RESEARCH PAPER

Perspectives from the Netherlands: Responses from, Strategies of and Challenges for Long-Term Care Health Personnel

Regard sur les Pays-Bas : réactions, stratégies et défis chez le personnel de santé des soins de longue durée

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Abstract

The outbreak of the COVID-19 crisis severely afflicted the Dutch long-term care sector. To protect vulnerable residents of nursing homes the government took several measures, of which the complete nationwide visitors' ban was the most restrictive. These measures had not only a large impact on residents but they also greatly impacted nursing home personnel. Based on a descriptive review and a few interviews, this paper discusses the measures taken in the Dutch long-term care sector and the challenges healthcare personnel encountered in terms of workload and well-being. It further explores the strategies that were implemented to support personnel to cope with these challenges.

Résumé

La crise de la COVID-19 a gravement touché le secteur néerlandais des soins de longue durée. Pour protéger les résidents vulnérables des foyers de soins, le gouvernement a pris plusieurs mesures, dont l'interdiction complète des visiteurs à l'échelle nationale était la plus restrictive. Ces mesures ont non seulement eu un impact important sur les résidents, mais elles ont également eu un impact important sur le personnel des foyers de soins. Sur la base d'un examen descriptif et de quelques entretiens, cet article examine les mesures prises dans le secteur néerlandais des soins de longue durée et les défis rencontrés par le personnel de santé en termes de charge de travail et de bien-être. Il explore en outre les stratégies qui ont été mises en œuvre pour aider le personnel à faire face à ces défis.

Introduction

As in many other countries, the Dutch long-term care (LTC) sector, already struggling with serious staffing issues, was severely afflicted by the COVID-19 pandemic. High rates of infections in nursing homes left residents susceptible to severe and oftentimes fatal complications due to their frailty and co-morbidities (van der Roest et al. 2020). In order to curb the rising infection rates, the Dutch government undertook several measures, including a visitor ban in all homes for the elderly (Schols et al. 2020). These measures had a large impact on residents who, without being able to go out or receive visitors, became socially isolated and lonely.

Simultaneously, COVID-19 response measures greatly impacted the healthcare personnel caring for nursing home residents. Staff were faced with an increased workload, often having to complete tasks with little to no access to personal protective equipment (PPE). Coupled with a shortage of healthcare personnel and testing materials, nursing home personnel were put under significant mental and physical stress to continue caring for susceptible residents. However, public recognition of the challenges that nursing home personnel encountered was rather low. According to nursing home associations, this lack of awareness is symptomatic of the low societal and political value accorded to the LTC sector in the Netherlands, creating concerns for elder care staffing, among other issues, in the long run. This paper will discuss the implications of the COVID-19 crisis for nursing home personnel and examine responses to these challenges.

Long-term elderly care in the Netherlands

The Dutch LTC scheme aims to institutionalize only the frailest of patients that require 24-hour care, encouraging the rest of its elderly population to remain at home and actively "age in place" (Alders and Schut 2019). Nursing homes, alongside other forms of LTC facilities, therefore, only provide care for the most vulnerable people in Dutch society (Verbeek et al. 2020).

The Dutch LTC system is divided into three acts: the *Social Support Act* (*Maatschappelijke Ondersteuning*, WMO) (Rijksoverheid 2015), the *Health Insurance Act*

(*Zorgverzekeringswet*, ZVW) (European Commission n.d.) and the *Long-Term Care Act* (*Wet Langdurige Zorg*, WLZ) (Government of the Netherlands n.d.). The WMO decentralized LTC to municipalities, aiming to strengthen the roles of social networks in the provision of care, and supporting elderly citizens to continue participating and living in society. Entitlements include home help, transport facilities and house adjustments (Kroneman et al. 2016). Only when their social networks are insufficient or incapable of providing care is an individual eligible to receive formal care, thereby allowing publicly funded support to become available (Alders and Schut 2019; Kroneman et al. 2016). The ZVW offers home nursing and personal care for citizens who require care for less than 24 hours per day (Kroneman et al. 2016). This act included community nursing as a benefit in the Dutch mandatory health insurance schemes, improving incentives for coordination between community nursing, primary care, rehabilitation and hospital care for the elderly (Kruse et al. 2020a). In line with one of the main aims of the 2015 LTC reform, these acts organize care closer to the citizens in their communities, thereby containing costs and enabling tailor-made solutions that are more efficient for all stakeholders involved (Kroneman et al. 2016). The WLZ provides care to the most vulnerable people of Dutch society. With strict eligibility requirements, only someone who requires 24-hour supervision or care in the vicinity can receive WLZ benefits. Care under the WLZ can be provided at home – as long as it is safe and healthy for the individual to remain at home – or within a residential care institution, such as a nursing home for the elderly (Alders and Schut 2019).

All Dutch residents are automatically insured for LTC under the WLZ. Healthcare financing is primarily public, through premiums, tax revenues and government grants (Wammes et al. 2020). There are currently around 2,348 nursing homes throughout the Netherlands offering care for the elderly (Zorgkaart Nederland 2021). In 2019, there were 115,394 elderly residents with high-level care needs institutionalized within nursing homes (CBS 2020).

To receive WLZ benefits, the Care Needs Assessment Center (abbreviated Ciz in Dutch) evaluates whether the individual has met all conditions for WLZ care – including the need for 24-hour care or supervision – and issues a WLZ-care needs assessment, stating that this person is entitled to LTC (Government of the Netherlands n.d.). The elderly within nursing homes are provided with a supportive and home-like environment, equipped with care to maintain their functional abilities for as long as possible (Backhaus 2017). Residents receive access to 24-hour health and personal care by multidisciplinary care teams, including nurses, nursing home physicians, psychologists, dietitians and more (Schols et al. 2020). Unique to the Netherlands are these specially trained nursing home medical physicians, providing medical care to nursing home residents. Most of the 24-hour care or supervision is provided by nursing staff composed of registered nurses, certified nurse assistants and nurse aides (Backhaus 2017).

Methodology

To investigate the implications of the COVID-19 crisis on nursing home personnel, the authors undertook a descriptive review combined with several interviews with nursing home personnel. Descriptive reviews are a qualitative tool used to determine the extent to which a pattern or trend can be found in a series of texts (Paré and Kitsiou 2017). A systematic search in Google Scholar was conducted over the period of March 2020, the start of the pandemic, until September 2021. The search terms used were *COVID-19, nursing home, long-term care, the Netherlands*. The Google Scholar platform was selected because professional publications and research reports in Dutch are better covered and more accessible on Google Scholar in comparison with PubMed. An additional search in PubMed with the same search terms did not result in additional sources.

The search resulted in 37 sources. The authors scanned all papers to investigate whether they met the inclusion criteria: a Dutch national focus, COVID-19 response measures, information on the first wave and relating to the LTC sector. There were no other exclusion criteria. All 37 sources were included in the analysis. For the analysis, the second author coded information resulting in the following main themes: national measures, consequences of COVID-19, measures taken in nursing homes, different types of challenges encountered by nursing home personnel and support structures to address the challenges. Based on the first coding, the second author identified patterns and similarities in the sources. These patterns were discussed with the other authors. These trends are presented in the Results section of this paper.

Because this review was done shortly after the start of the pandemic, the authors undertook six semi-structured interviews with different Dutch LTC personnel (a director, two team managers, two members of nursing staff and a vocational therapist) to check whether important trends were missed in official publications. These interviews also helped contribute to a more detailed understanding of the challenges discussed in the literature on a rather general level. The interviewees worked for three different nursing home organizations in different parts of the Netherlands. This selection was made to have a representation of the different levels (direction, management, work floor) of the nursing home organization. A semi-structured interview format was chosen due to its fluid and interpretative nature. During the interviews, the researcher asked a list of predefined questions in addition to open-ended and responsive questions as to what had just been said, allowing the interview to venture into new topics and reveal new insights (Wilson 2013). This provided the researcher with the freedom to explore new ideas and perspectives, bringing to light issues the researcher had not previously anticipated or encountered (Braun and Clarke 2013).

Participants were recruited through a public LinkedIn post and thereafter through a snowball technique to recruit additional participants from the acquaintances of individuals interviewed. Interviews were recorded on a mobile phone and later transcribed semi-verbatim into a Word document. All interviewee names were changed to ensure anonymity. The

authors received ethical approval (#FHML-REC/2021/003) from the Maastricht University Ethics Board for the interviews conducted. For the analysis of the interviews, the authors used the same themes found in the descriptive review. All themes and trends found in the review were confirmed by the interviews. The analysis of the interviews did not reveal major gaps but did contribute to a better understanding and additional insights. The following section will present the results of the descriptive review and interviews. The authors only refer explicitly to the interviews when discussing points that were not found in the literature. We refer to the interviewees with an initial and a number: D = director; T = team manager; N = nursing staff; V = vocational therapist.

Results

COVID-19 and protection measures in LTC homes

The outbreak of COVID-19 within the Netherlands posed significantly higher risks to the vulnerable residents institutionalized within nursing homes (Kruse et al. 2020a). The Dutch response primarily aimed to slow the spread of the virus, avoid a demand peak on the strained healthcare system and protect vulnerable population groups – primarily the elderly (Kruse et al. 2020a). Within the first wave, Dutch nursing homes registered 10,287 COVID-19 positive patients, with 1,915 recorded deaths (Verenso 2020b). With restrictive testing policies during the first few weeks of the first COVID-19 wave, figures are estimated to be higher (Schols et al. 2020).

In order to reduce the infection risks, several measures were taken. From the start, the general behavioural guidelines, such as hand washing and no handshaking that were enforced by the Dutch government, were implemented in nursing homes as well. With a rising number of cases, as in many other countries, the Dutch government created a nationwide visitor ban in all homes for the elderly (RIVM 2020). From March 19 to May 25, 2020, nursing homes closed their doors to visitors and non-essential working staff to protect the vulnerable inhabitants from contracting COVID-19 (Gerritsen and Voshaar 2020). This visitors' ban prioritized curbing the number of infections, replacing physical visits with calls and putting social and daytime programs on hold (van der Roest et al. 2020). Despite the visitors' ban, by the first week of April, around 40% of nursing homes reported COVID-19 infections, with over 200 resident infections a day (Sizoo et al. 2020).

In line with national measures, Dutch nursing homes followed the regularly updated COVID-19 directives developed by Verenso, the Dutch Association of Elderly Care Physicians (2020b). Information on how to act with a (suspected) case of COVID-19, including testing, isolation procedures and treatment, was disseminated across the Dutch LTC sector. Internal crisis teams within nursing homes worked to optimize communication, review infection control practices and implement new protocols for staff (Schols et al. 2020). To reduce the infection risk, many homes introduced rather strict compartmentalization, where healthcare personnel were allowed to visit only one department during their shift.

In most homes, residents infected with (suspected) COVID-19 were treated within their rooms as much as possible, whereas some nursing homes chose to create COVID-19 positive and negative zones to better manage the sick residents (Schols et al. 2020).

For the care of sick patients, the regular guidelines on treating viral respiratory tract infections and administering oxygen were followed, in addition to the advanced care planning treatment preferences of residents (Federatie Medisch Specialisten 2021; Schols et al. 2020). Upon recovery, residents could leave isolation when they no longer displayed any symptoms for at least 24 hours, had had no fever for 48 hours and if the start of the first symptom had been at least 14 days ago (Schols et al. 2020). Seriously ill residents unable to recover were provided with in-house palliative care and were granted special permission to receive visitors despite the nationwide nursing home visitor ban (Government of the Netherlands 2020).

Specific protocols were developed for the use of PPE, such as face masks, gloves and face shields. Nursing home personnel worked in close proximity to vulnerable residents with minimal to no PPE (Gerritsen and Voshaar 2020). The use of PPE was reserved solely for providing care to residents with confirmed and suspected COVID-19. This restriction on the use of PPE was probably partly motivated by the severe shortages in PPE during the first few weeks of the first wave. Furthermore, initial sick-leave policies for nursing home staff only allowed personnel with a fever to stay at home, whereas staff displaying only mild cold symptoms were asked to continue working (Schols et al. 2020).

The testing policy in nursing homes was rather restricted as well, perhaps partly motivated by a national shortage in testing capacity in the first few weeks of the first COVID-19 wave. Before April 6, 2020, elderly care physicians within nursing homes made the decision of whether to test residents for COVID-19 based on a national case definition of two of the following symptoms at minimum: fever or feeling feverish, cough or dyspnea (Schols et al. 2020). If two nursing home residents had already tested positive within an institution, the testing policy advised against testing any further due to a lack of available tests (Kruse et al. 2020a).

Prior to the pandemic, the LTC sector faced a shortage in care personnel. LTC institutions tried several methods to attract more personnel, including creating flexible worker schedules and reorganizing personnel responsibilities within LTC organizations. Personnel were encouraged to move between organizations to solve pressing shortages in staff (Kruse et al. 2020a). Toward the beginning of the pandemic, most nursing home organizations discouraged this mobility of professionals between nursing homes in fear of increasing the spread of the virus (Kruse et al. 2020b). Therefore, the pandemic worsened the LTC staff shortage situation.

Challenges for healthcare workers

The first concern of most employees was the risk of infection. Particularly, employees who had to work without access to PPE in close proximity to vulnerable residents felt anxiety around personal infection and feared infecting either vulnerable residents or their families

at home (Gerritsen and Voshaar 2020). The interviews revealed that some care personnel also experienced serious pressure from their own family members, who felt indignant about their perceived exposure to risk due to of lack of PPE and suggested that the employer should first take adequate measures (D1, N2, V1).

According to a survey with 2,902 respondents conducted by the Dutch Association of Nursing Staff, almost half the nursing staff expressed that they had experienced pressure to work without access to PPE (Kruse at al. 2020a). Initial sick leave policies asked staff members to continue working if they suffered from a mild cold without fever, which, in combination with initial restrictive testing policies and insufficient PPE, contributed to feelings of anxiety and not being heard (Schols et al. 2020). LTC personnel dealt with the shortage of PPE in different ways. Some reused the equipment or visited several patients with the same set, while realizing that this created additional risks in the spreading of the virus (N1). In some homes, care personnel used the same set for several visits in succession to one isolated resident during the whole day (N2, T2).

The compartmentalization of care and isolation practices reduced the risk of infections, but also generated additional challenges (Schols et al. 2020). In many care homes, personnel had to stay at the department for their entire shift. Interviewees mentioned there were no separate rooms where they could spend their breaks (D1, T2). Especially in departments for residents that suffer from dementia, it was impossible to keep distance and maintain isolation rules (Schols et al. 2020). Given their mental condition, residents were not able to understand these measures. For residents showing no symptoms of COVID-19, these rules were often relaxed; in cases of infection, however, there were some situations where care personnel didn't see other options than to use methods of coercion (T2).

The visitors' ban created additional challenges and a significant increase in workload for care personnel. Not only did they no longer have the care and support family and volunteers provided to residents, they now also had to organize digital and socially distant solutions for nursing home residents and their families (Verbeek et al. 2020). Creative constructions were often introduced; for instance, specific cabins with two compartments (Verbeek et al. 2020). In particular, the interviewees mentioned the "pausmobiel" (pope-mobile), a vehicle with glass sides in which families could visit their elderly loved one while staying protected (D1, N2). Especially for residents with dementia, this was the most comprehensible way of maintaining contact with their families (Verbeek et al. 2020). Occasionally, the visitors' ban was met with a lot of resistance from families who still insisted on seeing their family member in the nursing home (Verbeek et al. 2020). In some cases, serious threats against care workers were made (D1, T2). After the visitors' ban was lifted, monitoring family visits added to the workload, as some visitors did not respect the general behavioural measures as prescribed by the Dutch government (Verbeek et al. 2020).

Care workers also experienced emotional stress related to circumstances in which residents with COVID-19 passed away (N1, N2, T2). Care personnel working at the regular departments reported that some residents they knew quite well suddenly disappeared to

COVID-19–positive sections, and if they didn't recover, they never saw them again. This was often also the case for family members who were only allowed to visit in a rather limited way during palliative care, some of whom arrived too late due to the fatal deterioration of residents.

Altogether, this generated very high stress levels, placing both physical and mental consequences on staff well-being. According to the survey conducted by the Dutch Association of Nursing Staff, 74% of nursing staff indicated they experienced higher levels of pressure on their mental health due to the pandemic (Kruse et al. 2020a).

Support strategies for care workers

Not all LTC homes encountered shortages of PPE. Some responded immediately to the first signs that COVID-19 was spreading in Europe and ordered additional equipment, although Dutch public health authorities still advised that no additional measures were required. This surplus was shared with other nursing homes, coordinated within the regional crisis teams in which LTC homes worked together. After Dutch nursing home associations raised the alarm of a severe lack of PPE in the LTC sector, the government launched a new centralized PPE allocation mechanism on April 13, 2020, which improved distribution to LTC facilities. This new distribution mechanism gradually increased the availability of PPE for nursing homes by mid-April (Kruse et al. 2020a).

To reduce the workload, some nursing homes focused on providing support to their staff, asking psychologists, occupational therapists, social workers and activity coordinators within nursing homes to work with patients in addition to nursing staff (Gerritsen and Voshaar 2020; personal interviews). Team leaders and managers gave support in caring for residents too. In addition, military nurses were brought in and Red Cross volunteers were recruited, while personnel from the catering and aviation sectors delivered support in non–care-related tasks (Kruse et al. 2020b).

Many nursing homes established "helplines" for nursing staff to address any problems healthcare workers were facing and to share ways to take care of themselves and others (Gerritsen and Voshaar 2020). Some nursing homes asked their psychologists and social workers to provide mental health support to care personnel. Some of the interviewees indicated that they preferred the last option as they knew these professionals already and they were familiar with the specific situation care personnel had to work in (T1, T2, V1). They also reported that team spirit – colleagues noticing when someone had a tough moment, stepping in for each other and giving a sympathetic ear when required – was essential in dealing with mental and emotional burden of the work (T2, N2).

On a national level, nursing home personnel were included in the initiative to provide a bonus for healthcare workers to acknowledge the additional efforts they made to provide care as best as possible in very difficult circumstances (Rijksoverheid 2021). However, the practical implementation of the bonus, where many care workers were excluded or never received the bonus at all, probably caused the opposite of what was intended (van Essen 2021).

Discussion and Conclusion

The first few weeks of the COVID-19 outbreak within the Netherlands brought much uncertainty, as experts tried to develop an understanding of the never-before-seen SARS-CoV-2 virus. Nursing home staff continued to care for the elderly as safely as possible, trying to find a good balance between maintaining strict hygiene protocols and delivering quality personal care to residents (VWS 2020). The consequences of COVID-19 and the protection measures taken put nursing home personnel under significant mental and physical stress as they continued caring for susceptible residents. Lack of available PPE and testing capacity and the expectation to continue working even when presenting symptoms of sickness (other than fever) created fear among nursing home personnel and their families of infecting others or becoming infected. The visitor ban created additional strain, as professional nursing home personnel had to take over tasks normally done by family and volunteers and had to invent and organize alternative forms of communication between residents and their families and other social activities. Although additional personnel, such as health personnel from the military and the Red Cross, were mobilized, this was not enough to compensate for the shortage of staff, and it is mainly the resilience of nursing home personnel that kept the sector going. This investigation showed that management who arranged for PPE in anticipation of the pandemic; organized support from other nursing home health personnel, including team managers, in the daily nursing care of residents; and procured mental health supports for healthcare personnel, along with team spirit, probably contributed to this resilience.

This situation in LTC during the first wave of COVID-19 was not unique to the Netherlands. Many countries in and outside Europe encountered similar issues (Riello et al. 2020; Stelnicki et al. 2020; White et al. 2021). Shortage of personnel, for instance, was reported all over Europe, Canada, and the US (Kuhlmann et al. 2020; White et al. 2021). In these countries, a visitor ban was introduced in nursing homes as well, with huge implications for both residents and personnel. Together with lack of access to PPE, this put a huge burden on healthcare personnel in LTC internationally.

From the experiences during and challenges from the first wave, the Dutch Ministry of Public Health, Welfare and Sports and the LTC sector drew some important lessons (AWO-ZL 2020; VWS 2020). One of the most important lessons learned was the importance of focusing more on supporting the mental health and well-being of nursing home staff in times of emergencies. The provision of mental health support offers nursing home personnel the opportunity to seek help and openly speak about the stress they are facing (VWS 2020). As concluded in other studies, management has an important role here, both by making counselling and formal support services available for personnel and by encouraging peer support (Baumann and Crea-Arsenio 2022; Brandon et al. 2021; Lavoie-Tremblay 2022; Stelnicki et al. 2020). As mentioned in this study, a strong team spirit helped personnel to cope with the mental burden of the situation.

A second important lesson learned was the need to adopt a better balance of physical safety and quality of life in the national COVID-19 response. Looking back, the mandatory

nationwide visitor ban, which according to the ministry and LTC sector could have been avoided if access to PPE would have been in place, is no longer considered an appropriate measure (Verenso 2020a; VWS 2020). This visitor ban is now seen as a demonstration of focusing on the "medical model" mindset, where a strict top-down approach was implemented without acknowledging the importance of quality of life and input from the parties affected (AWO-ZL 2020). Similar conclusions with respect to the mandatory visitor ban have been drawn in other countries, such as Canada (Baumann and Crea-Arsenio 2022; Lavoie-Tremblay 2022).

Going forward, delegating some of the decisions rendered at the national government level to managers of nursing homes, might provide a better means by which to establishing the balance between safety and well-being (Verenso 2020a; VWS 2020). Providing this responsibility to managers would allow for more flexibility and customization according to the local circumstances and infections within nursing homes, rather than implementing a national strategy (AWO-ZL 2020; VWS 2020). Such tailor-made solutions would be designed in collaboration with all parties involved, including residents, families, and healthcare workers, to best fit the needs of all affected and better ensure a balance between strict hygiene protocols and quality of life. Opening lines of dialogue between stakeholders will ensure open communication and knowledge sharing from the start of an outbreak to the end (VWS 2020).

Finally, alleviating occupational stress also rests on addressing nursing home staffing shortages. As mentioned before, during the pandemic some *ad hoc* measures, such as bringing in military health personnel, Red Cross volunteers and staff from hospitality and aviation, were taken by governments and the LTC sector. Furthermore, encouraging former care staff to temporarily return and provide support, creating staff-lending systems across nursing homes, and allowing volunteers and nursing students to work more hours helped to address the staff shortage (Verenso 2020a; VWS 2020). But even more important than finding additional staff in times of emergencies is recruiting staff in regular times. A prerequisite to make work in nursing work more attractive is to reward it better, financially and symbolically. In the Netherlands, the trouble around the ad-hoc bonus generated serious concerns as to whether staff shortage in LTC will be addressed adequately soon. As in other countries, the LTC sector was neglected for a long time and desire to work in the sector is relatively low (Baumann et al. 2022; Kuhlmann et al. 2020; Lavoie-Tremblay et al. 2022; Stelnicki et al. 2020). To make LTC disaster-proof in the future, a drastic change in policy is needed internationally.

Limitations

Limitations of this study relate to the period during which this descriptive review was made – relatively shortly after the first wave of COVID-19, with the pandemic still ongoing. In this continuously evolving situation, new research and reports were released; with greater distance, insights and evaluation may change along with more long-term impacts of the crisis.

Furthermore, only a limited number of interviews were performed. Although information from these interviews was valuable, we did not reach saturation, so we may have missed some of the challenges healthcare personnel were confronted with and/or measures taken to address these challenges.

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