was used to analyze the data. For the analysis, the Excel program was used to organize and share the coding process.

2.6 | Quality criteria

Guba and Lincoln's criteria (Korstjens & Moser, 2018) were applied: (a) credibility: triangulation by investigators, use of multiple qualitative data collection (interview transcripts, quotations and researcher notes), and participant validation; (b) transferability: in-depth descriptions of the design, participants, context, sampling, data collection, and analysis were provided; (c) dependability: audits of the research protocol were conducted by external

researchers; and (d) confirmability: reflexive reports were recorded in data collection and analysis.

3 | RESULTS

Sixteen interviewees (10 women and six men) were included, with a mean age of 57.1 years ($SD \pm 6.46$) (Table 2).

Three themes were identified: (a) building the relationship with nurses; (b) challenges for maintaining the relationship with nurses; and (c) challenges of nursing care during the first outbreak.

3.1 | Theme: building the relationship with nurses

The families described how, prior to the first outbreak of the pandemic, they were integrated into the dynamics of the center, in aspects such as decision making, being a key link of information between nurses and their loved ones with dementia, establishing relationships with the nurses and other health professionals:

“Before, everything was different, they counted on you for everything, for food, changing positions, his sleep. You

were involved with them [the nurses] to take care of my father.” (P7).

This relationship was considered very positive and was based on the closeness with the professionals and the continuous exchange of information about the care and daily aspects of the residents.

During the first outbreak of the pandemic, the relationship with nurses changed. The interviewees highlighted the loss of contact with nurses and with the designated person in charge of their loved one's care. They were unaware of which nurses continued to work, as they only saw and had a relationship with the professional who was in charge of the visits. As a result, they perceived a distancing and estrangement from the nurses:

“The contact is not the same, only the minimum necessary. The pandemic has alienated us all.” (P2).

The interviewees explained how the nurses tried to alleviate the restrictions by improving communication with the families using video conferencing through digital platforms and applications with nurses' smartphones, and the exchange of information regarding the resident's physical and emotional health status, daily activities within the residence, and the nursing care provided.

“The role of the nurses was essential in helping us communicate with my mother and see her by video call. The nurses gave her their cell phones and set up the video call so we could see each other.” (P6).

In addition, video calls with families were incorporated as part of the scheduled care, to maintain contact between family and residents:

“The days when I could talk to her, I was on a high for the whole week.” (P10).

Moreover, the nursing home management provided regular updates on the condition of the facility, the status of the pandemic within the nursing home (number of residents infected), and measures taken to protect residents. This information was provided only to families who had loved ones in the nursing home and was not for public use.

“Since us families couldn't be there, they tried to keep us informed of everything related to the pandemic within the residence. We were grateful for the information because everything was uncertain.” (P12).

Theme: challenges for maintaining the relationship with nurses.

This theme describes how families struggled to continue to maintain close contact with the nurses in the nursing home. The interviewees described two relevant challenges for them: frequent nurse turnover, and lack of time.

Before the pandemic, the interviewees recounted there was almost no nursing turnover, the staff was

always the same and it was easy to know and get to know the nurse who was caring for their loved ones:

“The best thing was knowing who was responsible for my mother's care, you knew that Lola and Miguel [pseudonyms] were going to be with her, you had reference people to go to and ask questions. In the end you knew them and there was a bond between them.” (P8).

During the pandemic there was a very high turnover of nurses, due to contagion of the virus and work abandonment. Consequently, the previous relationships built with their reference nurses were lost:

“Nurses terminate their contracts, they come and go. It is difficult to have a relationship of trust with them.” (P5).

In addition, interviewees believed that excessive nursing turnover negatively influenced residents, as the routine they established around the nurses who cared for them was disrupted:

“A person with dementia needs a routine, they need to feel and know the caregiver, they get used to the person and how they are treated... All of this is broken.” (P9).

The amount of time nurses spent contacting and interacting with families decreased during the first wave due to excessive workload, this impacted resident care and well-being, and decreased their interaction with families:

“They don't have time. They are always running around, and I can't engage them in conversation because they don't take a break.” (P10).

Moreover, the interviewees avoided “interrupting” the nurses, because it meant taking away time for them to spend with the residents:

“They have a lot of things to do. If I want to initiate a more direct, minimal relationship with any of them, I know I'm taking time away from them being able to attend to a resident.” (P15).

Theme: challenges of nursing care during the first outbreak.

This theme describes how the nursing care applied during the first wave led to difficulties in maintaining the relationship and/or contact between the families and the residents, because it has limited their access to the nursing home, limited their time to stay with the residents and limited their physical contact with their loved one.

Because of the confinement, care was reorganized to curb contagion, and visits were restricted. The interviewees did not readily accept these restrictions:

“I dealt with it so badly. I don't know which is more dangerous, the virus or not having contact with the people who love them.” (P14).

Although the families did not accept the restrictions, they were powerless, as they stood against government directives that supported the decisions made in the nursing homes against COVID-19. “Resignation” is the word most often used to describe their experience of restraint.

This term meant, according to their accounts, being tolerant and patient in the face of adversity, by accepting something unwanted that cannot be changed. However, they viewed these restrictions as necessary to stop the escalation of contagion:

“The only thing you could do was to wait, to be patient in this situation. You became resigned and gave in to everything that was happening, to wait for things to get better.” (P15).

Before the pandemic, the main objective of families was to maintain continuous contact with the resident through frequent visits; to accompany them in their new “world” in the residence, and in their routines and dynamics of the center; and to establish close contact where physical contact was an essential tool. The pandemic broke this contact with the residents and visiting times were limited:

“We only have 20 minutes. You’re stressed out. You pray that nothing happens to make you waste the time you have.” (P10).

Physical contact disappeared: no kissing or hugging due to the risk of contagion. Although the interviewees approved of the safety measures (masks, social distance, etc.), they felt they were distanced from their loved ones and increasingly lost contact. However, the main fear was that their loved ones would die alone and that they would not be able to say goodbye:

“I have suffered for my mother. All I asked is that if she had to leave this world, I could hold her hand and give her a kiss.” (P9).

The interviewees believed that their loved ones would not be fully aware of all these changes in care and restrictions due to their dementia. However, some interviewees considered that, although residents with dementia were not fully aware of the situation, they had been affected by the changes in routine and the lack of physical and emotional contact with their family:

“They may not have been affected by COVID itself, but changing their routine, having less contact with their family and with the nurses who used to take care of them may have affected them in some way.” (P14).

Despite the restrictions, strict visiting times were allowed. All interviewees recounted the need to have physical contact again, to hug, and to kiss their loved ones:

“I felt bad that I couldn’t touch her. I realized that what my mother needed was someone to stimulate her, to touch her. She is not stimulated by someone who is five feet away with his face covered.” (P11).

4 | DISCUSSION

Our results show how families built relationships with nurses and integrated with them to care for their loved

one; however, after the start of the first wave, they had difficulty continuing to have a close relationship with them. Also, nursing care during the first wave limited their access to the nursing home, limited their time spent with residents, and limited their physical contact with their loved one. Following the official declaration of the pandemic, nursing homes adopted restrictive measures to curb the spread of the virus (Spanish State Official Newsletter, 2020b). Thus, according to Frahsa et al. (2020) imposing restrictions to visits was a difficult decision for residents’ relatives to accept, even comparable to imprisonment. This is in line with our findings, showing that this was not a measure easily accepted by the interviewees, who experienced it with resignation. Moreover, Chee (2020) described that the residents felt lonely and isolated from the outside world with this measure, as they could not see their relatives or have contact with the volunteers. In addition, Frahsa et al. (2020) described how due to the restricted visits, family members were no longer involved in the residents’ lives and the various safety measures, such as masks, increased the residents’ sense of loneliness. In addition, they described how the efforts made by professionals were not visible to family members and how family members felt that the nursing homes were more concerned with stopping the contagion than ensuring the well-being of the residents.

Our results show that the nurses provided families with greater information regarding contagions, measures taken and isolation in order to reduce the distance imposed by the restrictions. Cousins et al. (2021) described the families’ concerns about the lack of information provided by the nursing home. In addition, Lázaro et al. (2020) reported that families were puzzled by the contrast between the data presented by the nursing home and the news portrayed by the media or government sources.

According to our findings, after imposing restrictions to visits, nurses used alternative systems of communication between residents and their families. Havaei et al. (2021) described how they began video calls and created a virtual mailbox for exchanging letters between families. In addition, according to Cousins et al. (2021) some nurses moved in and lived at the facility to provide 24-hr support to residents and conduct video calls.

Moreover, once restricted visits to residents were initiated, Verbeek et al. (2020) described that it was an emotional time for the families, and it was difficult for them not to have physical contact and to maintain security measures. Our results concur with the families’ need to hug their loved ones again. Paananen et al. (2021) depicted how families were frustrated because they were unable to touch their relatives or participate in their care, and therefore they sometimes felt that their visits were

useless. Although the new forms of interaction were appreciated, some relatives perceived the interaction protocols as being unfair.

Our results show that some interviewees believed that having dementia protected their elders from being aware of the pandemic. In contrast, Cousins et al. (2021) described how isolation, lack of contact with their families, and the change of routine within the nursing home led to disorientation and distress in these residents. In addition, Leontjevas et al. (2021) showed how the interviewees in their study considered that those residents with mild or moderate cognitive impairment had a worse experience during confinement, in relation to the impact on their emotional state (depression, increased agitation, longing for their loved ones).

Our findings have implications for organization, nursing home policy and nursing care during events such as pandemics. Thus, these findings can help to reorganize and plan care, focusing on the establishment of alternative nurse-family communication measures; the reorganization of care, incorporating the maintenance of continuous contact and stimulation with residents with dementia as a crucial measure; and the incorporation and integration of the family in decision making in situations of restrictions and confinement.

4.1 | Limitations

As this is a qualitative study, the results cannot be extrapolated to all family members of people with dementia living in a nursing home. The reasons why the results cannot be extrapolated not only depend on the nature of the qualitative design, but could also be due to differences in the profiles of the elderly admitted to the nursing homes and/or in the criteria for admission (e.g., nursing homes with residents with a greater or lesser degree of dependency and/or cognitive impairment). Furthermore, qualitative studies tend to discuss their limitation in generalizing the results in terms of nomothetic statistical terms, whereas there is an analytical or idiographic generalization that justifies the value of the results of qualitative studies, and where generalization can be made from and about cases (Vasileiou et al., 2018). Second, the failure to pilot the question guide could influence the results; however, the researchers mitigated this aspect by conducting member checking and giving all participants the option to contribute new information on those aspects they felt needed to be included from their perspective. Third, the non-inclusion of all family members (regardless of their degree of kinship) occurred for two reasons: first, the study focused on the family members who carried the

burden of care before admission, who in Spain were children and spouses (first degree of kinship); and second, the families chose as their interlocutor to participate in the study the member who was responsible for the care of the elderly before admission to the nursing home, which coincided with being children and/or spouses. Data were collected from a single nursing home because this was the only one that agreed to participate during the first wave of the pandemic. Furthermore, although Excel was used for the coding and organization of the data, the use of the computer-assisted qualitative data analysis (CAQDAS) using specific software is also recommended for the qualitative analysis (Moser & Korstjens, 2018).

5 | CONCLUSIONS

The relationships that were built between families and nurses prior to the start of the first wave of COVID-19 have changed, due to difficulties in maintaining contact and rapport between families and nurses, and because of the implementation of “in extremis” nursing care that prohibited and/or limited family access within the nursing home, and restricted physical and temporary contact with residents. Changes need to be made in the organization of care within nursing homes in order to adapt to restrictions due to events such as the COVID-19 pandemic. Examples for changes in nursing practice include enhancing the support and stimulation of the relationship and contact with the residents’ relatives, encouragement of the communication using different strategies and tools (e.g., digital platforms), facilitating the monitoring of nursing care by relatives and promotion of the relative’s integration and determination of their role and involvement in the programmed care. This change in the practice and organization of care should be established jointly, between nurses and families.

AUTHOR CONTRIBUTIONS

Study design: María SALCEDO-PÉREZ-JUANA, Domingo PALACIOS-CEÑA, and Cesar FERNÁNDEZ-DE-LAS-PEÑAS. Data collection: María SALCEDO-PÉREZ-JUANA, and Carmen JIMENEZ-ANTONA. Data analysis: Domingo PALACIOS-CEÑA, María SALCEDO-PÉREZ-JUANA, Cristina GARCÍA-BRAVO, and Rosa María MARTINEZ-PIÉDROLA. Study supervision: Domingo PALACIOS-CEÑA, Cesar FERNÁNDEZ-DE-LAS-PEÑAS, and Rosa María MARTINEZ-PIÉDROLA. Manuscript writing: Domingo PALACIOS-CEÑA, María SALCEDO-PÉREZ-JUANA, and Cesar FERNÁNDEZ-DE-LAS-PEÑAS. Critical revisions for important intellectual content: María SALCEDO-PÉREZ-JUANA, Cristina GARCÍA-BRAVO, Carmen JIMENEZ-ANTONA, Rosa María MARTINEZ-

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CONFLICT OF INTEREST

The authors declare there is no conflict of interest.

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