



‘Going through the Eye of the Storm’: The Impact of Covid-19 on the Long-Term Dementia Care Workforce

RESEARCH

ANDREA CAPSTICK 

GIORGIA PREVIDOLI 

ANA BARBOSA 

CLARE MASON 

*Author affiliations can be found in the back matter of this article



ABSTRACT

Context: Official guidance on Covid-19 failed to take account of the prevalence of dementia among people living in care homes or its implications for implementing infection control measures.

Objective: To gain insight into the experience of those charged with implementing Covid-19 restrictions in long-term dementia care environments.

Methods: Twenty members of the long-term dementia care workforce shared their experiences, using interviews, online discussion groups, or written personal accounts.

Findings: Thematic analysis identified four key aspects of the participants’ experience: 1) Confusion and stress arising from the implementation of new policies, which changed very frequently; 2) The negative impact of measures such as social isolation, PPE, and coronavirus testing on people living with dementia and their families; 3) The impact on their own mental health and well-being over time; 4) Creative problem-solving and collaboration in the face of these challenges. Analysis suggests that the social care dementia workforce faced many of the same challenges identified for acute healthcare workers, with the addition of a sense of personal bereavement and responsibility when residents died.

Limitations: The study is United Kingdom (UK)-dominated. Data were collected retrospectively and relate predominantly to the first wave of the pandemic. Most participants were studying on a MSc programme on which the first and third authors teach.

Implications: Future guidance to care homes must take account of the high numbers of people with cognitive difficulties living in such environments. Co-designed strategies are needed to address the longer-term implications of Covid-19 for the social care dementia workforce.

CORRESPONDING AUTHOR:

Dr. Andrea Capstick

University of Bradford, GB
a.j.capstick@bradford.ac.uk

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INTRODUCTION

David Cameron's Prime Minister's Challenge, launched in 2015, pledged to make Britain the best place in the world to live with dementia by the year 2020. When coronavirus hit the dementia social care sector early in 2020 this was already far from the reality. Long-term care for people living with dementia was already in crisis due to chronic underfunding and understaffing (Yeatts et al 2018). People living with dementia in care homes were among the most severely affected members of the United Kingdom (UK) population during the Covid-19 pandemic (Alzheimer's Society 2020; Cousins et al 2021).

For some time after its onset, there was little acknowledgement by the British government of the pandemic's impact on long-term care, and care home deaths were not included in nightly news reports for several weeks. At this point the focus was almost entirely on deaths in hospital; and there was, as Daly (2020: 985) points out, 'a slow, late and inadequate response to the risk and reality of COVID-19 in care homes as against that in the National Health Service'.

Between March 2020 and January 2022 there were 45,632 Covid-19 related deaths of care home residents in England and Wales (Office for National Statistics 2022). By the end of 2021 there had been more than 3,700 deaths of Scottish care home residents (Scottish Care Inspectorate 2021) and over 1,100 in Northern Ireland (Northern Ireland Statistics and Research Agency 2021). Estimates suggest that up to 86 per cent of care home residents in England and Wales have dementia (Comas-Herrera et al 2021) so it is reasonable to conclude that there have been well over 40,000 deaths of care home residents with dementia in the UK; approximately 25 per cent of all deaths recorded to date.

In addition to those who died from coronavirus, many care home residents with dementia experienced a serious deterioration in their physical or mental health due to prolonged periods of physical confinement and social isolation. There were also many excess deaths, not directly related to Covid-19 itself, and these have been attributed to mental and physical deterioration as a result of social isolation (Briggs et al 2021) and delays in treating other conditions (Burns and Howard 2021). The Office for National Statistics (ONS) which covers England and Wales recorded more than 5,000 excess deaths among people living with dementia in the first four months of the pandemic alone. In spite of the existence of an active All-Party Parliamentary Group (APPG) on Dementia, the UK Government seemed to take little account of either the nature of dementia, or its prevalence in care homes, when devising guidance for this sector.

THE IMPACT OF CORONAVIRUS ON THE DEMENTIA WORKFORCE IN SOCIAL CARE

Early in the Covid-19 pandemic, most published work focused on the experiences of National Health Service

(NHS) staff and took the form of commentaries and reviews drawing inferences from previously published work (see, for example, Blake et al 2020; Greenberg et al 2020; Magner et al 2021; Mo & Shi 2020). Challenges for healthcare workers noted by these authors include anxiety related to unclear guidelines, rapid changes in guidance; emotional strain and physical exhaustion from the provision of care to very frail patients, fear of contamination for themselves and their families, and moral injury (psychological distress resulting from action, or lack of action, which violates their usual moral code).

A cross-sectional survey carried out by Lai et al (2020) provided early evidence that front line workers in China were experiencing similar psychological consequences as a direct result of the coronavirus pandemic, with half of all respondents reporting symptoms of depression. In-depth interviews carried out with geriatric nurses from Spain, Italy, Peru and Mexico found that all four groups were exhausted and overwhelmed as a result of their experiences (Serabia-Cobo et al 2020) and interviews carried out with chaplains in older people's care facilities in the Netherlands found evidence of moral distress as a result of the pandemic (van der Geugten et al 2022).

Shaukat et al (2020) and Spoorthy et al (2020) highlight similarities between health care staff and those working in social care, suggesting that their experiences are likely to be similar. Indeed, there are additional challenges for the social care workforce. First, compared to healthcare professionals working in hospital, the care home workforce is accorded less social value (Nyashanu et al 2020). They are less well-paid, and opportunities for career progression are limited (Pautz et al 2020). There is also a legacy of systemic failures and structural inequalities resulting from austerity measures (Goodman et al 2020). Those working in long-term care tend to form lasting bonds and close relationships with their residents, whose deaths are thus often experienced as personal bereavements (Marcella & Kelley 2015). It might therefore be argued that feelings of grief, guilt and responsibility will be more intense in such long-term care environments than in an acute hospital setting.

There is, as yet, relatively little empirical research on the impact of Covid-19 on the dementia care workforce, and qualitative studies are still rare. In an early survey of English care home providers, Rajan et al (2020) found that the guidance to care homes changed frequently and was often reported to be self-contradictory or impossible to implement. A rapid review conducted by Embregts et al (2020) suggests that because people living with dementia often have difficulty comprehending or retaining new information, infection control measures taken in long-term care cause agitation and distress among residents unable to retain explanations of why such measures are needed. A survey carried out by Brady et al (2021) in the Republic of Ireland found moderate to

severe post-traumatic stress disorder (PTSD) in 45.1 per cent of nursing home staff, and a systematic review by Gray et al (2021) identified similar findings in studies from eleven countries including the UK. In one of the earliest qualitative studies to be published relating specifically to dementia, Briggs et al (2021) found increased stress and mental health problems among care home staff.

Towers et al (2020) point out that future guidance needs to be co-designed with workforce members who have lived through the pandemic, and understand from first-hand experience what needs to change. This article aims to contribute to that project by sharing findings on the lived experiences of those working at the front line of social care provision for people living with dementia during the pandemic. The article also reports on coping strategies adopted by the dementia workforce in order to support their own and their residents' well-being.

METHODS

RECRUITMENT

The study team recruited 20 dementia care practitioners (18 female, 2 male) who either worked directly in long-term dementia care environments (residential and nursing homes) or in allied services which brought them into contact with care homes during the period in question (March to June 2020) e.g. social services, those social enterprises with clients admitted to long-term care during the pandemic. Fifteen participants were based in England, with one each from Isle of Man, Republic of Ireland, Canada, Australia and Germany.

The majority of participants were students on a part-time Masters' degree programme in Dementia Studies run by the University where the first and third authors teach. One participant was a student on a different programme within the same Faculty, and one was initially recruited to the PPI (Patient and Public Involvement) group (see below) as a relative of a person living with dementia in a care home, but chose to switch to being a participant as s/he also worked in a care home.

ETHICS

Ethics approval was granted by the University's Humanities, Social and Health Sciences Committee for Ethics in Research on 30 July 2020 (Ref E825). It was recognised that participants would be undergoing stressful situations both at work and at home due the pandemic, and that some may be experiencing, or might experience in future, mental health problems, including PTSD, as a consequence of these experiences. Participants self-selected for involvement in the study, were able to contribute as much or as little as they wished using a choice of data collection methods, and were directed to relevant sources of help and support, should they feel they needed it, including Shout, the UK 24-hour crisis line for frontline health and social care workers, and

its overseas equivalents. The team held regular project update meetings which participants could attend and discuss any problems or concerns. Participants were given a number code on joining the study, and all data used was anonymised to ensure that individual persons or care organisations could not be identified.

Data were anonymised, and transcribed where required by a researcher (second author) who had no involvement with the MSc programme, or previous relationship with participants. The information sheet assured students that not taking part would have no impact on their studies.

PATIENT AND PUBLIC INVOLVEMENT (PPI)

The project had a dedicated PPI lead (fourth author). Four Experts by Experience were recruited in total, one of whom was employed in a care home, and later decided to take part as a research participant. The remaining three members, all white British and female, each had one or more relatives living with dementia in a UK care home between March and June 2020. The PPI group members took part in regular discussions with the participants and researchers via Zoom, sharing their experiences, giving feedback on data collection methods, contributing to identification of emerging themes from the data analysis, and writing for the regular project blog series.

People living with dementia in the community were invited to join the PPI group, but responses the study team received suggested that the negative impact the coronavirus pandemic was already having on their lives, under the social distancing restrictions then in place, made them reluctant to contribute to Covid-related research. In addition several commented that they did not have experience of care homes.

DATA COLLECTION

The study team understood that it would be difficult for participants to take part in research whilst also studying and dealing with the problems posed by the pandemic itself. As a result participants could choose to take part either by semi-structured online interview (seven participants), written response submitted by email (eight participants), or asynchronous online discussion forum (five participants).

Questions, which were the same regardless of the mode of response, are shown in [Table 1](#).

A further phase of the study, not discussed in this article, used photovoice methods to elicit participants' experiences of living and working through the pandemic (Capstick and Barbosa 2022).

DATA ANALYSIS

The average length of interview was one hour. Written responses varied from a few lines to several pages. Thematic analysis was carried out using an immersive approach to the whole data set, following an approach recommended by Nowell et al (2017) for enhancing

How did your work bring you into contact with people who have dementia during the pandemic?
What stands out most in your memory about the beginning of the lockdown period?
What was it like in your workplace (or care home you have contact with) then?
What have been the main problems or concerns for care staff you work with?
Is there a particular incident related to the care of a person, or people, with dementia that stands out in your memory?
What was the worst thing that happened?
What was the best thing that happened?
Is there one piece of learning from this experience that you would like to pass on?

Table 1 Questions for participants.

the trustworthiness of qualitative data analysis. Lincoln and Guba (1985) suggested that trustworthiness in qualitative research is established by adherence to four criteria: credibility, transferability, dependability, and confirmability, and that this parallels the conventional quantitative research criteria of validity and reliability. Within this study the four criteria were met in the following ways: the interview/prompt questions were piloted with one participant during an online focus group attended by the research team and two PPI group members; the lead author and second author read the contributions of all 20 participants several times; the lead author coded potential themes, checking these with the co-authors and PPI group. When a consensus was reached about key themes, a final check was conducted to ensure all relevant data were accounted for.

RESULTS

Four key aspects of the participants' experience of the first wave of the coronavirus pandemic were identified: 1) Confusion and stress arising from the implementation of new policies, which changed very frequently; 2) The impact of measures such as social isolation, PPE and coronavirus testing on people living with dementia and their families; 3) The impact on participants' own mental health and well-being over time; 4) Creative problem-solving and collaboration in the face of challenges.

A significant overall finding was that although the questions in Table 1 were intended to elicit their own experiences of the pandemic, participants tended to refer first to the impact of Covid-19 on the people living with dementia and their families with whom their work brought them into contact. References to the worst thing that happened, for example, were almost invariably something that had affected one of their clients or residents, rather than themselves. The impact on their own emotional well-being was usually more difficult to elicit and tended to emerge later in the data collection process, somewhat independently of the prompt questions. Findings under each of the four key themes are presented below.

THEME 1: "WHAT'S WRONG? WHAT'S RIGHT?" CONFUSION AND STRESS ARISING FROM FREQUENT CHANGES OF GUIDANCE

Almost all participants referred to a sense of disorder, and even of chaos, in the early stages of the pandemic. This was frequently related to issues around risk management and infection control. There was considerable uncertainty around diagnosis and symptomatology of coronavirus, as well as the measures taken to control its spread. Government guidance was noted to have changed frequently and was often impossible to implement in practice. A lack of clear information from official sources was mentioned by almost all participants.

P13: The guidance changed every day... We had a big staff meeting, because we were all getting so worked up and wondering, 'What's wrong? What's right?'

Whilst it may not be literally true that guidance changed every day (one participant even said 'every hour') this exaggeration conveys the participant's sense of loss of control and the impossibility of keeping up with changes. This general uncertainty was increasingly compounded by the realisation that specific guidance related to people living with dementia was either inadequate or missing altogether, and that promised support was not materialising.

P9: And it's like, it's, it's not clear and it's just kind of been left hanging,... you know, 'What about people with dementia's needs?' 'What about them?'

P11: There was talk of there being volunteers to support the home through staffing shortages. None of that ever seemed to happen. There was never a magic number that you could ring if you were short.

As hospitals tried desperately to free up space to treat acute cases, there was a move toward discharging hospital patients to care homes. Participants felt pressured to accept these admissions, and this led to a heightened sense of personal responsibility. Fear

of making the wrong decision was also frequently mentioned, particularly in the face of remote or unclear leadership.

P15: We were initially advised that those potentially with the virus would be quarantined on one unit. This didn't happen and no explanations were given as to why. Those admitted from hospital were sprinkled across the whole home.

P11: I was very aware that if I made the wrong call it could have devastating effects. The impact of that responsibility on my shoulders... The director just never came into the home at all once the pandemic was declared.

Due to discharges from hospital to care homes, or other sources of infection, coronavirus had often spread rapidly among residents, resulting in varying numbers of cases and deaths. A number of participants had witnessed deaths from coronavirus, and some commented on the traumatic nature of these fatalities:

P14: Raymond eventually passed away, but not peaceful. For a few hours he struggled to breathe... The experience was all very traumatic; I have seen many people pass away in my role, but Raymond will stay with me.

P13: The nursing home was split, with the upstairs for advanced [dementia] and downstairs more residential. Suddenly, you went upstairs and it was just silence.

I think we had maybe three downstairs. It was mostly upstairs that they got the virus.

THEME 2: "A WHOLE CRAZY, HOT POTATO KIND OF SITUATION": THE IMPACT OF SOCIAL ISOLATION, PPE, AND CORONAVIRUS TESTING

In addition to concerns about infection control, the implications of lockdown for the well-being of people living with dementia became more apparent over time, resulting in a perpetual juggling act in which keeping people safe and keeping them happy were often at odds with each other. This often led to a marked deterioration in emotional well-being, as family visits, socialising between residents and outdoor activities ceased. As Participant 1 refers to (at least indirectly) below, guidance on infection control was often in direct contradiction to other requirements of care home providers, such as Deprivation of Liberties Safeguarding (DoLS),

P1: We were in constant contact with infection control, saying, 'But I can't keep them in their room, right?...I know that, ideally, I should keep

them in their room, but they won't stay in their room and I can't lock the door? What can I do?' ...It's just been a whole crazy, hot potato kind of situation.

P3: For weeks Vera was not allowed to see family and spent her days trying to get the bus home and waiting at the door. Her husband suddenly passed away and Vera was given this news over Facetime and not allowed to see any family to help process the news.

Whilst many homes tried hard to maintain contact between people living with dementia and their families, using means such as window visits and online interfaces, the shortcomings of these forms of communication quickly became apparent.

P3: Henry's wife... would come daily to visit him at his window but there was no touch exchanged, no holding of hands, washing his face, or giving him a kiss... Thankfully she was able to come in to visit in person during his final days.

P20: Although we eventually set up some online resources, the technology was a barrier for some of the people who were feeling the most isolated.

The lack of personal protection equipment (PPE) and inconsistency in guidance on its use were frequently mentioned as a problem in the early stages of the pandemic. Even though ingenuity was often used to source supplies of PPE, participants felt they and their residents had been left exposed to potential harm. Over time, it also became apparent that caring for people living with dementia whilst wearing PPE raised its own problems:

P5: We had to ring round the local vets and dentists asking for gloves, because our order of gloves wasn't guaranteed to come... If it hadn't been for the generosity of the community, we wouldn't have had any of the PPE that we needed.

P6: When he went into isolation for 14 days [he] struggled with recognising the carers due to the PPE and at times this made him suspicious. This... may have been a factor in him deteriorating.

Participants recounted experiences of coronavirus taking precedence over other aspects of healthcare, leading to delays in treatment.

P10: [She] fell in the care home and we suspected she fractured her hip. It was felt in her best interests [by a GP and a hospital doctor] to

keep her at the care home and not admit her for treatment, as they felt her risk of catching Covid-19 was too high...The care home found it difficult to manage her pain and distress....

Not all stories were negative, however. One participant recounted the story of a man living with dementia who had become ill under lockdown, whilst living alone in the community. Admitted to a care home for six weeks of rehabilitation, he made a good recovery, reflecting the important but rarely-acknowledged role that care home staff played in keeping the majority of their residents safe and well during the crisis.

P8: He recovered from his delirium as well as put on weight. Recently... he seems quite similar to how he was pre lockdown, so it's been great that he has recovered so well.

THEME 3: "WE HAVE HAD A HARROWING TIME": IMPACT ON THE MENTAL HEALTH AND WELL-BEING OF THE SOCIAL CARE DEMENTIA WORKFORCE

Dominant feelings reported in the early stages of the pandemic were shock, disbelief, fear, uncertainty, apprehension and dread. As time went on and residents began to fall ill and die, these feelings changed to guilt, loss and grief. Uncertainty about the duration of lockdown conditions was also a factor contributing to the stress participants experienced during this phase.

P9: ...None of us really knew how long the lockdown was going to continue for... Although we all took on board the new way of working... it didn't really help with the trauma that we were seeing.

Some participants mentioned their emotional state at this time had been affected by the relative lack of attention being given by the outside world to the plight of care homes; a feeling that they were 'out of sight, and out of mind'. This was exacerbated by the weekly 8 pm doorstep 'Clap for the NHS' which took place in the UK in the first 12 weeks of lockdown, which they felt implied that they or their clients were not a priority by comparison. Participant 4 here makes an interesting reference to being put on the 'back line' in direct distinction to 'front line' NHS workers.

P4: We all clapped, every single Thursday, without fail, because, at the end of the day, they [NHS workers] were doing a really good job, but we just felt that we were put a little bit on the *back line*. There was all that support for the NHS, as in you know, they need the PPE, but we needed it as well and we couldn't actually get hold of it.

Coronavirus cases started to rise again in the autumn of 2020 while the study team were still collecting data, and reports of feeling burnt out and unable to cope increased at this point. Loss of a sense of personal efficacy also played a part in generating these feelings.

P9: ...That sense of just feeling quite rubbish about it, that you couldn't make life any easier, because there was... no light at the end of the tunnel. It was just 'That's how it is now', and we've just got to live with it.

Participants were aware that the repercussions of the pandemic were likely to continue for a long time, and that without proper support or acceptance of responsibility by those in authority, this was likely to have further implications for their own and others' well-being.

P1: We've gone through the eye of the storm, the height of the pandemic. Now it feels that we're very much going to be dealing with the fallout.

THEME 4: 'GOING ABOVE AND BEYOND': TEAMWORK, CREATIVITY, AND RESILIENCE

On a more positive note, many participants mentioned improved relationships with colleagues during this period. Often these changes helped to mitigate negative impacts of the pandemic, and the resulting teamwork approach and multi-tasking were frequently mentioned as the best thing to come out of the pandemic. Many participants referred to 'going the extra mile', working long hours and making personal sacrifices in order to keep things going. In some care homes relationships between staff and residents changed too.

P13: We got so close to everyone we were working with. It was like working with your best friends. Before, we had our separate lives. During the lockdown that was our life, so we just ended up being like this family. I think that was the best thing.

P7: We had to do our own laundry. So, you know, we've got [residents] who could motor around, to pick up the laundry, help load the washing machine... So, we were running it as if it was a family, a big family house.

Some care homes had taken their own measures to support staff, including drawing on support from volunteers:

P11: A retired nurse that used to work here came back to do some volunteering. The staff can go and talk to her. It is totally confidential. They have a safe place to go and just say how they feel.

Despite what they had endured, several participants expressed hopes that the coronavirus pandemic would be taken as a lesson in how things need to change in long-term social care for people living with dementia.

P18: As much as it has caused pain and uncertainties, I remain hopeful that Covid-19 will bring about a much needed change in aged care, especially for those living with dementia.

DISCUSSION

The findings from this qualitative study add support to the previous quantitative research carried out by Rajan et al (2020) and identify evident breaches of the ‘ring of care’ the UK government claimed to have thrown around care homes. It is also clear that the social care dementia workforce experienced many of the same challenges identified in research related to NHS staff. First, as found by Mo and Shi (2020) almost all participants referred to confusion and stress related to unclear and rapidly-changing guidelines. In some cases, changes of direction or lack of guidance on issues such as testing on (re)admission from hospital to care homes had led to fatalities. There was an evident burden of undeserved guilt for members of this workforce. In keeping with the findings of Blake et al (2020) participants reported extreme emotional strain and physical exhaustion from the provision of care to very frail residents. They gave examples of working long hours with little time for recovery between shifts, and having to care for residents with serious illnesses or injuries within the care home environment, due to the halt on hospital admissions.

Participants also referred to experiencing moral injuries (Greenberg et al 2020). For example, whilst family members were prevented from visiting care homes, the same care homes were often pressured to admit older people who were already infected with hospital-acquired coronavirus. Practitioners were thus forced to enact guidance which they believed to be unfair on the one hand and dangerous on the other, a clear violation of their moral codes. By comparison, fear of contamination for themselves and for their families (Lai et al 2020) was less of an overt theme emerging from this body of data, although several participants had, themselves, been ill with coronavirus.

As in previous research by Nyashanu et al (2020) there were indications that participants were aware of themselves as a less elite group in the public imagination than front line healthcare staff. This tended to emerge in references to being excluded from public forms of valorisation such as the UK’s weekly clap early in the pandemic, given less priority for personal protection equipment (PPE), put under pressure to take admissions to relieve the NHS, and not receiving additional support

with their own needs (e.g. from the promised volunteer register). None of the participants referred directly to inadequate pay or lack of career structure as sources of personal grievance.

In line with the findings of Embregts et al (2020) participants made numerous references to the difficulty—and in some cases impossibility—of implementing non-dementia specific guidance within dementia care environments and their frustration and despair over this was often palpable, particularly in the case of residents who believed their families to have abandoned them. There was also much evidence of grief, bereavement, and conditions consistent with personal or vicarious trauma (Benfante 2020) when residents died. This was particularly noticeable when the relationship had developed over a number of years, or when death resulted from the emergency admission of hospital patients who were found to have coronavirus.

The novel findings of this study are, first, that participants most often related their answers to interview questions to the well-being of people living with dementia and their families, rather than to their own safety or mental health. Second, participants also told us of many creative coping strategies they had adopted to deal with the situation. Whilst much has been said in recent months about the need to develop resilience in order to ‘build back better’, participants in this study have already demonstrated resilience, creativity, team-building and innovative approaches during the course of the pandemic. Rather than imputing blame or imposing rescue packages from the outside, the UK government now needs to listen to, and learn *from*, this seldom-heard workforce.

LIMITATIONS OF THE STUDY

This study has a number of limitations. First, it is UK-dominated, with 15 participants from England, and five from outside the UK. Challenges in other countries may have been broadly similar, but national responses and support mechanisms clearly differed. We have taken care not to draw inferences about the situation within the UK from data related to other countries, whilst still including some data which reflect commonalities of experience internationally.

Second, due to funding constraints, and study pressures for participants, the period of time during which data was collected was limited to August–November 2020. At the beginning of this period it was widely believed that the peak of the pandemic was over. Participants also shared their experiences retrospectively and this may have impacted on the trustworthiness of the data. The degree of consistency between accounts, and robustness of the key themes which emerged, suggest this was not a major problem but, ideally, it would have been helpful to repeat the data collection at more than one point in time, in order to check whether participants’ memories of what happened remained consistent.

Third, this was a convenience sample, made up of participants most of whom were studying on a MSc programme on which the first and third authors teach. This could be considered a power imbalance, leading potential participants to be more likely to agree to take part, and to provide compliant answers. This limitation is mitigated by the fact that the students in question were adult learners on a distance learning programme, many of whom held responsible posts in their workplace. Data from these participants were also collected by a researcher not previously known to them, and there is little evidence that they painted an unduly positive picture of the care provided by their organisation or themselves personally. Indeed, most participants disclosed feelings of guilt, sorrow and inadequacy which appear very genuine.

CONCLUSIONS

The lived experience of those who work in care homes for people living with dementia has been almost entirely elided from public discourse about what happened during the Covid-19 pandemic. They were placed under immense pressure to implement policies that were not designed for people with cognitive difficulties, and faced with an apparent inability at government level to anticipate the impact of successive waves of new guidance on this client group. In the aftermath of Covid-19 more research now needs to be done to enable care provider organisations to retain experienced staff in difficult times. Although the UK government's recent publication *Building Back Better: Our Plan for Health and Social Care* (Department of Health and Social Care 2021) earmarks new funding for staff training in the aftermath of Covid-19, there is a danger, in the current climate, that 'quick fix' solutions may be adopted, and these are unlikely to be cost-effective over time. Instead, an approach is needed more in keeping with the principles of restorative justice. This rests on hearing the voices of those who have suffered moral injuries and using those experiences to inform the future co-design of guidance for care homes in the case of continued waves of coronavirus, or other epidemic or pandemic diseases. Mazzucato (2020) an international expert on restorative justice, draws on principles set out by the United Nations (2005; 2006; 2017) to summarise the steps that are needed (see Table 2).

To bear witness to what has been endured
To preserve the memories of those who have been lost
To guarantee non-recurrence
To promote healing and reconciliation
To restore confidence in the institutions of the State

Table 2 Principles of restorative justice (Mazzucato 2020).

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COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR AFFILIATIONS

Andrea Capstick  orcid.org/0000-0002-6775-0266
University of Bradford, GB

Giorgia Previdoli  orcid.org/0000-0002-9932-0586
Bradford Institute for Health Research, GB

Ana Barbosa  orcid.org/0000-0001-9644-8237
University of Bradford, GB

Clare Mason  orcid.org/0000-0003-1623-6029
University of Bradford, GB

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